GROUP DENTAL INDEMNITY AGREEMENT

This Group Dental Indemnity Agreement ("Agreement") is made by and between THE CITY OF HOUSTON, TEXAS ("City" or "Policyholder"), a home-rule city of the State of Texas principally situated in Harris County, acting by and through its governing body, the City Council, and ______________________________ ("Contractor") an insurance company authorized and admitted to do business in the State of Texas whose principal office is located at __________________________.

WHEREAS, it is the Policyholder’s desire to provide a fully insured group dental indemnity policy to its Employees and their Dependents; and

WHEREAS, Contractor has agreed to issue a dental indemnity policy in the form attached hereto as Exhibit "A" (the "Policy"); and

WHEREAS, the Policyholder and Contractor in furtherance of the provisions of said Policy and to implement its provisions have agreed to various additional matters not contained in the Policy which they desire to set forth in this Agreement between the parties;

NOW, THEREFORE, the parties agree as follows:

ARTICLE I.
Duties of Contractor

In consideration of the mutual agreements contained herein and other good and sufficient consideration the receipt of which is acknowledged by the parties, Contractor agrees to perform the following services and to provide the Performance Guarantees set out in Exhibit "B":

1. Contractor shall cause the Policy attached hereto as Exhibit "A" to be issued to the Policyholder.

2. Contractor shall prepare or provide the necessary data processing, educational materials, printed materials; and identification cards for use in conjunction with the Policy.

3. Contractor shall assist in answering all questions arising in the administration of this Agreement and the Policy.

4. Contractor shall keep books and records and do all the clerical record keeping in connection with its management and administration of this Agreement and the Policy attached thereto and make same available to Policyholder for its inspection.

5. Contractor shall assist in the preparation and distribution as required by law and in such manner as Contractor may determine to be appropriate, of information and reports concerning this Agreement. Contractor shall prescribe such procedures, rules and regulations as it shall deem necessary or proper for the efficient administration, except if such procedures are found to be in violation of this Agreement, then this Agreement will govern.
6. Contractor shall submit to the Policyholder, a report entitled "Summary Claims Paid By Benefit Type" and a report entitled "Group Claim Payment Report by (1) Plan (2) Member and (3) Provider" and such other reports as shall be mutually agreed upon by the parties. To the extent that a fee will be imposed for any additional report Contractor shall notify the Director and obtain written approval before producing the report.

7. Contractor shall maintain a Houston office with a toll-free telephone number available for Members.

8. Contractor shall provide a copy of the Policy for each Member upon written request.

ARTICLE II.

Release, Indemnity and Insurance

1. **RELEASE**

   CONTRACTOR AGREES TO AND SHALL RELEASE POLICYHOLDER, ITS AGENTS, EMPLOYEES, OFFICERS, AND LEGAL REPRESENTATIVES (COLLECTIVELY THE “POLICYHOLDER”) FROM ALL LIABILITY FOR INJURY, DEATH, DAMAGE, OR LOSS TO PERSONS OR PROPERTY SUSTAINED IN CONNECTION WITH OR INCIDENTAL TO PERFORMANCE UNDER THIS AGREEMENT, EVEN IF THE INJURY, DEATH, DAMAGE, OR LOSS IS CAUSED BY THE POLICYHOLDER’S SOLE OR CONCURRENT NEGLIGENCE AND/OR THE POLICYHOLDER’S STRICT PRODUCTS LIABILITY OR STRICT STATUTORY LIABILITY.

2. **INDEMNIFICATION**

   CONTRACTOR AGREES TO AND SHALL DEFEND, INDEMNIFY, AND HOLD POLICYHOLDER, ITS AGENTS, EMPLOYEES, OFFICERS, AND LEGAL REPRESENTATIVES (COLLECTIVELY THE “POLICYHOLDER”) HARMLESS FOR ALL CLAIMS, CAUSES OF ACTION, LIABILITIES, FINES, AND EXPENSES (INCLUDING, WITHOUT LIMITATION, ATTORNEYS’ FEES, COURT COSTS, AND ALL OTHER DEFENSE COSTS AND INTEREST) FOR INJURY, DEATH, DAMAGE, OR LOSS TO PERSONS OR PROPERTY SUSTAINED IN CONNECTION WITH OR
INCIDENTAL TO PERFORMANCE UNDER THIS AGREEMENT INCLUDING, WITHOUT LIMITATION, THOSE CAUSED BY:

(a) CONTRACTOR’S AND/OR ITS AGENTS’, EMPLOYEES’, OFFICERS’, DIRECTORS’, CONTRACTORS’, OR SUBCONTRACTORS’ (COLLECTIVELY IN NUMBERED PARAGRAPHS 1-3, “CONTRACTOR”) ACTUAL OR ALLEGED NEGLIGENCE OR INTENTIONAL ACTS OR OMISSIONS;

(b) THE POLICYHOLDER’S AND CONTRACTOR’S ACTUAL OR ALLEGED CONCURRENT NEGLIGENCE, WHETHER CONTRACTOR IS IMMUNE FROM LIABILITY OR NOT; AND

(c) THE POLICYHOLDER’S AND CONTRACTOR’S ACTUAL OR ALLEGED STRICT PRODUCTS LIABILITY OR STRICT STATUTORY LIABILITY, WHETHER CONTRACTOR IS IMMUNE FROM LIABILITY OR NOT.

CONTRACTOR SHALL DEFEND, INDEMNIFY, AND HOLD THE POLICYHOLDER HARMLESS DURING THE TERM OF THIS AGREEMENT AND FOR FOUR YEARS AFTER THE AGREEMENT TERMINATES. CONTRACTOR’S INDEMNIFICATION IS LIMITED TO $500,000 PER OCCURRENCE. CONTRACTOR SHALL NOT INDEMNIFY THE POLICYHOLDER FOR THE POLICYHOLDER’S SOLE NEGLIGENCE.

