

A-15769 / tg



**MASTER GROUP CONTRACT
(DELTA DENTAL PPO PLUS PREMIER™)**

THIS CONTRACT is made between Delta Dental of New Jersey, Inc., of Parsippany, New Jersey, (hereinafter referred to as "Delta Dental®") and

Group Name: City of Atlantic City
Group No.: 09826
Group Address: 1301 Bacharach Blvd., 416
Atlantic City, NJ 08401

(hereinafter referred to as the "Employer")

FOR AND IN CONSIDERATION of the mutual covenants set forth herein, acceptance of the Application which is made a part of this **Contract**, and payment of the **Contract Charges**, **Delta Dental** and the **Employer** agree and are subject to the terms, obligations and responsibilities described in this **Contract**. **Employer's** payment of **Contract Charges** as they appear in the **Contract** shall be deemed acceptance of the **Contract** terms and shall not require **Employer's** signature.

Date: July 1, 2025

DELTA DENTAL OF NEW JERSEY, INC.

By: _____

Paul J. Di Maio
President

ATTEST:

CITY OF ATLANTIC CITY

BY: Paula Geletei
Paula Geletei, City Clerk

BY: Marty Small, Sr.
Marty Small, Sr., Mayor

DATE: 7-23-05

WITNESS

SEE FRONT PAGE
DELTA DENTAL

BY: _____
President

The Agreement is approved as to form and execution.

Date: 7/21/05

BY: Peter T. Sallata
Peter T. Sallata, Esq.
Assistant City Solicitor

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ARTICLE I - TERM OF CONTRACT

1. The "Effective Date" of this Contract is July 1, 2025.
2. The "Contract Term" of this Contract is the period of ¹² ~~24~~ months, commencing on the Effective Date, and each succeeding ¹² ~~12~~-month period for as long as this Contract remains in force (each ¹² ~~12~~-month period is a separate Contract Term.).
3. The "Anniversary Date" of this Contract is July 1, 2026 and the 1st day of July of each subsequent year for as long as this Contract remains in force.

ARTICLE II - DEFINITIONS

1. "Allowed Amount" means the fee amount used in calculating the Benefit for the given Covered Service. The Benefit may be less than the Allowed Amount due to Benefit Limitations. The Allowed Amount may be less than the Approved Amount.
2. "Alternate Treatment Limitation" means the Benefit under this Contract is based on the least costly Covered Service Delta Dental determines is sufficient for the diagnosis or treatment of a dental problem.
3. "Another Delta Dental Plan" means a Delta Dental member company in a state other than New Jersey and/or a Delta Dental member company affiliate of such corporation.
4. "Approved Amount" means the total fee which the Delta Dental Premier Dentist or the Delta Dental PPO Dentist has agreed to accept as payment in full for the Dental Service provided. It includes both Delta Dental's Benefit Amount and the Covered Person's payment obligation. For Non-Participating Dentists it is the fee actually charged for the Dental Services provided.
5. "Benefit" or "Benefit Amount" is the dollar amount which Delta Dental will pay under this Contract toward a Covered Service.
6. "Benefit Limitations" are restrictions on the Benefit Amounts payable under this Contract. Benefit Limitations include the following: (a) the Coverage Percent specified in Article IV Section 3; (b) the Deductible amount specified in Article IV Section 3; (c) the Benefit Maximums specified in Article IV Section 3; (d) the Limitations and Specific Exclusions described in Article IV Section 4; and (e) the General Exclusions contained in Article IV Section 5.
7. "Benefit Maximum" means the total dollar limit that Delta Dental will pay toward Covered Services for each Covered Person during a Coverage Period.
8. "Civil Union" means a Civil Union under the New Jersey Civil Union Act (L. 2006, c. 103) or a same sex relationship validly established under the law of another state that gives substantially all of the rights and obligations of married couples.
9. "Civil Union Partner" means a person who is a party to a Civil Union.

10. **"Claim"** is a request to **Delta Dental** to pay a **Benefit** under this **Contract**.
11. **"Coinsurance Percent"** means the percentage of the **Allowed Amount** for a **Covered Service** paid by a **Covered Person** after any applicable **Benefit Limitations**.
12. **"Completion Date"** means the date that a **Dental Service** is finished. Most **Dental Services** are finished in one day. The **Completion Date** for multistage **Dental Services** is defined in Article IV Section 6 of this **Contract**.
13. **"Comprehensive"** means when a **Dental Service** is inclusive of a related **Dental Service**. For example: periodontal osseous surgery is the **Comprehensive Dental Service** as it includes not only a periodontal flap procedure but also flap entry and closure.
14. **"Contract"** means this document.
15. **"Contract Charge"** is defined as the rate or dollar amount paid or payable on a monthly basis for coverage under this **Contract**.
 - (a) The **"Employee"** rate is defined to be the rate covering the **Employee** only.
 - (b) **"Employee & Spouse Rate"** is defined to be the rate covering the **Employee** plus his/her **Spouse**.
 - (c) **"Employee & Child(ren) Rate"** is defined to be the rate covering the **Employee** plus any number of children.
 - (d) **"Family Rate"** is defined as a composite rate of the "Two Party" and "Three Party" rates. The Family Rate is applicable to all **Employees** having **Dependent** coverage.
16. **"Coverage Effective Date"** means the date, beginning at 12:01 a.m., that the **Covered Person** becomes eligible for **Benefits** under this **Contract**.
17. **"Coverage Expiration Date"** means midnight on the date that all **Covered Persons** stop being eligible for the **Benefits** under this **Contract**.
18. **"Coverage Percent"** means the percentage of the **Allowed Amount** to be paid by **Delta Dental** for a **Covered Service**. It is specified in Article IV Section 3 of this **Contract**.
19. **"Coverage Period"** means the term of this **Contract**, in months, beginning on the **Coverage Effective Date** and ending on the **Coverage Expiration Date**, during which most covered **Dental Services** must be completed by the **Completion Date** as defined in this **Contract** to be eligible for a **Benefit** under this **Contract**.

20. **“Covered Person”** is defined to be the eligible **Employee** (as defined in Article III Section 1. It may also include each eligible **Dependent** for whom **Contract Charges** are being paid under this **Contract**. A **Covered Person** shall cease to be covered by this **Contract** at the point when such **Covered Person** ceases to meet the definition of **Employee** and/or **Dependent**. A **Covered Person** shall also cease to be covered if coverage is otherwise terminated under the provisions of this **Contract**.
21. **“Covered Service(s)”** are defined as **Dental Services** that are listed under the heading “Description of Eligible Dental Services” in Article IV Section 4. **Covered Services** are eligible for payment of **Benefits** under this **Contract** subject to applicable **Benefit Limitations**.
22. **“Deductible”** means the specified dollar amount that a **Covered Person** is required to pay toward a **Covered Service** each **Coverage Period** before **Delta Dental** will pay any **Benefit** toward the **Covered Service**. That dollar amount is specified in Article IV Section 3.
23. **“Delta Dental®”** means **Delta Dental** of New Jersey, Inc.
24. **“Delta Dental Participating Dentist”** is defined as a **Dentist** who participates in the Delta Dental network either as a **Delta Dental Premier Dentist** or as a **Delta Dental PPO Dentist**.
25. **“Delta Dental PPO™ Dentist”** means a **Dentist** who has a **Delta Dental PPO Dentist** agreement in force with **Delta Dental** or, in states other than New Jersey, is a **Dentist** identified by **Another Delta Dental Plan** as a **Delta Dental PPO Dentist**. They are listed in the most recent Directory or listing of **Delta Dental PPO Dentists**. For purposes of this **Contract**, a **Delta Dental PPO Dentist** has agreed to perform eligible **Dental Services** under this **Contract** and accept payment from **Delta Dental** on the basis provided in this **Contract**. For purposes of this **Contract**, a **Delta Dental PPO Dentist** does not include a **Delta Dental Premier Dentist**.
26. **“Delta Dental Premier® Dentist”** is defined as a **Dentist** who (a) is licensed to practice **Dentistry** in the State of New Jersey and has a participation agreement in place with **Delta Dental** and has agreed to perform eligible **Dental Services** under this **Contract** and accept payment from **Delta Dental** on the basis provided in this **Contract** or (b) is authorized to practice **Dentistry** in any other state and is bound by virtue of an agreement between **Delta Dental** and **Another Delta Dental Plan** to accept payments from **Delta Dental** on the basis provided in this **Contract**. For purposes of this **Contract** a **Delta Dental Premier Dentist** does not include a **Delta Dental PPO Dentist** as defined in this **Contract**.
27. **“Dental Service(s)”** means dental treatment and related procedures rendered by a **Dentist** or oral surgeon or other person duly licensed to render that treatment by the state in which they were rendered.
28. **“Dentist”** means a person duly licensed to practice **Dentistry** in the state in which the treatment is rendered.