3. RELEASE AND INDEMNIFICATION, (COPYRIGHT, TRADEMARK, AND TRADE SECRET INFRINGEMENT)

CONTRACTOR AGREES TO AND SHALL RELEASE AND DEFEND, INDEMNIFY, AND HOLD HARMLESS THE POLICYHOLDER, ITS AGENTS,
EMPLOYEES, OFFICERS, AND LEGAL REPRESENTATIVES (COLLECTIVELY THE “POLICYHOLDER”) FROM ALL CLAIMS OR CAUSES OF ACTION BROUGHT AGAINST THE POLICYHOLDER BY ANY PARTY, INCLUDING CONTRACTOR, ALLEGING THAT THE POLICYHOLDER’S USE OF ANY EQUIPMENT, SOFTWARE, PROCESS, OR DOCUMENTS CONTRACTOR FURNISHES DURING THE TERM OF THIS AGREEMENT INFRINGES ON A PATENT, COPYRIGHT, OR TRADEMARK, OR MISAPPROPRIATES A TRADE SECRET. CONTRACTOR SHALL PAY ALL COSTS (INCLUDING, WITHOUT LIMITATION, ATTORNEYS’ FEES, COURT COSTS, AND ALL OTHER DEFENSE COSTS, AND INTEREST) AND DAMAGES AWARDED.

CONTRACTOR SHALL NOT SETTLE ANY CLAIM ON TERMS WHICH PREVENT THE POLICYHOLDER FROM USING THE EQUIPMENT, SOFTWARE, PROCESS, AND DOCUMENTS WITHOUT THE POLICYHOLDER'S PRIOR WRITTEN CONSENT. WITHIN 60 DAYS AFTER BEING NOTIFIED OF THE CLAIM, CONTRACTOR SHALL, AT ITS OWN EXPENSE, EITHER (1) OBTAIN FOR THE POLICYHOLDER THE RIGHT TO CONTINUE USING THE EQUIPMENT, SOFTWARE, PROCESS, AND DOCUMENTS OR, (2) IF BOTH PARTIES AGREE, REPLACE OR MODIFY THEM WITH COMPATIBLE AND FUNCTIONALLY EQUIVALENT PRODUCTS. IF NONE OF THESE ALTERNATIVES IS REASONABLY AVAILABLE, THE POLICYHOLDER MAY RETURN THE EQUIPMENT, SOFTWARE, OR DOCUMENTS, OR DISCONTINUE THE PROCESS, AND CONTRACTOR SHALL REFUND THE PURCHASE PRICE.
4. **INDEMNIFICATION – SUBCONTRACTOR’S INDEMNITY**

CONTRACTOR SHALL REQUIRE ALL OF ITS SUBCONTRACTORS (AND THEIR SUBCONTRACTORS) TO RELEASE AND INDEMNIFY THE POLICYHOLDER TO THE SAME EXTENT AND IN SUBSTANTIALLY THE SAME FORM AS ITS RELEASE AND INDEMNITY TO THE CITY.

5. **INDEMNIFICATION PROCEDURES**

(A) **Notice of Claims.** If the Policyholder or Contractor receives notice of any claim or circumstances which could give rise to an indemnified loss, the receiving party shall give written notice to the other party within 30 days. The notice must include the following:

(a) a description of the indemnification event in reasonable detail,
(b) the basis on which indemnification may be due, and
(c) the anticipated amount of the indemnified loss.

This notice does not estop or prevent the Policyholder from later asserting a different basis for indemnification or a different amount of indemnified loss than that indicated in the initial notice. If the Policyholder does not provide this notice within the 30 day period, it does not waive any right to indemnification except to the extent that Contractor is prejudiced, suffers loss, or incurs expense because of the delay.

(B) **Defense of Claims**

(a) **Assumption of Defense.** Contractor may assume the defense of the claim at its own expense with counsel chosen by it that is reasonably satisfactory to the City. Contractor shall then control the defense and any negotiations to settle the claim. Within 10 days after receiving written notice of the indemnification request, Contractor must advise the City as to whether or not it will defend the claim. If Contractor does not assume the defense, the City shall assume and control the defense, and all defense expenses constitute an indemnification loss.

(b) **Continued Participation.** If Contractor elects to defend the claim, the City may retain separate counsel to participate in (but not control) the defense and to participate in (but not control) any settlement negotiations. Contractor may settle the claim without the consent or agreement of the City, unless it (i) would result in injunctive relief or other equitable remedies or otherwise require the City to comply with restrictions or limitations that adversely affect the City, (ii) would require the City to pay amounts that Contractor does not fund in full, (iii) would not result in the City’s full and complete release from all liability to the plaintiffs or claimants who are parties to or otherwise bound by the settlement.

6. **Insurance**
(a) Risks and Limits of Liability. Contractor shall maintain the following insurance coverages in the following amounts:

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>LIMIT OF LIABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers' Compensation</td>
<td>• Statutory for Workers’ Compensation</td>
</tr>
<tr>
<td>Employer's Liability</td>
<td>• Bodily Injury by Accident $100,000 (each accident)</td>
</tr>
<tr>
<td></td>
<td>• Bodily Injury by Disease $100,000 (policy limit)</td>
</tr>
<tr>
<td></td>
<td>• Bodily Injury by Disease $100,000 (each employee)</td>
</tr>
<tr>
<td>Commercial General Liability: Bodily and Personal Injury; Products and</td>
<td>• Bodily Injury and Property Damage, Combined Limits of</td>
</tr>
<tr>
<td>Completed Operations Coverage</td>
<td>$1,000,000 each Occurrence, and $1,000,000 aggregate</td>
</tr>
<tr>
<td>Automobile Liability</td>
<td>• $1,000,000 combined single limit for (1) Any Auto or (2) All Owned, Hired, and Non-Owned Autos</td>
</tr>
<tr>
<td>Professional Liability</td>
<td>• $1,000,000 per occurrence; $1,000,000 aggregate</td>
</tr>
<tr>
<td>Excess Liability applicable each to CGL, and Auto</td>
<td>• $1,000,000</td>
</tr>
</tbody>
</table>

Aggregate Limits are per 12-month policy period unless otherwise indicated.

(b) Insurance Coverage. At all times during the term of this Agreement and any extensions or renewals, Contractor shall provide and maintain insurance coverage that meets the Agreement requirements. Prior to beginning performance under the Agreement, at any time upon the Director’s request, or each time coverage is renewed or updated, Contractor shall furnish to the Director current certificates of insurance, endorsements, all policies, or other policy documents evidencing adequate coverage, as necessary. Contractor shall be responsible for and pay (a) all premiums and (b) any claims or losses to the extent of any deductible amounts. Contractor waives any claim it may have for premiums or deductibles against the City, its officers, agents, or employees. Contractor shall also require all subcontractors or consultants whose subcontracts exceed $100,000 to provide proof of insurance coverage meeting all requirements stated above except amount. The amount must be commensurate with the amount of the subcontract, but no less than $500,000 per claim.

(c) Form of insurance. The form of the insurance shall be approved by the Director and the City Attorney; such approval (or lack thereof) shall never (a) excuse non-compliance with the terms of this Section, or (b) waive or estop the City from asserting its rights to terminate this
Agreement. The policy issuer shall (1) have a Certificate of Authority to transact insurance business in Texas, or (2) be an eligible non-admitted insurer in the State of Texas and have a Best's rating of at least B+, and a Best's Financial Size Category of Class VI or better, according to the most current Best's Key Rating Guide.

(d) **Required Coverage.** The City shall be an Additional Insured under this Agreement, and all policies, except Professional Liability and Worker's Compensation, shall explicitly name the City as an Additional Insured. The City shall enjoy the same coverage as the Named Insured without regard to other Contract provisions. Contractor waives any claim or right of subrogation to recover against the City, its officers, agents, or employees, and each of Contractor’s insurance policies except professional liability must contain coverage waiving such claim. Each policy, except Workers’ Compensation and Professional Liability, must also contain an endorsement that the policy is primary to any other insurance available to the Additional Insured with respect to claims arising under this Contract.

All certificates of insurance submitted by Contractor shall be accompanied by endorsements for 1) Additional Insured coverage in favor of the City for Commercial General Liability and Automobile Liability policies, and 2) Waivers of Subrogation in favor of the City for Commercial General Liability, Automobile Liability and Workers’ Compensation/Employers’ Liability policies. The Director will consider all other forms on a case-by-case basis.

(e) **Notice.** CONTRACTOR SHALL GIVE 30 DAYS’ ADVANCE WRITTEN NOTICE TO THE DIRECTOR IF ANY OF ITS INSURANCE POLICIES ARE CANCELED OR NON-RENEWED. Within the 30-day period, Contractor shall provide other suitable policies in order to maintain the required coverage. If Contractor does not comply with this requirement, the Director, at his or her sole discretion, may immediately suspend Contractor from any further performance under this Agreement and begin procedures to terminate for default.

**Other Insurance**

If requested by the Director, Contractor shall furnish adequate evidence of Social Security and Unemployment Compensation Insurance, to the extent applicable to Contractor’s operations under this Agreement.

**ARTICLE III.**

**MISCELLANEOUS**


2. The provisions of this Agreement may be amended at any time, and from time to time, by the Policyholder upon concurrence of the Policyholder’s Mayor, Human Resources Director and City Attorney in order to comply with state, federal, or local law; provided, however, that no amendment shall deprive any Member of any benefits to which he became
entitled in connection with any claim incurred before the date of the amendment. Such amendment may not be unreasonably withheld.

3. It is the Policyholder’s intent that the Policy be funded only by Covered Persons’ contributions, and the Policyholder shall have no obligation to provide funding for the Policy.

4. All definitions used in this Agreement shall have the meaning assigned to them as set forth in the Policy.

5. Any notice, consent or other communication required by, or to be given pursuant to the Agreement, shall be in writing and delivered to the intended recipient thereof. A notice shall be deemed delivered if mailed to the intended recipient by registered or certified mail, return receipt requested, postage prepaid to the following address (subject to change of such address by prior written notice):

To Policyholder: City of Houston
Director of Human Resources
P.O. Box 248
Houston, Texas 77001-9931

To Contractor: ___________________________
_________________________
_________________________

With a copy to: ___________________________
_________________________
_________________________

6. **Term and Termination**

   (a) This Agreement shall be in effect for an initial period of three (3) years beginning at 12:01 a.m. on May 1, 2016 and ending at 11:59 p.m. on April 30, 2019.

   (b) This Agreement may be renewed by the City for two additional one-year terms at the sole option of the Director, provided that the Director gives written notice of such renewal to Contractor no later than (60) sixty days before the end of the Initial Term or before the anniversary of any Renewal period.

   (c) This Agreement will terminate simultaneously with the termination of the Policy.

   (d) No provision of this Agreement shall survive in the event the Policy is terminated in accordance with its terms.

   (e) Contractor shall cooperate in a reasonable manner and for a reasonable period of time with the transition of coverage to a successor vendor or provider.
7. Governing laws

Contractor shall comply with all applicable state and federal laws and regulations and all provisions of the City of Houston Charter and Code of Ordinances. Venue for purposes of this Agreement shall be in Houston, Harris County, Texas.

8. Pay or Play

The requirements and terms of the City of Houston Pay or Play program, as set out in Executive Order 1-7-Revised, as amended from time to time, are incorporated into this Agreement for all purposes. Contractor has reviewed Executive Order No. 1-7-Revised and shall comply with its terms and conditions.

9. CONTRACTOR DEBT

IF CONTRACTOR, AT ANY TIME DURING THE TERM OF THIS AGREEMENT, INCURS A DEBT, AS THE WORD IS DEFINED IN SECTION 15-122 OF THE HOUSTON CITY CODE OF ORDINANCES, IT SHALL IMMEDIATELY NOTIFY THE CITY CONTROLLER IN WRITING. IF THE CITY CONTROLLER BECOMES AWARE THAT CONTRACTOR HAS INCURRED A DEBT, HE OR SHE SHALL IMMEDIATELY NOTIFY CONTRACTOR IN WRITING. IF CONTRACTOR DOES NOT PAY THE DEBT WITHIN 30 DAYS OF EITHER SUCH NOTIFICATION, THE CITY CONTROLLER MAY DEDUCT FUNDS IN AN AMOUNT EQUAL TO THE DEBT FROM ANY PAYMENTS OWED TO CONTRACTOR UNDER THIS AGREEMENT, AND CONTRACTOR WAIVES ANY RECURSE THEREFOR.