29. **"Dentistry"** is defined as the evaluation, diagnosis, prevention and/or treatment (non-surgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a **Dentist**, or another person duly licensed to render that treatment by the state or country in which they were rendered within the scope of his/her education, training and experience.
30. **"Dependent"** is defined as each person who meets the criteria established by the **Employer**. This is described in the Endorsement to this **Contract**. This is also any person who is entitled by law to be covered incident to the **Employee's** coverage.

For purposes of this definition, **"Dependent"** shall include the **Employee's Spouse**, a former **Spouse** for whom the **Employee** is legally liable to provide dental coverage, a **Civil Union Partner** or **Domestic Partner**, a biological child, stepchild, foster child, legally adopted child, child of the **Employee's Spouse, Civil Union** or **Domestic Partner**, and children under a court appointed guardianship. Persons in military service are not eligible to be **Dependents** under this **Contract**.

31. **"Domestic Partner"** means a person who is a party to a domestic partnership under the New Jersey Domestic Partnership Act, N.J.S.A. 26:8A-1 et seq.
32. **"Employee"** is defined to be person who is employed by the **Employer** who is eligible for coverage as provided in Article III Section 1 of this **Contract** herein. An **"Employee"** must also have been designated as an **Employee** to **Delta Dental** by the **Employer**. Persons in military service are not eligible for **Benefits** under this **Contract**.
33. **"Excluded"** or **"Exclusion"** mean **Dental Services** and/or charges for which no **Benefit** is payable under this **Contract**.
34. **"In Conjunction With"** means in close association with or as part of another episode of treatment including, but not limited to, being performed on the same day.
35. **"NMAC"** means the **Non-Participating Dentist Maximum Amount Used for Benefit Calculation** as defined herein.
36. **"Non-Participating Dentist"** means a **Dentist** that does not participate in the Delta Dental network either as a **Delta Dental PPO Dentist** or as a **Delta Dental Premier Dentist**. A **Non-Participating Dentist** is a **Dentist** that does not have an agreement in place with **Delta Dental**.
37. **"Non-Participating Dentist Maximum Allowed Charge"** or **"NMAC"** means the highest fee which **Delta Dental** uses for purposes of calculating the **Allowed Amount** for a **Covered Service** performed by a **Non-Participating Dentist**. This fee level for New Jersey is established by **Delta Dental** for **Dental Services** rendered in New Jersey and by **Another Delta Dental Plan** for **Non-Participating Dentists** in that respective state. The **Non-Participating Dentist Maximum Allowed Charge** may vary by region or locality within a state. The **NMAC** for this **Contract** is the **UCR** as defined herein.

38. "PMAC" means the **Premier Participating Dentist Maximum Approved Charge** as defined herein.
39. "PPO Approved Fee" means the fee approved by **Delta Dental** or **Another Delta Dental Plan** for **Dental Services** rendered by the **Delta Dental PPO Dentist** for a **Covered Service** rendered by the **Delta Dental PPO Dentist** in the respective state. It can be changed from time to time by **Delta Dental** or by **Another Delta Dental Plan**. The **PPO Approved Fee** may vary by region or locality within a state or by type of dentist, such as a general dentist or a specialist.
40. "**Premier Participating Dentist Maximum Approved Charge**" or "**PMAC**" is defined as the highest amount which **Delta Dental** approves for purposes of compensating the **Delta Dental Premier Dentist** for a **Covered Service**. This includes the amount payable by both **Delta Dental** and the **Covered Person**. The **Premier Participating Dentist Maximum Approved Charge** may vary by region or locality within a state.
41. "**Procedure**" is defined to be a dental procedure to which a separate procedure number has been assigned in the Procedure Code and Nomenclature List of the American Dental Association and which is an eligible **Dental Service** under this **Contract**, as more fully described in Article IV Section 4 of this **Contract**.
42. "**Spouse**" means the **Employee's** lawful **Spouse**, **Civil Union Partner** or **Domestic Partner**.
43. "**Treatment Plan**" is defined to be the written statement, on a form (**Attending Dentist's** Statement) prescribed by **Delta Dental**, of diagnosis(es) or prognosis(es) and the course and types of care and treatment to be rendered by a **Dentist** to a **Covered Person** together with associated charges when such statement is signed by the **Dentist** and **Covered Person**. **Delta Dental** may, in its discretion, approve a **Treatment Plan** for payment of **Benefits** in whole or in part. **Delta Dental's** determination as to payment of **Benefits** under a **Treatment Plan** is final.
44. "**UCR**" means the **Usual, Customary and Reasonable** fee as defined herein.
45. "**Usual, Customary and Reasonable**" or "**UCR**" means the highest fee that **Delta Dental** uses for purposes of calculating the "**Nonparticipating Dentist Maximum Allowed Charge**" or "**NMAC**", that is the **Allowed Amount** for a **Covered Service** performed by a **Non-Participating Dentist**. The **UCR** is calculated by **Delta Dental** using the most recent applicable **Delta Dental** database of submitted charges. The **UCR** represents the 95th percentile of submitted charges for the paid procedure and may vary by region or locality within a state.

ARTICLE III - ELIGIBILITY AND CONTRACT CHARGES

1. Every **Employee** within the classification set forth below shall be eligible for coverage for himself and his **Dependents**, where applicable. If, on or after the **Coverage Effective Date**, he shall have completed the period of continuous employment set forth for such classification. There must be at least ten (10) **Employees** covered by this **Contract** for any person to be eligible for benefits hereunder. All **Employees** eligible for coverage under this Article on the **Coverage Effective Date** must be offered coverage on that date.

CLASSIFICATION OF ELIGIBLE EMPLOYEES	PERIOD OF CONTINUOUS EMPLOYMENT PREREQUISITE TO ELIGIBILITY
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(a) All present **Employees** working at least N/A hours per week.

(a) Coverage shall be effective as of the **Effective Date** of the **Contract**.

(b) All future **Employees** working at least N/A hours per week.

(b) Coverage shall be effective on the first of the month following 60 days of employment.

2. Each **Employee** may be asked to complete and give to the **Employer** to file with **Delta Dental** an application or enrollment form on behalf of himself and his **Dependents**, if any, as a prerequisite to coverage under this **Contract**.
3. Each **Employee** becoming eligible subsequent to the **Effective Date** may be asked to file an application or enrollment form through the **Employer** with **Delta Dental** on the date that he becomes eligible or within 31 days thereafter.
4. Any person becoming an **Employee** subsequent to the **Effective Date** and eligible for coverage under Article III Section 1, must be offered coverage in the eligible group.
5. The **Employer** shall maintain records from which may be determined the types of coverage selected, names, birth dates and addresses of all **Employees** and **Dependents** covered by this **Contract**. Such information shall be furnished to **Delta Dental** by the **Employer** at such time or times and in such form and detail as may reasonably be required by **Delta Dental** to maintain a currently accurate record of all **Covered Persons**. The **Employer** shall, as required, make verifications as to **Dependents** entitled to receive benefits under this **Contract**.
6. **Delta Dental** shall be entitled to rely on information furnished to it by the **Employer**, and the **Employer** agrees to hold **Delta Dental** harmless for any inaccuracy of such information. Clerical errors or delays in keeping or recording data relative to coverage shall not invalidate coverage which would otherwise be validly in force. The **Employer** shall be responsible for **Contract Charges** for all **Covered Persons** appearing on lists the **Employer** submits to **Delta Dental**.

7. Except and to the extent expressly provided in an Endorsement to this Section, in the event an **Employee** dies, or his employment is terminated, coverage hereunder respecting such **Employee**, and his **Dependents**, if any, shall terminate on the date on which such event occurs. The **Employer** shall report promptly to **Delta Dental** all such **Employee** who have terminated coverage. In the event of termination of coverage under the provisions of this Section, **Delta Dental** shall not be liable for any **Benefits** for any otherwise eligible **Dental Services** completed after the date on which the termination occurs.

8. **Contract Charges** under this **Contract**:

(a) shall be as follows:

Coverage	Monthly Charge
Employee	\$58.86
Employee & Spouse	\$120.18
Employee & Child(ren)	\$144.38
Family	\$206.04

b) are due and payable in advance and shall be paid to **Delta Dental** at intervals no less frequently than monthly. **Employer** agrees to electronically send eligibility files to **Delta Dental** on a monthly basis identifying each person covered for that period, his ID number, and his **Dependent** status.

(c) for each **Covered Person** hereunder shall be made payable by the **Employer** to **Delta Dental** and transmitted to Delta Dental of New Jersey, Inc., P.O. Box 36843 Newark, New Jersey 07188-6483, in accordance with the charges set forth in subparagraph (a) of this Section or the most recent amendment thereto.

9. (a) **Employer** and **Delta Dental** will cooperate fully to make every reasonable effort under the circumstance considering the chances of successful recovery and the costs thereof, to recover any payment made to a **Covered Person** or dental care provider which is in excess of the amount which the person was entitled to receive under this **Contract** ("Overpayments").