CONTRACTOR SHALL FILE A NEW AFFIDAVIT OF OWNERSHIP, USING THE FORM DESIGNATED BY CITY, BETWEEN FEBRUARY 1 AND MARCH 1 OF EVERY YEAR DURING THE TERM OF THIS AGREEMENT.

10. This Agreement together with its exhibits constitutes the entire agreement between the parties.

11. The following Exhibits are attached to this Agreement and incorporated herein for all purposes; and the parties agree to comply with the provisions set out therein:

Exhibit “A” - Group Indemnity Insurance Policy

Exhibit “B” - Performance Guarantees

Exhibit “C” - Drug Detection and Deterrence Policy

Exhibit “D” - Minority and Women Business Enterprises

Exhibit “E” - Group Dental Indemnity Contributions

Exhibit “F” – Scope of Services
IN WITNESS HEREOF, the City of Houston and _____________________ have made and executed this Agreement in multiple copies, each of which is an original.

CONTRACTOR:

ATTEST/SEAL: ________________________________

By _______________________  By: __________________________
Name:      Name: ________________________________
Title:      Title: ________________________________

ATTEST/SEAL: ________________________________

CITY OF HOUSTON, TEXAS

Approved by: ________________________________

City Secretary  Mayor

APPROVED: ________________________________

COUNTERSIGNED BY: ________________________________

Director  City Controller
Department of Human Resources

_________ City Purchasing Agent

APPROVED AS TO FORM: ________________________________

DATE COUNTERSIGNED: ________________________________

_________ Sr. Assistant City Attorney
L.D. File No. ________________________________
EXHIBIT "A"

GROUP INDEMNITY INSURANCE POLICY

GROUP APPLICATION

(Name of Insurance Company)

(Address)

This Group Application is for a Group Dental Indemnity Policy ("Policy") to be issued to the CITY OF HOUSTON, TEXAS ("Policyholder") a home-rule city of the State of Texas principally situated in Harris County, acting by and through its governing body, the City Council, and _______________________________, with a principal office located at __________________________ ("Contractor").

By accepting this Group Application, __________________________ (Name) and THE CITY OF HOUSTON, TEXAS, agree to be bound by the provisions of this Policy, together with any riders or amendments thereto. Coverage will be for eligible Members of Policyholder and their Dependents who enroll for coverage under the Policy. Eligible Members of Policyholder are those persons who appear on the eligibility lists provided by Policyholder and eligible Dependents as defined in Section III of this Policy.

The effective date of coverage for new eligible Members and Dependents and of termination of coverage will be (check appropriate blank):

<table>
<thead>
<tr>
<th>Coverage Effective Date</th>
<th>Termination Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Date of hire</td>
<td>___ Date employment ends</td>
</tr>
<tr>
<td>___ First of month</td>
<td>___ 15th or last day of Policy Month for which the Employee has made the required contribution</td>
</tr>
<tr>
<td>___ The 1st or 16th of the month following 30 DAYS of employment as a full-time employee (average of 30 or more hours per week and have PT/30 designation in the City of Houston Payroll System)</td>
<td>___ Other (Refer to Section X)</td>
</tr>
<tr>
<td>___ Other (Refer to Article III)</td>
<td>___ Other (Refer to Section X)</td>
</tr>
</tbody>
</table>

The Policy shall be in effect for an initial period of thirty-six (36) months beginning at 12:01 a.m. on May 1, 2016 and ending at 11:59 p.m. on April 30, 2019 (the "Initial Term").
ELIGIBLE CLASSES
ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS

BASIS OF INSURANCE
Personal Coverage [ X ] Contributory or
[ ] Non-Contributory
Dependent Coverage [ X ] Contributory or
[ ] Non-Contributory

Employee Contributions/Premiums during the first twelve months of this Policy will be as follows:

$_____ per employee per month for employee only coverage;
$_____ per employee per month for employee plus one dependent coverage;
$_____ per employee per month for employee plus two or more dependents coverage;
$_____ per retiree per month for retiree only coverage;
$_____ per retiree per month for retiree plus one dependent coverage; and
$_____ per retiree per month for retiree plus two or more dependents coverage.

Employee Contributions/Premiums during all remaining years shall be as described in Exhibit "E" to the Group Dental Indemnity Agreement.
IN WITNESS HEREOF, the City of Houston, Texas and ____________________ have made and executed this Group Indemnity Policy in multiple copies, each of which is an original.

ATTEST/SEAL:

By: ________________________________
Name: ______________________________
Title: ______________________________

ATTEST/SEAL:

CITY OF HOUSTON, TEXAS

Signed by:

__________________________  _________________________________
City Secretary     Mayor

APPROVED:

__________________________  _________________________________
Director     City Controller
Department of Human Resources

APPROVED AS TO FORM:

__________________________  _________________________________
Sr. Assistant City Attorney     DATE COUNTERSIGNED:
L.D. File No. __________________
GROUP DENTAL INDEMNITY POLICY

CERTIFICATE OF INSURANCE

Provided for:

THE CITY OF HOUSTON

(Herein called the Policyholder)

issued by:

________________________________________

(Herein called Contractor)

GROUP DENTAL INDEMNITY POLICY

This is to certify that Contractor has issued and delivered to the above named Policyholder a Group Dental Indemnity Policy. The Policy insures the Policyholder’s Employees who:

• Are eligible for the insurance;
• become insured; and
• continue to be insured

according to the terms of the Policy.

The terms of the Policy which affect an Employee’s insurance are set forth in the following pages. These pages are part of the Policy.

Account Number: ____________

Authorized Signature     Authorized Signature
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</tbody>
</table>
GROUP DENTAL INDEMNITY POLICY

This Group Dental Indemnity Policy is issued by _________________________ ("Contractor") a ___________________ established under the laws of the State of ________________ and doing business in Texas whose principal office is located at ________________ to the CITY OF HOUSTON, TEXAS ("Policyholder") a home-rule city of the State of Texas principally situated in Harris County, acting by and through its governing body, the City Council.

SECTION I - DEFINITIONS

Unless otherwise required by the context, the following definitions shall control:

1. ACCIDENTAL BODILY INJURY means only bodily injury sustained accidentally and independently of all other causes by an outside traumatic event or due to exposure to the elements.

2. ACTIVE EMPLOYEE means:
   a. A person who, as an Employee or an Elected Official, is regularly scheduled to work not less than an average of thirty (30) hours per week in the service of the Policyholder and who is compensated for such services by salary, wages or emoluments of office; or
   b. A person who, for a period of time not to exceed twelve (12) months, is on leave of absence approved by the Policyholder.

3. CHILD OR CHILDREN means a child born to you, foster child, stepchild, or a child legally adopted by you or a grandchild who is considered your Dependent for federal income tax purposes and is Primarily Dependent upon You. It also includes a child whose adoption is anticipated and for whom you have legal support obligations, a child for whom you are legal guardian, a child for whom you have been ordered to assume dental responsibility by a court of law.

4. CONTRIBUTIONS OR PREMIUMS means the payments of Employee payroll deductions and other manual premiums by Policyholder in accordance with Section V of this Policy.

5. COVERED EXPENSE(S) means charges for dental services or appliances that are necessary, meaning that they are broadly accepted professionally as essential to the treatment of the Member's condition, provided such charges are reasonable in amount. The reasonable charge
for a service or appliance is the lesser of (a) the charge usually made for it by the provider who furnished it, and (b) the prevailing charge made for it, in the same geographic area by those of similar professional standing. In determining whether a charge is reasonable, Contractor will also consider unusual circumstances or complications arising in connection with the service performed to the extent that they required additional time, skill and experience. Charges incurred outside the United States or its territories will be calculated based on the usual and prevailing fees applicable in Houston, Texas. If the usual and prevailing charges for a service or supply cannot be determined because of the unusual nature of the service or supply, Contractor will determine to what extent the charge is reasonable, taking into account (a) the complexity involved, (b) the degree of professional skill required, and (c) any other pertinent factors.

6. **COVERED PERSON** means any person entitled to benefits hereunder.

7. **DEFERRED RETIRED EMPLOYEE** means an Employee of the Policyholder who as a member of one of the various State statutory pension plans that are offered to the Policyholder's employees:
   
   a. Has completed sufficient service time and/or met any other applicable requirements to be eligible to receive a deferred pension under the terms of the pension plan; and
   
   b. Will attain the age necessary to commence actually receiving benefit payments under the pension plan on or before the fifth anniversary of the Employee's severance from active service with the Policyholder.
   
   c. Has been continuously covered by an Employer sponsored health benefits plan from the end of your active service until the beginning of a deferred pension according to the terms of the pension plan.
8. **DENTIST** means a Doctor of Dental Surgery (D.D.S.) Or a Doctor of Medical Dentistry (D.M.D.) who holds a lawful license authorizing the person to practice dentistry in the locale in which the service is rendered.

9. **DEPENDENT** means:
   - Your lawful spouse; and
   - Any child of yours who is
     - less than 26 years old.
     - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage. Proof of the child’s condition and dependence must be submitted to the dental carrier within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the dental carrier may require proof of the continuation of such condition and dependence.
     - Disabled; provided that in the case of a Child who is twenty-six (26) years of age or older but incapable of self-sustaining employment because of mental retardation or physical handicap and Primarily Dependent upon the Employee for support and maintenance, such Dependent Child must have been a Member either prior to attaining twenty-six (26). Employee shall furnish Contractor proof of such incapacity and dependency within thirty one (31) days before the Dependent Child's attainment of the limiting age and from time to time thereafter as Contractor deems appropriate.

   The term **DEPENDENT** shall not be held to include (1) a legally separated spouse, or (2) a spouse or Child on active military duty for any country.

   Contractor reserves the right to require whatever documentation it determines to be reasonably necessary to establish to its satisfaction that any claimed Dependent meets all applicable requirements of this definition.

   An Employee may elect to be covered only as an Employee or as a Dependent, but not both simultaneously. If and when a Member terminates coverage under this Policy as an Employee or Dependent, such person shall have a right to continue coverage under either
definition that continues to apply, if any. If a Member ceases to be an Employee and could also be covered as a Dependent then such Member must comply with Section III (1)(e)(iii).

10. **DEPENDENT COVERAGE** means an Employee's coverage under this Policy with respect to his Dependents.

11. **DIRECTOR** means the Director of the Department of Human Resources of the City of Houston or his or her designee.

12. **DISABLED** means any medically determinable physical or mental condition that prevents a person from engaging in self-sustaining employment.

13. **ELECTED OFFICIAL** means any of the Mayor, City Council Members, and City Controller of the City of Houston.

14. **EMERGENCY CARE** means bona fide emergency services provided after the sudden onset of a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
   a. Placing the Members health in serious jeopardy;
   b. Serious impairment to bodily function; or
   c. Serious dysfunction of any bodily organ or part.

15. **EMERGENCY PALLIATIVE TREATMENT** means any dental procedures necessary to alleviate (but not cure) acute pain or temporarily alleviate (but not cure) conditions requiring the immediate attention of a Dentist to prevent irreparable harm to the Covered Person.

16. **EMPLOYEE** means any Active Employee, Deferred Retired Employee or Retiree, or Survivor.

17. a. **INCURRED DATE** means the date on which a particular service or supply that gives rise to an expense or charge rendered or obtained.
   
   b. **INCURRED DATE** (for purposes of Section VII only) means:
      i. for an appliance or modification of an appliance the date the impression is taken.
      ii. for a crown, bridge, or gold restoration, the date the tooth is prepared.
      iii. for root canal therapy, the date the pulp chamber is opened.
      iv. for all other services, the date the service is received.
18. **INJURY** (or non-occupational injury) means only an Accidental Bodily Injury that does not arise, and that is not caused or contributed to, by, or as a consequence of, any injury that arises out of or in the course of any employment or occupation for compensation or profit.

19. **MEMBER** means any Employee or Dependent as described in Section III herein.