(b) **Employer** assigns to **Delta Dental** the authority to pursue recovery of Overpayments and **Delta Dental** will pursue all reasonable means of recovery of Overpayments under the circumstances. However, it is expressly understood and agreed that **Delta Dental** is not obligated to commence litigation unless the provisions of subsection 9(c)(i), (ii) and (iii) are satisfied.

(c) **Delta Dental** will assume liability for an unrecovered Overpayment only if and at such time as it is determined that:

- (i) The Overpayment was caused by either the failure of **Delta Dental** to act with the care, skill, prudence and diligence under the overall circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with the aims in accordance with the terms and conditions of this **Contract**; or a **Delta Dental** act or omission which was fraudulent or criminal;
 - (ii) All reasonable means of recovery under the circumstances have been exhausted; and
 - (iii) **Delta Dental's** acts or omissions were not undertaken at the express direction of **Employer**.
10. Such recoupment provision as is agreed upon in writing by **Delta Dental** and **Employer**.
 11. In the event this **Contract** terminates for any reason, the **Employer** shall be liable for all **Contract Charges** due and unpaid while this **Contract** was in force.
 12. The **Contract Charges** and rates established in Section 8, subparagraph (a) of this Article may be subsequently adjusted at the end of the **Contract** term in accordance with the most current rating formulae on file with the Department of Insurance of the State of New Jersey.

ARTICLE IV - DENTAL BENEFITS: EXTENT OF COVERAGE AND DELTA DENTAL PAYMENT

Subject to the **Benefit Limitations** set forth in this **Contract**, **Delta Dental** will provide **Covered Persons** with the dental benefits as listed in this Article beginning at 12:01 A.M. Eastern Standard Time on the **Effective Date** of this **Contract** only to the extent that: (a) the **Dental Services** are rendered to the **Covered Person** by a **Dentist** or other person authorized by law to perform the **Dental Services**; (b) the **Dental Services** are necessary to maintain the oral health of the **Covered Person**; (c) the **Dental Services** are performed in accordance with the accepted dental practices in the community; and (d) the **Dental Services** are completed while this **Contract** is in force.

1. BASIS AND EXTENT OF DELTA DENTAL PAYMENT

(a) Services by Delta Dental PPO Dentists

Payment for **Covered Services** rendered to **Covered Persons** by **Delta Dental PPO Dentists** shall be as follows:

(i) Delta Dental's Benefit Amount

Delta Dental shall pay or otherwise discharge for each **Covered Person** who receives eligible **Dental Services** completed by a **Delta Dental PPO Dentist**, the **Coverage Percents** specified on the Schedule of Benefits.

The **Coverage Percent** shall be applied against the fee level below for the **Dental Service** upon which the **Benefit** is based subject to and after application of the **Benefit Limitations** and **Exclusions**.

The fee level shall be the least of: (a) the **Delta Dental PPO Dentist's** fee for the **Dental Service** filed with **Delta Dental** or **Another Delta Dental Plan**; (b) the actual fee charged for the **Dental Service**; (c) the **PPO Approved Fee** for the **Dental Service** upon which the **Benefit** is based.

(ii) Covered Person's Payment

The **Delta Dental PPO Dentist** shall charge and collect from the **Covered Person** the difference between **Delta Dental's Benefit Amount** for the respective service (after application of any applicable **Deductible** and **Benefit Limitations**) and the **Approved Amount** for the **Dental Service**.

(iii) Total Charge

The **Delta Dental PPO Dentist** shall accept as payment in full for each **Covered Service Delta Dental's Benefit Amount** and the **Covered Person's** payment as described above and shall make no additional charge for the **Covered Service**. The total charge will not exceed the lowest of (a) the **Delta Dental PPO Dentist's** fee for the **Dental Service** filed with **Delta Dental** or **Another Delta Dental Plan**; (b) the actual fee charged for the **Dental Service**; (c) the **PPO Approved Fee** for the **Dental Service** upon which the **Benefit** is based.

(b) Services By Delta Dental Premier Dentists

Payment for **Covered Services** rendered to **Covered Persons** by **Delta Dental Premier Dentists** shall be as follows:

(i) Delta Dental's Benefit Amount

Delta Dental shall pay or otherwise discharge for each **Covered Person** who receives eligible **Dental Services** completed by a **Delta Dental Premier Dentist**, the **Coverage Percents** specified on the Schedule of Benefits.

The **Coverage Percent** shall be applied against the fee level below for the **Dental Service** upon which the **Benefit** is based subject to and after application of the **Benefit Limitations** and **Exclusions**.

The fee level shall be the least of: (a) the **Delta Dental Premier Dentist's** fee for the **Dental Service** filed with **Delta Dental** or **Another Delta Dental Plan**; (b) the actual fee charged for the **Dental Service**; or (c) the **Premier Participating Dentist Maximum Approved Charge (PMAC)** for the **Dental Service** upon which the **Benefit** is based.

(ii) Covered Person's Payment

The **Delta Dental Premier Dentist** shall charge and collect from the **Covered Person** the difference between **Delta Dental's Benefit Amount** for the respective service (after application of any applicable **Deductible** and **Benefit Limitations**) and the **Approved Amount** for the **Dental Service**.

(iii) Total Charge

The **Delta Dental Premier Dentist** shall accept as payment in full for each **Covered Service Delta Dental's Benefit Amount** and the **Covered Person's** payment as described above and shall make no additional charge for the **Covered Service**. The total charge will not exceed the lowest of: (a) the **Delta Dental Premier Dentist's** fee for the **Dental Service** filed with **Delta Dental** or **Another Delta Dental Plan**; (b) the actual fee charged for the **Dental Service**; or (c) the **Premier Participating Dentist Maximum Approved Charge (PMAC)** for the **Dental Service** upon which the **Benefit** is based.

(c) Services by Non-Participating Dentists

Payment for **Covered Services** rendered to **Covered Persons** by **Non-Participating Dentists** shall be as follows:

(i) Delta Dental's Benefit Amount

Delta Dental shall pay or otherwise discharge for each **Covered Person** who receives eligible **Dental Services** completed by a **Non-Participating Dentist** the **Coverage Percents** specified on the Schedule of Benefits.

The **Coverage Percent** shall be applied against the fee level below for the **Dental Service** upon which the **Benefit** is based subject to and after application of the **Benefit Limitations** and **Exclusions**.

The fee level shall be the least of: (a) the actual fee charged for the **Dental Service**; or (b) the **Non-Participating Dentist Maximum Amount Used for Benefit Calculation (NMAC)** for the **Dental Service** upon which the **Benefit** is based. The **NMAC** for this **Contract** is the **UCR** as defined.

(ii) Covered Person's Payment

The **Non-Participating Dentist** shall charge and collect from the **Covered Person** the difference between the actual fee charged and **Delta Dental's Benefit Amount** for the **Dental Service**.

(iii) Total Charge

The **Non-Participating Dentist** will collect the entire fee he or she has charged for the **Dental Service**.

2. COVERAGE TERMS

The following sections outline the coverage terms used in the Schedule of Benefits. These Sections contain information about Deductibles, Benefit Maximums, Coverage Percent and Coinsurance Percent, Benefit Limitations and Exclusions, and Alternate Treatment Limitations.

- (a) If the Schedule of Benefits set forth below includes a **Deductible**, **Delta Dental** shall deduct that amount from the **Benefit** it would otherwise make on behalf of a **Covered Person** under subparagraphs (a), (b), (c) and/or (d) Article IV Section 1 of this **Contract**; provided:
 - (i) that the **Deductible** shall apply once each calendar year for each **Covered Person**
 - (ii) that the sum of the **Deductibles** for an **Employee** and his **Dependents** for each calendar year shall not exceed the Aggregate Maximum Calendar Year **Deductible** set forth below in the Schedule of Benefits; and
 - (iii) that the **Deductible** does not apply separately to each category of eligible **Dental Services**.
- (b) **Benefit Maximum:** If the Schedule of Benefits set forth below includes a **Benefit Maximum** for the calendar year, **Delta Dental** shall not be obligated to pay for or otherwise discharge, in whole or in part, any fees for any **Covered Person** in excess of that **Benefit Maximum** during any calendar year. Unless otherwise stated, there is no separate **Benefit Maximum** that applies to each category of eligible **Dental Services**.
- (c) **Payment for Orthodontic Services:** Subject to all other conditions set forth in this Article, **Delta Dental** will make payments for the orthodontic treatment plan in monthly installments. These installments are equal to the total **Allowed Amount** for the remainder of the approved orthodontic **Treatment Plan** divided by the total number of months in the entire period of the approved orthodontic treatment. The patient must still be in active treatment and maintains current eligibility.
- (d) **Coverage Percent and Coinsurance Percent:** The **Coverage Percent** for each **Covered Service** is listed in the Schedule of Benefits. By way of illustration, this **Contract** computes **Benefits** by applying the **Coverage Percent** to the **Allowed Amount** for the **Covered Service**. If the **Coverage Percent** shown is "60%," **Delta Dental** will pay 60% of the **Allowed Amount** for the **Covered Service**, after any applicable **Deductible**. The amount that a **Covered Person** must pay is the difference between the **Benefit** paid for the **Dental Service** and the **Approved Amount** for the **Dental Service**.

The **Coinsurance Percent** for each **Covered Service** is based on the **Coverage Percent** listed in the Schedule of Benefits in Article IV Section 3 of this **Contract**. It is the percentage of the **Allowed Amount** for a **Covered Service** paid by a **Covered Person** after any applicable **Benefit Limitations**. By way of illustration, if the **Coverage Percent** is 60%, **Delta Dental** will pay 60% of the **Allowed Amount** for the **Covered Service** (after application of any **Deductible**) and the **Coinsurance Percent** is 40%.

- (e) **Benefit Limitations and Exclusions:** This **Contract** does not cover every aspect of dental care or every **Dental Service** recommended or performed by a **Dentist**. **Covered Services** are subject to **Benefit Limitations** and **Exclusions**. If a service is not eligible for a **Benefit**, the **Covered Person** is obligated to pay the **Dentist** the full **Approved Amount** for that **Dental Service**.
- (f) **Alternate Treatment Limitation:** A **Covered Person** may select a more costly **Dental Service** than one **Delta Dental** decides is sufficient for the diagnosis or treatment of the **Covered Person's** condition. This does not mean that the choice of treatment is wrong or insufficient. However, certain **Benefits** under this **Contract** are based on the least costly **Covered Service** that **Delta Dental** decides is sufficient for the diagnosis or treatment of the **Covered Person's** dental problem. If the **Dental Service** performed is a more costly treatment, the **Covered Person** is financially responsible for the difference between **Delta Dental's Benefit Amount** and the **Approved Amount** for the actual **Dental Service** performed.

3. SCHEDULE OF BENEFITS

COVERAGE PERCENT

Eligible Dental Services	Delta Dental PPO Dentists	Delta Dental Premier Dentists	Non- Participating Dentists
Diagnostic and Preventive	100%	100%	100%
Basic	100%	100%	100%
Crowns	100%	100%	100%
Endodontics	100%	100%	100%
Periodontics	100%	100%	100%
Prosthodontics	75%	75%	75%
Oral Surgery	100%	100%	100%
Orthodontic	100%	100%	100%
Implants	75%	75%	75%

DEDUCTIBLES:

Calendar Year **Deductible** for Diagnostic and Preventive, Basic, Crowns, Endodontic, Periodontic, Prosthodontic, Oral Surgery & Implant services: N/A*

Aggregate Maximum Calendar Year **Deductible** per family for Diagnostic and Preventive, Basic, Crowns, Endodontic, Periodontic, Prosthodontic, Oral Surgery & Implant services: N/A*

Calendar Year **Deductible** for Orthodontic services: N/A

Aggregate Maximum Calendar Year **Deductible** per family for Orthodontic services: N/A

*The **Deductible** applies once each Calendar Year and does not apply separately to each **Dental Service** category.

BENEFIT MAXIMUM:

Maximum Calendar Year Payment for Diagnostic and Preventive, Basic, Crowns, Endodontic, Periodontic, Prosthodontic, Oral Surgery & Implant services: \$2,250.00**

The maximum payment is an aggregate maximum for each calendar year. There is no separate maximum for each **Dental Service category.

Maximum Annual Payment for Orthodontic Services: \$2,000.00

4. DESCRIPTION OF ELIGIBLE DENTAL SERVICES

(a) **Diagnostic and Preventive**

(i) ***Covered Services***

Diagnostic:

Provides the necessary procedures to assist the **Dentist** in evaluating the existing conditions to determine the required dental treatment. These services include: oral examination and diagnostic services (including necessary dental x-rays).

Preventive:

Oral Prophylaxis. Topical application of fluoride. Space maintainers, except when used as an activating device, once per space for missing posterior teeth for children under age 14.

(ii) ***Limitations***

Diagnostic:

Examinations are limited to two (2) per calendar year; Panorex or complete mouth radiograph series will be provided only once in a five (5)-year period, unless special need is shown. Complete mouth radiograph, at least 6 months must elapse before a supplementary bitewing radiograph will be benefitted. Supplementary bitewing radiographs will be provided at most twice per calendar year for **Covered Persons** prior to attaining 19 years of age and at most once per calendar year period for **Covered Persons** age 19 or more, unless special need is shown.

Preventive:

(A) Prophylaxis is limited to two (2) per calendar year.

(B) Topical application of fluoride will only be provided to **Covered Persons** prior to attaining 19 years of age, and only twice per calendar year.

(C) Application of sealants (i.e., topically applied resin material used to seal development grooves and pits in teeth for the purpose of preventing decay) is a **Covered Service** only for **Dependents** under 16 years of age; includes the application of sealants only to occlusal surfaces of permanent molar teeth (not including third molars) with the occlusal surfaces intact, no occlusal caries (decay), and with no occlusal restorations; and does not include any repair or replacement of a sealant on any tooth. (Such repair or replacement is considered to be included in the fee for the initial placement of the sealant). The application of a sealant is a **Covered Service** only once in a lifetime per tooth.

(iii) *Specific Exclusions*

- (A) Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene, dietary instructions or other diagnostic tests not specifically mentioned, including but not limited to, laboratory tests, susceptibility tests and periodontal susceptibility tests.
- (B) Periodontal scaling is not an eligible service when provided **In Conjunction With** prophylaxis.

(b) **Basic**

(i) *Covered Services*

Restorative:

- (A) Restorations consisting of silver amalgam, acrylic, plastic or silicate cement and the buccal surface of bicuspid (or other material approved by **Delta Dental** at its sole discretion).
- (B) Cone beam CT capture and interpretation for field of view: less than one whole jaw; one full dental arch – mandible; one full dental arch - maxilla with or without cranium; or full view of both jaws with or without cranium subject to limitations and exclusions.

Emergency Care:

Necessary palliative treatment or other emergency care relating to any eligible **Dental Services** under this **Contract**.

(ii) *Limitations*

- (A) Tooth preparation, acid etching, temporary restorations, bases, pulp caps, impressions, local anesthesia and other services which are part of a complete dental procedure are considered components of that complete dental procedure and are included in the fee for that complete dental procedure.
- (B) Cone beam CT capture and interpretation is limited to one (1) per Calendar Year.

(iii) *Specific Exclusions*

- (A) Surgical procedures to correct congenital malformations or development malformations, and procedures, appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure lost by attrition, or related to TMJ, TMD or occlusal equilibration.
- (B) Allowance is made for only one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed and replacement is limited to once in a twelve (12)-month period.
- (C) Any endodontic, periodontal, oral surgical and restorative procedures related to overdentures.
- (D) Cone beam CT capture and interpretation for TMJ series.

(c) **Crowns/Onlays**

(i) *Covered Services*

Crowns and onlays when teeth cannot be restored with silver amalgam or composite resins (or other material approved by **Delta Dental** at its sole discretion). **Benefits** will be limited to teeth that cannot be restored by any other means, including severe loss of tooth structure resulting from caries and/or fracture.

(ii) *Limitations*

- (A) Replacement of crowns, onlays, post and cores and core buildups will be made only after five (5) years have elapsed from the date of the prior major restorative (i.e., crown, onlay, pontic) services, even if not covered by **Delta Dental** at the time of the prior service.
- (B) Porcelain crowns or jackets, cast crowns with acrylic veneers, and/or full cast crowns are not eligible services for children under 12 years of age. An allowance will be made for an acrylic crown or preformed stainless steel crown.

(iii) *Specific Exclusions*

Periodontal splinting and/or crown and bridgework used **In Conjunction With** periodontal splinting.

(d) **Endodontics**

(i) ***Covered Services***

Necessary procedures for pulpal therapy and root canal therapy.

(ii) ***Limitations***

Root Canal Therapy is limited to permanent teeth, unless no permanent successor is present, and is limited to once per tooth in a lifetime.

(iii) ***Specific Exclusions***

(A) Any endodontic, periodontal, oral surgical and restorative procedures related to overdentures.

(B) Synthetic graft materials.

(C) Extraoral grafts.

(e) **Periodontics**

(i) ***Covered Services***

Necessary procedures for treatment of the tissues supporting the teeth.

(ii) ***Limitations***

(A) Periodontal surgery is an eligible service only once in a three (3)-year period including any surgical re-entry and is limited to treatment of periodontal disease only and not for pre-restorative (crown lengthening purposes).

(B) Periodontal scaling and root planing in the same quadrant are limited to once every two (2) years.

(iii) ***Specific Exclusions***

(A) Any endodontic, periodontal, oral surgical and restorative procedures related to overdentures.

(B) Curettage is not an eligible service **In Conjunction With** periodontal surgery.

(C) Periodontal splinting and/or crown and bridgework used **In Conjunction With** periodontal splinting.