20. **OPT-OUT RETIREE** means an individual who meets the Employee’s eligibility requirements set forth in this Agreement, who has retired from the service of the Policyholder and is receiving retirement benefit payments under one of the several pension plans offered by the Policyholder, and who opts to not continue coverage in the Policy for himself/herself and his/her then covered Dependents at the time when such person assumed Retiree status and opts out of the Policy, such person and his or her Dependents were continuously enrolled in the Policy or an Alternative Dental Plan. Notwithstanding the foregoing, new Dependents of such Retiree, acquired after such Retiree opted out and after Retiree opts to re-enroll as a Member in the Policy, shall be permitted to enroll.

21. **OPT-IN RETIREE** means an Opt-Out Retiree who is eligible to re-enroll himself/herself, his/her newly acquired dependents and his/her previously covered Dependents in the Policy at a later date in accordance with normal enrollment guidelines under Policy provisions.

22. **PERSONAL COVERAGE** means a Member’s coverage under this Policy with respect to himself.

23. **POLICY** means this Group Dental Indemnity Policy together with all schedules, amendments, endorsements and riders attached hereto.

24. **POLICY MONTH** means a period commencing on the first day of any calendar month and continuing until the same day of the next succeeding calendar month.

25. **POLICYHOLDER** means the City of Houston

26. **PRIMARILY DEPENDENT** means receiving more than fifty percent (50%) of support from the Employee, meeting the requirements to be claimed as a Dependent on the Employee's federal income tax return and being a Child of the Employee.

27. **RETIREE** means a person who has retired from the service of the Policyholder on or after 07/01/93 and is receiving retirement benefit payments under one of the several pension plans offered by the Policyholder.

28. **RETIRED DISABLED FOLLOWING CATASTROPHIC INJURY ON DUTY (RDFCID)** means an individual who meets the Active Employee’s eligibility requirements set forth in Article I.2 of this Agreement, who is catastrophically injured in the course and scope of
performing his/her job; and, as a result is totally and permanently disabled; and, is receiving retirement benefit payments under one of the several pension plans offered by the Policyholder; and, is receiving or is eligible to receive Lifetime Income Benefits according to provisions of §408.161 of the Texas Labor Code, provided that between the time when such person first assumes Retiree status and when such person seeks to enroll in the Policy, such person and his or her dependents were continuously enrolled in the Policy or an Alternative Dental Benefits Plan. Notwithstanding the foregoing, new Dependents of such Retiree, acquired after such Retiree enrolled as a Member in the Policy, shall be permitted to enroll in accordance with Policy provisions.

29. **SURVIVOR** means any person who becomes a Member under this definition. In the event of termination of an Employee's coverage due to death of the Employee, coverage of his surviving covered Dependents may be continued following the date of death, provided that the Employee's surviving spouse or, in the absence of a surviving spouse, the Employee's eldest Dependent, shall be deemed to be the Employee for purposes of this Policy, and further provided that the Contributions required with respect to all such Dependents of the deceased Employee are made. Coverage for such Dependents shall terminate on the earliest of the following dates:

- **a.** The last day of the month in which the Dependent attains age 26; (but this event shall only terminate coverage of the Dependent who is attaining age 26, and not the coverage of the other Dependents).

- **b.** As to a Dependent Child of the deceased Employee, the last day of the month in which such Dependent Child ceases to be a Dependent as defined in this Policy.

- **c.** The last day of the month in which the Dependent becomes eligible for coverage hereunder as an eligible Employee, or under any other employer-sponsored policy, plan or program of group dental coverage; or

- **d.** Upon the date of termination of this Policy.

Coverage under this definition shall be limited to Dependents who were covered at the time of the Employee's death, except that coverage may also be extended to any newborn natural Child of the deceased Employee in accordance with the provisions of Section III of this Policy that pertain to newborn children.

Notwithstanding the foregoing, if any provisions of the Revised Civil Statutes of Texas would entitle a Survivor under this definition to expanded eligibility under the Policy, then such
Survivor shall be eligible for expanded eligibility in accordance with the provisions of the Revised Civil Statutes of Texas for so long as they apply to that Survivor.

SECTION II - GENERAL PROVISIONS

1. **THIS POLICY**
   
   a. **ENTIRE POLICY.** This Policy, together with the Group application and the applications of the Covered Persons, constitute the entire agreement for coverage.
   
   b. **WORKERS’ COMPENSATION.** This Policy is not instead of and does not affect any requirement for coverage by workers’ compensation insurance.
   
   c. **GENDER.** The use of masculine pronouns in this Policy shall apply to persons of both sexes unless the context clearly indicates otherwise.
   
   d. **HEADINGS.** The headings used in this Policy are for the purpose of convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading. In all cases, the full text of this Policy will control.
   
   e. **FREE CHOICE OF DENTIST.** A Member covered hereunder will have free choice of his dentist.

2. **STATEMENTS**
   
   a. **NOT WARRANTIES.** Statements made by or on behalf of any person to obtain coverage under this Policy shall be deemed representations and not warranties.
   
   b. **MISSTATEMENTS ON APPLICATION.** If any relevant fact has been misstated by or on behalf of any person to obtain coverage under this Policy, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement, an equitable adjustment of any Contributions will be made.
   
   c. **TIME LIMIT FOR MISSTATEMENT.** No misstatement made to obtain coverage under this Policy shall be used to void the coverage of any person which has been in force for a period of two (2) years or to deny a claim for a loss incurred after the expiration of such two (2) year period. The provisions of this paragraph shall not apply if any such misstatement has been made fraudulently.
d. **USE OF STATEMENTS** No statement made by or on behalf of any person shall be used in any contest unless a copy of the written instrument containing such statement has been or is furnished to such person or to any person claiming a right to receive benefits with respect to such person.