- (D) Periodontal scaling is not an eligible service when provided **In Conjunction With** prophylaxis.
- (E) Except to the extent covered under the Special Health Care Needs Benefit, Periodontal Prophylaxis will only be an eligible service after active Periodontal Therapy has been performed. Any combination of Preventative Prophylaxis and Periodontal Prophylaxis will be limited to two (2) in a calendar year.
- (F) Synthetic graft materials.

(f) **Prosthodontics**

(i) ***Covered Services***

Dental Prosthesis is to be provided where masticatory function is impaired and/or teeth are missing. Full or partial dentures should be constructed when deemed necessary to replace missing teeth (not including third molars). The adjustment or repair of existing prosthetic appliances is included. Fixed bridgework will only be a **Covered Service** when the use of a removable prosthetic device is inadequate.

(ii) ***Limitations***

- (A) Replacement will be made of an existing denture only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances satisfactory will be provided in accordance with this **Contract**. Prosthodontics appliances including abutment crowns will be replaced only after five (5) years have elapsed from the date of prior service. For purpose of replacement, a single crown is equivalent to an abutment crown, pontic or an onlay.
- (B) If, in the provision of prosthodontics services, the **Covered Person** and the **Dentist** decide on personalized restorations or employ specialized techniques as opposed to standard procedures, **Delta Dental** will allow the appropriate amount for the standard denture toward such treatment and the **Covered Person** is responsible for the difference in cost.
- (C) A fixed bridge is not an eligible service **In Conjunction With** an allowance for a partial denture in the same arch.
- (D) **Benefits** for fixed bridges and removable cast partial dentures are not provided for patients under sixteen (16) of age.
- (E) Relines, adjustments, repairs and rebases are not payable within six (6) months of insertion of the prosthesis.

(iii) *Specific Exclusions*

- (A) Any procedures, restorations or appliances associated with periodontal splinting.
- (B) Personalization, characterization and precision attachments.
- (C) Any endodontic, periodontal, oral surgical and restorative procedures related to overdentures.

(g) **Oral Surgery**

(i) *Covered Services*

Extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures, and surgical and adjunctive treatment for minor pathological conditions. General anesthesia when administered in a dental office by a **Dentist** licensed to perform this service.

(ii) *Specific Exclusions*

- (A) Surgical procedures to correct congenital malformations or development malformations, and procedures, appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure lost by attrition, or related to TMJ, TMD or occlusal equilibration
- (B) Any endodontic, periodontal, oral surgical and restorative procedures related to overdentures.
- (C) Synthetic graft materials.
- (D) Extraoral grafts.

(h) **Orthodontics**

(i) ***Covered Services***

Comprehensive Orthodontic Services for a correctable major malocclusion that significantly interfere with proper form and function of the dentition, if prescribed in a **Treatment Plan** (Attending **Dentist's** Statement), and consisting of the initial and subsequent installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of existing malocclusion and its attendant sequelae through the correction of malposed teeth.

(ii) ***Limitations***

(A) All **Covered Persons** are eligible to receive orthodontic services under the **Contract**.

(B) For the purpose of determining **Benefit** payments available for treatment in progress at the commencement or termination of a **Covered Person's** coverage hereunder, all orthodontic services shall be deemed to have been rendered on the date such services were performed.

(C) **Delta Dental's** obligation to make monthly payments, pursuant to Article IV Section 4(g), for orthodontic services set forth in an approved **Treatment Plan** shall cease upon termination of orthodontic treatment for any reason prior to the completion of the services set forth in the **Treatment Plan**.

(D) If a **Covered Person** is receiving orthodontic services when his coverage under this **Contract** begins, **Delta Dental** shall only be responsible to make payment for the cost of that portion of the **Covered Person's** orthodontic services, determined in accordance with Article IV Section 4(g), which corresponds to the time period during which the **Covered Person** is actually covered by this **Contract**.

(iii) ***Specific Exclusions***

(A) The replacement and/or repair of any appliance furnished under a **Treatment Plan** shall not be a **Covered Service** under this **Contract**.

(B) After the completion of orthodontic services as set forth in a **Treatment Plan**, any further orthodontic services rendered to the same **Covered Person** shall not be a **Covered Service** under this **Contract**.

- (C) Orthodontic surgery (orthognathic surgery).
- (D) Tooth guidance appliance, minor tooth movement and pre-prosthetic orthodontics, such as molar uprighting.
- (E) Myofunctional Therapy.

(i) **Implants**

(i) ***Covered Services***

Implants for the replacement of missing natural teeth that are not third molars.

(ii) ***Limitations***

- (A) No **Benefit** will be paid for an implant crown within 60 months of the placement of any crown on the same tooth whether a natural tooth or an implant tooth.
- (B) No **Benefit** will be paid for an implant within 60 months of any implant at the same location (determined by tooth number or location in an arch).
- (C) No **Benefit** will be paid for any implant services performed on persons under 19 years of age.
- (D) Local anesthesia as well as any special sterilization techniques are included in the implant service procedures and no separate **Benefit** will be paid for them.
- (E) The fees for surgery and cast restorations (crowns, onlays, bridges, and implants) include working radiographs and post-operative radiographs and no separate **Benefit** will be paid for them. A radiograph will be benefitted only for diagnostic purposes.
- (F) No **Benefit** will be paid for an abutment unless it is followed by an abutment supported prostheses.

(iii) ***Specific Exclusions***

- (A) Implants, abutments, or crowns for other than natural missing teeth.
- (B) Implants, abutments, or crowns for third molars.
- (C) Provisional crowns done with an implant.

- (D) Any implant intended to replace a single missing tooth unless the teeth abutting the missing tooth space are intact, unrestored, or minimally restored.
- (E) Any implant if either abutment tooth requires a crown or is reasonably expected to require a crown.
- (F) Periodontal and oral surgery procedures (other than extractions) **In Conjunction With** surgical implant placement or in association with salvage attempts of a failing implant.
- (G) Computerized tomography (CT) scans, surgical stents, surgical guides, sinus lifts, ridge preservation or augmentation in an extraction site in preparation for an implant procedure.
- (H) Implants done to restore a space beyond the normal complement of natural teeth (for example, placing two implants in the space of #19).
- (I) Synthetic graft materials.
- (J) Extra-oral grafts.

(j) **Special Health Care Needs**

(i) ***Covered Services***

A **Covered Person** with special health care needs may be eligible for additional services for: exams, hygiene services such as cleanings, periodontal maintenance and plaque removal as described in this Section, and dental case management, sedation/anesthesia or nitrous oxide for individuals identified with sensory processing disorders. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition such as anxiety due to autism spectrum disorder (ASD), down syndrome, cerebral palsy or other condition associated with sensory processing disorder that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

If a **Covered Person** has a qualifying special health care need, (s)he should notify the **Dentist** that the plan includes this Special Health Care Needs benefit. The **Dentist** will notify **Delta Dental** of the **Covered Person's** eligibility for the additional services.

Additional services include unlimited oral exams and up to four (4) visits provided in any combination per calendar year for prophylaxes or cleaning (CDT 01110 and 01120), periodontal maintenance (CDT 04910) or scaling to remove plaque (CDT 04346).

Except as stated above, additional **Covered Services** provided due to special health care needs will be subject to the same **Coverage Percent**, limitations, and **Exclusions** that would otherwise apply for such **Covered Services** under this Contract.

(ii) *Specific Exclusions*

- (A) Periodontal root planing and scaling (CDT 04341 and CDT 04342) is not subject to additional benefits for a covered person with special health care needs.
- (B) Benefits for more than four (4) cleanings/prophylaxes or listed periodontal procedures in any combination are not covered.
- (C) Nitrous oxide administered to a covered person who does not have a documented condition associated with a sensory processing disorder is not a covered benefit.

5. **GENERAL EXCLUSIONS (Applicable to All Dental Services)**

(a) No **Benefit** payment shall be provided under this **Contract** for:

- (i) Services rendered for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability laws; services which are provided by any Federal or State or Provincial government agency, or are provided without cost to the **Covered Person** by any municipality, county or political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable eligible dental benefits contained in this **Contract**.
- (ii) Services performed or items furnished for any conditions, disease, ailment or injury occurring while the **Covered Person** is on active duty during military service, or for services or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision of any of the foregoing.
- (iii) **Dental Services** performed prior to the date the **Covered Person** became eligible for such services under this **Contract**, unless the treatment was a year in duration and was completed after the enrollee became eligible.
- (iv) Analgesics (such as nitrous oxide (except when provided for individuals identified with sensory processing disorders under the Special Health Care Needs Benefit)) or other euphoric or prescription drugs.
- (v) Bases or procedures of an experimental nature.
- (vi) Charges for hospitalization, including hospital visits.
- (vii) Laboratory tests and/or laboratory examinations.

- (viii) Services to correct minor tooth movement.
- (ix) Any service or item which is determined by **Delta Dental's** Dental Director not to be a necessary service or item for the treatment of the **Covered Person's** condition, disease or injury. **Delta Dental** reserves the right to review the **Covered Person's** dental records, including necessary radiographs, photographs, and models to determine whether a service or item is necessary.
- (x) Broken appointments.
- (xi) Completion of **Claim** forms and Pre-Treatment Estimates; copying or providing documents or radiographs.
- (xii) Periodontal charting is considered a component of the diagnosis and treatment of periodontal disease and is not a chargeable procedure.
- (xiii) Infection control and OSHA procedures are not chargeable to a **Covered Person**.
- (xiv) Any service that has not been performed by a person duly licensed as an oral surgeon or as a **Dentist** in the state in which the treatment was rendered or by their auxiliary personnel in accordance with applicable law.
- (xv) Expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
- (xvi) Expenses for replacement of a lost, missing or stolen prosthetic device or other duplicate appliance.
- (xvii) Expenses for services or supplies for which no charge is made that the **Covered Person** is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.
- (xviii) Expenses for myofunctional therapy.
- (xix) Expenses for appliances or restorations necessary to alter vertical dimension or to restore occlusion.
- (xx) Expenses for services or supplies for accidental injury.
- (xxi) Expenses which are incurred in connection with any injury or disease arising out of the ownership, maintenance or use of a motor vehicle, except as required by NJAC 11:3-37.3. For expenses incurred in connection with any injury or disease arising out of the ownership, maintenance, or use of a motor vehicle, this Contract shall be secondary.

- (xxii) **Dental Services** for which a **Claim** was not received by **Delta Dental** within twelve (12) months after the date when the **Dental Service** was finished.
- (xxiii) Duplicative **Dental Services** performed on the same day.
- (xxiv) **Dental Services** rendered outside of the United States and its territories.
- (xxv) **Delta Dental** will not coordinate benefits unless the other plan provides benefits for dental services pursuant to Article V.
- (xxvi) A subset of a more **Comprehensive Service** (or a lesser **Dental Service** considered included in the **Comprehensive Service**).
- (xxvii) Specialized techniques including but not limited to swing locks, dolder bars, special staining, halder bars, connector bars, metal bases, cone beam capture imaging interpretation and manipulation, ridge augmentation and/or preservation.
- (xxviii) **Dental Services** submitted for payment as part of a **Claim** which has knowingly inaccurate information pertinent to the **Claim** (such as the **Dental Service** actually rendered, the date of service, the existence of other coverage, or the fee for the **Dental Service**).
- (xxix) Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; occlusal adjustments; post removal; gingivectomy **In Conjunction With** restorations; impressions; lab fees and material; local anesthesia services in conjunction with operative or surgical procedures, and other **Dental Services** which **Delta Dental** considers to be part of a more **Comprehensive Dental Service**.
- (xxx) Desensitizing agents, home rinses and gels, toothbrushes, dental floss, personal hygiene items, other preparations and items for home use.
- (xxx1) **Dental Services** for which the **Dentist** does not normally charge.
- (xxx2) **Dental Services** performed by the **Dentist** for an immediate family member of the **Dentist** such as mother, father, **Spouse**, children, brother, sister, or for a **Covered Person** in the **Dentist's** household.
- (xxx3) **Dental Services** to diagnose or treat jaw joint disorders, such as, but not limited to, myofascial pain syndrome and temporo mandibular joint disorders.
- (xxx4) **Dental Services** which have not been completed during the **Coverage Period**.

- (xxxv) Sales taxes on **Dental Services**.
- (xxxvi) Surgical procedures to correct congenital malformations or development malformations, and procedures, appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure lost by attrition, or related to TMJ, TMD or occlusal equilibration.
- (xxxvii) Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.)
- (xxxviii) Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.
- (xxxix) Temporary procedures and appliances, pulp caps, occlusal adjustments, and except when provided to individuals under the Special Health Care Needs Benefit inhalation of nitrous oxide (for individuals identified with sensory processing disorders), analgesia, local anesthetic, and behavior management.
- (xl) Post removal (not in conjunction with root canal therapy).
- (xli) Maxillofacial surgery and prosthetic appliances.
- (xlii) All other services not specifically included in this **Contract**.
- (b) In the event that a **Covered Person** transfers from the care of one **Dentist** to that of another **Dentist** during a course of treatment, or if more than one **Dentist** renders services for the same dental procedure, **Delta Dental** shall not be liable for more than the amount it would have been liable had but one **Dentist** rendered all these services during each course of treatment, nor shall **Delta Dental** be liable for duplication of services rendered.

6. OTHER PAYMENT RULES THAT AFFECT THIS COVERAGE

- (a) **Dental Services Requiring Multiple Visits:** Some **Dental Services** take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, orthodontia, and endodontic procedures. **Delta Dental** will pay for **Covered Services** that need multiple visits only upon completion of the **Dental Services**. The **Completion Date** is deemed to be the date of service for these **Dental Services**.

- (b) **In-Process Treatment:** **Dental Services** started before the person is a **Covered Person** are not entitled to any **Benefit**. Examples of the **Dental Services** which may be performed over more than one visit include, but are not limited to, fixed bridgework, full or partial dentures, crowns, and root canal therapy. The **Completion Date** of these **Dental Services** must occur before the **Coverage Expiration Date** in order for them to be due any **Benefit** under this **Contract**. The **Completion Date** is the date of insertion for removable prosthetic appliances; the insertion date for fixed partial dentures and for crowns and onlays is the cementation date, no matter what the type of cement is used. The **Completion Date** for root canal therapy is the date the canals are permanently filled.

If this **Contract** provides coverage for orthodontic services, **Benefits** for in process orthodontic services will be prorated so that **Delta Dental** pays a **Benefit** based on the length of time the **Covered Person** is covered under this **Contract** as compared to the total amount of time for which the **Covered Person** will have received those **Dental Services**. For example, if the **Dental Services** plan is for twenty-four (24) months and (10) months of treatment have already been performed prior to the **Covered Person** being covered under this **Contract**, **Delta Dental** will make payments of one fourteenth ($1/14^{\text{th}}$) of the balance that remains, based upon the monthly calculation described above. Payments will stop at the earlier of the completion of the **Dental Services** or the date when the person is no longer a **Covered Person**.

- (c) **Incomplete Treatment:** One **Dentist** may start a **Dental Service** and another **Dentist** may finish it. If this happens, **Delta Dental** will pay no **Benefit** for the **Dental Service** performed by the **Dentist** who started but did not complete the **Dental Service**. **Delta Dental's** payment of a **Benefit** will only be for the **Dental Services** rendered by the **Dentist** who finishes the **Dental Service**.

7. METHOD OF PAYMENT

Except as may otherwise be required to comply with state or federal law:

- (a) **Payment to Delta Dental Participating Dentists:** **Delta Dental** shall make payments for eligible **Dental Services** rendered by a **Delta Dental PPO Dentist** or a **Delta Dental Premier Dentist** to the **Dentist**.
- (b) **Payment to Non-Participating Dentists:** **Delta Dental** shall make payment for eligible **Dental Services** rendered by a **Non-Participating Dentist** to the **Employee** or as required or allowed by law.
- (c) Notwithstanding subparagraphs (a) and (b) of this Section, **Delta Dental** shall make payment for eligible **Dental Services** for which charges are made directly or indirectly by a corporation, hospital, clinic, or other entity which includes other than **Delta Dental Participating Dentists** to the **Employee**.

ARTICLE V - COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS AND OTHER PROVISIONS REGARDING PAYMENT

A. COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

1. APPLICABILITY

This Coordination of Benefits ("COB") provision applies to this Plan when a **Covered Person** has dental care coverage under more than one Plan. A **Covered Person** may be covered for dental benefits or services by more than one Plan. For instance, he or she may be covered by this **Contract** as an **Employee** and by another Plan as a **Dependent** of his or her **Spouse**. If he or she is covered by more than one Plan, this provision allows **Delta Dental** to coordinate what it pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary Plan and which is the secondary Plan. Coordination of Benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the **Covered Person** is covered.

2. DEFINITIONS

The words shown below have special meanings when used in this Article V. Please read these definitions carefully.

(a) "Allowable Expense" means the charge for any **Dental Service** for which the **Covered Person** is liable when the **Dental Service** is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

Since this **Contract** provides benefits for **Dental Services**, it will coordinate benefits only with a Plan that also provides benefits for **Dental Services**.

When this **Contract** is Coordinating Benefits with a Plan that restricts Coordination of Benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which Coordination of Benefits applies as an Allowable Expense.

(b) "Claim Determination Period" means a Calendar Year, or any portion of a Calendar Year, during which a **Covered Person** is covered by this **Contract** and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

"Plan" means coverage with which Coordination of Benefits is allowed.

i) Plan includes:

- 1) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- 2) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- 3) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- 4) Group hospital indemnity benefit amounts that exceed \$ 150.00 per day;

5) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

ii) Plan does not include:

- 1) Individual or family insurance contracts or subscriber contracts;
- 2) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- 3) Group or group-type coverage where the cost of coverage is paid solely by the **Covered Person** except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- 4) Group hospital indemnity benefit amounts of \$ 150.00 per day or less;
- 5) School accident-type coverage;
- 6) A State plan under Medicaid.