**SECTION III - ELIGIBILITY FOR COVERAGE; EFFECTIVE DATES**

1. **ELIGIBILITY**

a. **Eligibility for Coverage**

i. **Active Employee** - An Active Employee is eligible for coverage under this Policy for himself and his eligible Dependents on the first or sixteenth of the month after completion of thirty (30) days of continuous employment as a full-time (regularly scheduled to work an average of thirty (30) or more hours per week and classified as PT/30 in the City of Houston Payroll System) employee of the Policyholder. A Deferred Retired Employee or Retiree is eligible for coverage for himself and his eligible Dependents on the date that he assumes Deferred Retired Employee or Retiree status, as applicable, with the Policyholder, subject to the limitation of Item iii of this Subsection.

ii. **Dependent** - Any Dependent acquired after the effective date of the Employee's coverage shall become eligible for coverage on the date he becomes a Dependent. Coverage of the Employee shall be a condition precedent to coverage of his eligible Dependents. However, the Employee is not required to cover all of his eligible Dependents.

iii. **Deferred Retired Employee or Retiree** - A Deferred Retired Employee (and his Dependents) shall be eligible for coverage under this Policy only to the extent that the Deferred Retired Employee (and his Dependents, if applicable) were Covered Persons hereunder when the Deferred Retired Employee ceased to be an Active Employee. A Retiree (and his Dependents) shall be eligible for coverage under this Policy only to the extent that the Retiree (and his Dependents, if applicable) were Covered Persons hereunder when the Retiree ceased to be an Active Employee or a
Deferred Retired Employee. Newly acquired Dependents of a covered Deferred Retired Employee or Retiree shall be eligible for coverage in the same manner as newly acquired Retiree shall be eligible for coverage in the same manner as newly acquired Dependents of Active Employees.

iv. **Survivor** - A Survivor becomes eligible for Personal Coverage on the first day of the month following the submission of an application for coverage provided such application was submitted within thirty-one (31) days of the person becoming a Survivor.

b. **Notification of Ineligibility**

A condition of participation in this Policy is Member's agreement to notify Contractor of any changes in status that affect the eligibility of the Member or any of his Dependents hereunder.

c. **Clerical Error**

i. Clerical errors made on the records of the Policyholder or Contractor and delays in making entries on such records shall not deprive any Member of coverage under this Policy, provided that the Member's application and any related materials (such as evidence of insurability or proof of financial dependence) have been submitted on a timely basis, Contractor has accepted the application and related material as satisfactory, and all required Contributions have been made.

ii. Clerical error by the Policyholder or Contractor shall not extend coverage beyond the date it would otherwise terminate pursuant to the terms of this Policy.

d. **Application for Coverage** - Coverage of each eligible Employee or Dependent shall be contingent upon the Employee's making application therefor in accordance with the approved procedures established by Contractor. Coverage shall become effective in accordance with Subsection 1(e) of this Section. Prematurely submitted applications for coverage, unless returned by Contractor to the Employee, shall be deemed to have been made on the date that all eligibility requirements applicable thereto have been met.

e. **Effective Dates** - The effective date of coverage for Employees and Dependents shall be determined on the basis of the following provisions:
i. If the application is for coverage of an Employee or of an Employee and his eligible Dependents, and if the application is made before the date of eligibility, then:

a. If the Employee is classified by the Policyholder as an Active Employee, the coverage shall become effective on the first day or sixteenth day of the Policy Month next following his date of eligibility; or

b. If the Employee is classified by the Policyholder as a Deferred Retired Employee or a Retiree, the coverage shall become effective on the first day or sixteenth day of the Policy Month next following his date of eligibility.

ii. If the application is for coverage of an Employee or of an Employee and his eligible Dependents, and if the application is made after the eligibility date, then no coverage shall be available or provided under this Policy, except as provided in 3 and 4 below.

iii. If the application is for coverage of a Dependent acquired after an Employee commences coverage under this Policy, then:

a. If the application is made within the first thirty-one (31) days following the Dependent's date of eligibility, coverage shall become effective on the Dependent's date of eligibility, subject to the tender of any applicable retroactive Contributions for the coverage.

b. If the application is made more than thirty-one (31) days following the Dependent's date of eligibility, no coverage shall be available or provided under this Policy except as provided in 3, 4, 5 and 6 below. However, certain Dependent Children may be added to this Policy as provided in part iv, below.

iv. An Employee already having coverage under this Policy may add a Dependent Child by making application during an authorized enrollment period for the Policy on or before that Child's fourth birthday. Coverage shall become effective as specified in the terms of the enrollment, or, if no terms are otherwise specified, on the first day or sixteenth day of the
Policy Month next following the thirty-first day after the date of filing of the application. Children who are added to this Policy shall not be covered for any services other than preventive services described in this Policy for the first year that they are Members of this Policy.

2. **Special Circumstances Enrollment.** Notwithstanding the other provisions of the preceding subsections, if an Employee has been covered by the Managed Care Dental Agreement, and then loses eligibility as a result of moving out of the Service Area as defined in the Managed Care Dental Agreement, then such Employee may transfer coverage to this Policy as provided in Article 3.2 of the Managed Care Dental Agreement.

3. **Late Enrollment.** All Active Employees who are eligible for coverage on May 1, 2016, and who have not made application for coverage as required under the preceding subsections shall not be entitled to coverage under this Policy unless and until the Policyholder has an enrollment.

4. **Newborn Children.** A newborn Dependent Child of the Employee or their spouse is covered from birth. However, the child must be enrolled by the Employee and any required additional premiums must be paid to Contractor no more than thirty-one (31) days after the date of birth in order for coverage to continue beyond the first thirty-one (31) days.

5. ** Adopted Children.** An adopted Dependent Child may be enrolled by Employee within either:
   1. 31 days after the Employee becomes a party in a suit for adoption; or
   2. 31 days of the date of adoption is final.

6. **Enrollment.** There will be an annual authorized period of time during which all covered Employees and their Covered Dependents may switch from this Policy to the other City-sponsored dental program.

7. **Policy Effective Date.** Initial coverage under this Policy shall become effective at 12:01 a.m. on May 1, 2016.