(c) "Primary Plan" means a Plan whose benefits for a **Covered Person's Dental Services** must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "i" or "ii" below exist:

- i) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
- ii) All Plans which cover the **Covered Person** use order of benefit determination rules consistent with those contained in the Coordination of Benefits provision and under those rules, the Plan determines its benefits first.

(d) "Reasonable and Customary" means an amount that is not more than the usual or customary charge for the service or supply as determined by a Plan, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

(e) "Secondary Plan" means a Plan which is not a Primary Plan. If a **Covered Person** is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits provision, has its benefits determined before those of that Secondary Plan.

3. PRIMARY AND SECONDARY PLAN

Delta Dental considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically or Dentally necessary and appropriate services on the basis that Prior Authorization was not obtained.

4. RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the **Covered Person** as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the **Covered Person** as a **Dependent**. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the **Covered Person** as an employee who is neither laid off nor retired, or as a **Dependent** of such person, shall be determined before those for the Plan that covers the **Covered Person** as a laid off or retired employee, or as such a person's **Dependent**. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the **Covered Person** as an employee, member, subscriber or retiree, or **Dependent** of such person, shall be determined before those of the Plan that covers the **Covered Person** under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a **Dependent** under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- i) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
- ii) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan which covered the other parent for a shorter period of time.
- iii) "Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- iv) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a **Dependent** under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- i) The benefits of the Plan of the parent with custody of the child shall be determined first.
- ii) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
- iii) The benefits of the Plan of the parent without custody shall be determined last.
- iv) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

5. PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

In order to determine which procedure to follow it is necessary to consider:

- i) The basis on which the Primary Plan and the Secondary Plan pay benefits; and
- ii) Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R & C), or some similar term. This means that the provider bills a charge and the **Covered Person** may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R & C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the **Covered Person** may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the **Covered Person** uses the services of a non-network provider, the plan will be treated as an R & C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation." This means that the HMO or other plan pays the provider a fixed amount per **Covered Person**. The **Covered Person** is liable only for the applicable deductible, coinsurance or copayment. If the **Covered Person** uses the services of a non-network provider, the HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- i) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the **Covered Person** shall not exceed the fee schedule of the Primary Plan. In no event shall the **Covered Person** be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the **Covered Person** receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is R & C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- i) The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The **Covered Person** shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the **Covered Person** has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the **Covered Person** be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan

If the **Covered Person** receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- i) The amount of any deductible, coinsurance or copayment required by the Primary Plan;

- or
ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

B. OTHER PROVISIONS REGARDING PAYMENT

1. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. **Delta Dental** has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. **Delta Dental** need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give **Delta Dental** any facts it needs to pay the claim.

2. FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, **Delta Dental** may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this Plan. **Delta Dental** will not have to pay that amount again. The term, "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

3. RIGHT OF RECOVERY

If the amount of the payments made by **Delta Dental** is more than it should have paid under the COB provision, it may recover the excess from one or more of:

- (a) The person it has paid or for whom it has paid;
- (b) Insurance companies; or
- (c) Other organizations.

The "amount of the payments made" includes the reasonable monetary value of any benefits provided in the form of services.

ARTICLE VI - RENEWAL, AMENDMENT OR TERMINATION OF THE CONTRACT

1. This **Contract** shall be automatically renewed from ~~Contract Term to Contract Term unless otherwise terminated pursuant to this Article.~~ 

This **Contract** may be amended at any time by mutual agreement of the parties provided that such amendment is reduced to writing, executed by the President of **Delta Dental** or his designated representative and by **Employer** and specifies the date the provisions of such amendment shall be effective.

2. This **Contract** may be terminated on any Anniversary Date by at least thirty (30) days prior written notice of termination given by the party desiring to terminate to the other party. The **Contract** may also be terminated at any time in accordance with a written agreement to do so duly signed by **Delta Dental** and **Employer**.

3. In the event that **Delta Dental** shall desire to change any terms and conditions of this **Contract** effective on an Anniversary Date, **Delta Dental** shall notify **Employer** of those revisions at least sixty (60) days in advance of the "Anniversary Date" and those revisions shall be effective unless **Employer** notifies **Delta Dental** at least forty-five (45) days prior to the "Anniversary Date" that it rejects those proposed revisions
4. **Delta Dental** may amend the **Contract Charges** shown in Article III Section 8, or the latest amendment thereof, as of any "Anniversary Date" by giving at least thirty (30) days prior written notice to the **Employer**.
5. **Employer's** payment of the amended charges shall be deemed acceptance of the amendment. If the **Employer** does not accept the amended charges, this **Contract** will terminate at the end of the month before the date on which the amended charges would have taken effect. In the event that this **Contract** is terminated pursuant to this Section, **Delta Dental** is empowered not to authorize **Treatment Plans** beyond the date of such termination.
6. This **Contract** may be terminated by **Delta Dental** at any time giving thirty (30) days prior written notice to the **Employer** in the event that cancellations by **Participating Dentists** of their agreements with **Delta Dental** make the performance of this **Contract** impracticable in the judgment of **Delta Dental**.
7. In the event that the number of **Employees** reported monthly by the **Employer** to **Delta Dental** shall be less than 700 in each of any three consecutive months, **Delta Dental** may, at its option, terminate this **Contract** upon written notice to the **Employer**. Such termination shall be effective as of the last day of the month in which notice of termination is given if the notice is given at least thirty (30) days prior to that date, or, if not, on the last day of the next month.
8. In the event that any payment due to **Delta Dental** pursuant to this **Contract** is not paid when due, it shall be considered a default in payment, and **Delta Dental** may, at its option and sole discretion:
 - (a) Continue the **Contract** in full force and effect for the remainder of the current "Contract Term," at which time the **Contract** shall terminate; or
 - (b) Terminate all further **Benefits** and be released from all further obligations hereunder at any time prior to the end of the current "Contract Term" by giving notice to the **Employer**; provided, however, that **Delta Dental** shall make payment for eligible **Dental Services** covered by this **Contract** which were completed by a **Dentist** prior to the termination.

In the event **Delta Dental** terminates this **Contract** pursuant to subparagraph (b) of this Section, the **Employer** shall be and remain liable to **Delta Dental** for the full amount of **Dentist's** statements paid or otherwise discharged by **Delta Dental** for services rendered after the default in payment, plus 25% of such amount (to compensate **Delta Dental** for its administration of the dental program), less any amounts paid by the **Employer** to **Delta Dental** after the default in payment.

9. In the event of termination of this **Contract** in accordance with the provisions of this Article, no **Covered Person** shall, on or after the date on which the termination occurs, be entitled to any further **Benefits** hereunder.
10. Notwithstanding Article VI Section 8, a **Covered Person** who is totally disabled as of the date on which termination of this **Contract** takes effect (the "Termination Date") shall be entitled to continued coverage as if this **Contract** had not terminated for a period of ninety (90) days beginning on the "Termination Date" without payment of any premium for such extension of coverage. In order to receive this continued coverage, the **Covered Person** must submit evidence to **Delta Dental** which substantiates that individual's total disability.
11. If the **Employer** makes any misrepresentation at the inception of this **Contract**, **Delta Dental** may declare this **Contract** null and void and may recover from the **Employer** all payments **Delta Dental** has made in excess of the **Contract Charges** received from the **Employer**.

ARTICLE VII - EXAMINATION, INFORMATION AND RECORDS

1. **Delta Dental** may require oral examination of a **Covered Person** by a **Dentist** designated by **Delta Dental** as part of its **Claim** review or utilization review process as a condition precedent to the approval of **Claims** hereunder. If such examination is requested of and refused by a **Covered Person**, **Delta Dental** may, without waiving any rights it may have, make payment to the **Dentist** in accordance with this **Contract** based upon available information and take such other action as it deems appropriate.
2. As a condition precedent to the approval of **Claims** hereunder, **Delta Dental** shall be entitled to receive from **Dentists**, physicians, hospitals or other sources, to such extent as may be lawful, such information and records relating to examination of or treatment rendered to a **Covered Person** as may be required for the processing of such **Claims**. Any such information in the possession of **Delta Dental** shall be available to the **Employee** or his or her authorized representative upon written consent of the attending **Dentist** or physician and the **Employee**.

ARTICLE VIII - EXCULPATION

All **Dental Services** paid for by **Delta Dental** shall be in accordance with the accepted dental practices in the community at the time, but **Delta Dental** shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any dental office or its employee or on the part of any **Dentist** or others engaged by him/her in the course of rendering **Dental Services** to any **Covered Person**. In no instance shall any **Dentist** rendering services be deemed an agent or employee of **Delta Dental**.

ARTICLE IX - GENERAL PROVISIONS AND NOTICES

1. **Delta Dental** shall make available to the **Employer** for delivery to each **Employee** covered hereunder an appropriate booklet or similar document summarizing the essential features of the coverage including the time, place and method for making **Claims** for **Benefits** and the **Employer** shall deliver this booklet or document to each of its **Employees**. The **Employer** and **Delta Dental** agree to consult to a reasonable and practical degree concerning all material published or distributed relating to this **Contract** so as to prevent any material from being published or distributed which is contrary to the terms of this **Contract**.
2. This **Contract**, all endorsements or riders hereto, the application of the **Employer** (a copy of which is attached to this **Contract**), and the individual applications or enrollment forms of the **Employees** shall constitute the entire contract between the parties. All statements contained in any such application for coverage shall be deemed representations and not warranties.
3. Whenever, in describing or referring to any person or party, any word importing the masculine gender is used, the same shall be understood to include and to apply to females as well as to males.
4. No change in this **Contract** or waiver by **Delta Dental** of any of its provisions shall be valid unless approved in writing by a duly authorized officer of **Delta Dental**.
5. No action shall be maintainable against **Delta Dental** for any **Claims** by or on behalf of the **Employer**, any **Covered Person**, or any **Dentist** unless brought within 12 months from the date of event on which the **Claim** is based.
6. Any notice given under this **Contract** shall be sufficient if given or made available to the **Employer**, when addressed to it at its office stated herein; if given to **Delta Dental**, when addressed to it at 1639 Route 10 East, Parsippany, NJ 07054; or if given to a **Covered Person**, when sent or made available to the **Employer** for delivery by the Employer to said **Covered Person**. The **Employer** shall notify **Delta Dental** of any change of address.
7. If **Delta Dental** payment is obtained by or for any person who is not entitled thereto, **Delta Dental** shall have the right to recover such payment from the payee or other person benefiting therefrom.
8. Indemnity in the form of cash will not be paid by **Delta Dental** to any **Employee** except in payment for services for which **Delta Dental** was liable under the **Contract** at the time such services were completed. If the Employee entitled to such payment is no longer living or is a minor, such payment may be made to such person as may, in **Delta Dental's** sole discretion, be deemed entitled thereto, and the liability of **Delta Dental** shall be thereby discharged to the extent of such payment.

9. Except as expressly otherwise provided by law, the **Benefits** and payments hereunder are personal and not assignable.
10. **Claims** for **Dental Services** rendered by New Jersey licensed **Dentists** or other persons acting pursuant to the applicable scope of practice authorized by law shall be made on the Attending **Dentist's** Statement forms as supplied by **Delta Dental**. Said forms may be obtained upon request to **Delta Dental** at P.O. Box 16354, Little Rock, AR 72231.
11. **Employer** hereby agrees to permit **Delta Dental**, through its auditors or other authorized representatives, on reasonable advance notice, to inspect the records of the **Employer** in order to verify the accuracy of lists of **Employees**, as prepared by the **Employer** and submitted to **Delta Dental**.
12. **Delta Dental** shall not be obligated to make payment for **Treatment Plans** submitted more than one year after the date of completion of the service.
13. This **Contract** is deemed to be issued and delivered in the State of New Jersey and is to be construed according to the laws of that State.
14. **Delta Dental** agrees to keep confidential and not release to any party any confidential information, including medical information with respect to any **Covered Person**, except as may be necessary or appropriate in connection with a provision of service by, processing of a **Claim** by, or other performance under this **Contract** by **Delta Dental**.

The Endorsement to the agreement

Article III Section 1

1. "**Employee**" is to be person who is a Employee of the **Employer** who is eligible for coverage as provided in Article III Section 1 of this **Contract** herein. An "**Employee**" must also have been designated as an **Employee to Delta Dental** by the **Employer**. Persons in military service are not eligible for **Benefits** under this **Contract**.

Article III Section 1

2. "**Dependent**" is defined to be the Eligible **Employee's** lawful spouse, a former spouse for whom the **Employee** is legally liable to provide dental benefits, and each dependent child, including stepchildren, foster children and legally adopted children from birth until the end of the calendar year in which age twenty-six (26) is attained. Those dependents in military service are not eligible as **Dependents** under this **Contract**.

For purposes of this definition, the following shall be included in the definition or use of the terms "spouse," "children," and stepchildren" and any other terms that denote the spousal relationship as those terms are used throughout this contract: (a) a party to a civil union or similar relationship with the **Employee** recognized by law as the equivalent of a marriage, and (b) a party to New Jersey domestic partnership with the **Employee** which existed as of July 2007.

"**Domestic Partner**" is defined as a person whom the **Employer** verifies meets the following criteria:

- i) Is not so closely related to the **Employee** that marriage would otherwise be prohibited.
- ii) Is not legally married to any other person.
- iii) The **Employee** and **Domestic Partner** live together, share common necessities of life and are responsible for each other's common welfare, including financial interdependence.
- iv) Is of the age of consent in the state of legal residence and competent to enter into such an arrangement.

Article III Section 7

3. In the event an **Employee** dies, or his employment is terminated, coverage hereunder respecting such **Employee**, and his **Dependents**, if any, shall terminate on the last day of the month in which coverage terminates.

Resolution of the City of Atlantic City

No. 523

Approved as to Form and Legality on Basis of Facts Set Forth

Factual contents certified to by

Assistant City Solicitor /s/ Karl Timbers

Director of Health & Human Services/s/ Shanece J. Jones

Prepared by City Solicitor's Office

Council Member RANDOLPH presents the following Resolution:

AUTHORIZING AN AGREEMENT WITH DELTA DENTAL OF NEW JERSEY, INC., FOR EMPLOYEE DENTAL COVERAGE FOR ONE (1) YEAR ESTIMATED COST IS BASED ON PREMIUM NUMBER OF EMPLOYEES AND STATUS AND THE ANNUAL ESTIMATED IN THE AMOUNT OF \$1,502,990.00

WHEREAS, the City of Atlantic City desires to enter into a Contract with **DELTA DENTAL OF NEW JERSEY, INC.** providers of health benefits and services for dental coverage for the City of Atlantic City; and

WHEREAS, this is requested to be awarded without competitive bids as an exception to same pursuant to N.J.S.A. 40A:11-5(1) (m) which can be deemed an Extraordinary Unspecifiable Service; and

WHEREAS, the City has requested and received a proposal for Dental Coverage and after review has recommended **DELTA DENTAL OF NEW JERSEY, INC.** as they are offering the same pricing structure as the two previous years which was superior as to price, coverage and quality of benefits; and

WHEREAS, the contract award shall be for one (1) year from July 1, 2025 and ending June 30, 2026; and

WHEREAS, **DELTA DENTAL OF NEW JERSEY, INC.** has completed and submitted a Business Entity Disclosure Certification which certifies that **DELTA DENTAL OF NEW JERSEY, INC.** has not made any reportable contributions pursuant to N.J.S.A. 19:44A-1 et seq. that would bar the award of a contract, and

WHEREAS, the Business Disclosure Entity Certification shall be placed on file with this resolution; and

WHEREAS, the vendor has committed to assuring the City that the benefits and contractual limitations are equal to or greater than the City's current plan and the estimated cost is based on premium number of employees and status and the annual estimated cost for 2025-2026 is **\$1,502,990.00**; and

NOW, THEREFORE, BE IT RESOLVED by the Council of the City of Atlantic City that the Mayor is duly authorized to execute and the City Clerk to attest an agreement with **DELTA DENTAL OF NEW JERSEY, INC.** for one (1) year beginning **July 1, 2025 to June 30, 2026** to be approved as to form and execution by the City Solicitor, which contract shall set forth more specifically the services to be performed; and

BE IT FURTHER RESOLVED, that pursuant to N.J.A.C. 5:50-14.5, the award of the above Contract is contingent upon the availability of sufficient funds in the 2025 & 2026 temporary and permanent budget and in the event said funds are not appropriated for this Contract, this award will have no effect and will then be null and void. This Contract is contingent upon the approval of the Director of the Division of Local Government Services in the Department of Community Affairs; and

BE IT FURTHER RESOLVED, that Public Notice of this Resolution shall be published in the **THE PRESS** at least once pursuant to the requirements of N.J.S.A 40A:11-1, et seq.,

July 21, 2025 12:52 PM

DO NOT USE SPACE BELOW THIS LINE												
RECORD OF COUNCIL VOTE ON FINAL PASSAGE												
COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	MOT.	SEC.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	SEC.
BAILEY	X						LACCA	X				
CROUCH	X					X	MARSHALL	X				
DUNSTON	X				X		SHABAZZ	X				
KURTZ	X						TIBBITT	X				
RANDOLPH, PRESIDENT								X				
X-Indicates Vote NV-Not Voting AB-Absent MOT-Motion SEC-Second												

This is a Certified True copy of the Original Resolution on file in the City Clerk's Office.

DATE OF ADOPTION: JULY 16, 2025

Paula Geletei

 /s/ Paula Geletei, City Clerk