8. **Open Enrollment.** There will be an annual open enrollment period of at least thirty (31) days during which any Employee or Dependent may be enrolled without penalty.
SECTION IV - TERMINATION OF COVERAGE AND EXTENSION OF BENEFITS

1. PERSONAL COVERAGE OF ACTIVE EMPLOYEES
   The Personal Coverage of any Active Employee covered under this Policy will terminate on the earliest to occur of the following dates:
   a. the date of termination of this Policy;
   b. the day of the Policy Month in or with respect to which he requests that such coverage be terminated, provided such request is made on or before such date;
   c. the date of the expiration of the last Policy Month for which the Employee has made a Contribution for Personal Coverage to which he has agreed in writing;
   d. the last day of the Policy Month coinciding with or next following the date of the Policy Month in which he ceases to be eligible for such coverage under this Policy; or
   e. the last day of the Policy Month coinciding with or next following the day of the Policy Month in which the termination of his employment occurs, unless the Employee qualifies for and continues coverage hereunder as a Deferred Retired Employee or Retiree. Termination of employment means cessation of Active Work. However, if cessation of Active Work is the result of:
      i. sickness or Accidental Bodily Injury, then an Employee's coverage may be continued so long as any sick or Injury leave or extension benefit granted therefor by the Employer, whether paid or unpaid, continues; or
      ii. a leave of absence that is authorized by the Employer, whether paid or unpaid, then an Employee's coverage may be continued so long as the authorized leave of absence continues, but for no longer than twelve (12) months from the date that the leave began.

   Any maximum period of continuation permitted by this provision may be extended at the discretion of Contractor in each individual case, provided that in so continuing an Employee's coverage, Contractor acts in a manner which precludes individual selection.

2. PERSONAL COVERAGE OF DEFERRED RETIRED EMPLOYEE
   The Personal Coverage of any Deferred Retired Employee covered under this Policy will terminate on the earliest to occur of the following dates:
   a. the date of termination of this Policy;
b. the date of the Policy Month in or with respect to which he requests that such coverage be terminated, provided such request is made on or before such date;

c. the date of expiration of the last Policy Month for which the Deferred Retired Employee has made a Contribution, in the event of his failure to make when due, any Contribution for Personal Coverage to which he has agreed in writing; or

d. the last day of the Policy Month coinciding with or next following the date of the Policy Month in which he ceases to be eligible for coverage under this Policy as a Deferred Retired Employee by attaining the age necessary to become eligible for pension benefits or otherwise, unless the Employee qualifies for and continues coverage hereunder as a Retiree.

3. PERSONAL COVERAGE OF RETIREES
The Personal Coverage of any Retiree covered under this Policy will terminate on the earliest to occur of the following dates:

a. the date of the termination of this Policy;

b. the day of the Policy Month in or with respect to which he requests that the coverage be terminated, provided the request is made on or before that date; or

c. the last day of the last Policy Month for which the Retiree has made a Contribution, in the event of his failure to make when due, any Contribution for Personal Coverage to which he has agreed in writing.

4. DEPENDENT COVERAGE
The Dependent Coverage of any Employee with respect to any of his Dependents who are covered under this Policy will terminate on the earliest to occur of the following dates:

a. the date of termination of this Policy;

b. the date of discontinuance of Dependent Coverage under this Policy;

c. the date that such Dependent becomes covered for Personal Coverage under this Policy;

d. the date of termination of the Employee to which such Dependent appertains;

e. the date of the expiration of the last Policy Month for which the Employee to which such Dependent appertains has made a Contribution, in the event of his failure to make, when due, any Contribution for Dependent Coverage to which he has agreed in writing;
f. after the thirty-first (31st) day following the acquisition of a new Dependent, with respect to that Dependent, unless prior to the expiration of the thirty-one (31) day period an application has been filed for the coverage of the Dependent and the Employee has tendered any required Contributions;

g. with respect to any Dependent, the date on which the Dependent ceases to be eligible for coverage under this Policy as a Dependent as defined in Section I, entitled "Definitions"; or

h. with respect to any Dependent, the date on which the Employee to which such Dependent appertains fails to furnish to the Policyholder, after due notice, any proof requested by the Policyholder pursuant to the provisions of this Policy that the Dependent is eligible for coverage under this Policy.

5. **EXTENSION OF BENEFITS**

Notwithstanding any other provision to the contrary, if a Covered Person's coverage terminates for any reason, benefits will continue for that Covered Person for thirty (30) days following the date of termination only for the following services, provided the following conditions have been met:

a. An appliance, or modification of an appliance for which an impression was taken while covered under this Policy;

b. A crown, bridge or gold restoration for which the tooth was prepared while covered under this Policy;

c. Root canal therapy, provided the pulp chamber was opened while covered under this Policy.

Benefits for the above services will be available only if benefits would have been provided had the Covered Person's coverage continued under this Policy.

**SECTION V – PAYMENTS**

1. **Contributions/Premiums.** During the Initial Term of this Policy, Policyholder will forward to Contractor the amounts specified in the Group Application and as set forth in Exhibit "F" attached hereto. It is the Policyholder's intent that this Policy be funded by Employee Contributions only, and the Policyholder shall have no obligation to provide funding for this Policy.
2. **Due Date.** Contributions will be payable to Contractor on the first (1st) day of each Policy Month based upon the number of Employees determined by Policyholder to be covered for benefits during such month by coverage category. It is understood that such number shall include those Employees who have elected to participate in this Policy. Contractor shall be permitted access during reasonable business hours to the records of the Policyholder for the purpose of verifying such number of Employees. Each payment by Policyholder shall be accompanied by an electronic eligibility file showing the name and social security number of all Employees covered for benefits during such month and any additions to or deletions from the preceding month. The twice monthly electronic eligibility file shall also include the information agreed to by the Policyholder and Contractor.

3. **Grace Period.** Contributions are due to Contractor on the first day of each Policy Month, however, Contributions are considered timely if received within forty-five (45) days of such due date.

**SECTION VI - SCHEDULE OF BENEFITS**

The Personal Coverage benefits and the Dependent Coverage benefits for which an Employee is covered under this Policy shall be those shown in the following Schedule of Benefits:

**COMPREHENSIVE DENTAL EXPENSE BENEFITS**

<table>
<thead>
<tr>
<th>Maximum Benefit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive, Basic, and Major Services</td>
<td></td>
</tr>
<tr>
<td>Combined Maximum Per Calendar Year</td>
<td>$1,500 per person</td>
</tr>
<tr>
<td>Orthodontic Lifetime Maximum</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Deductible</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Accumulation Period</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Family Limit</td>
<td>3 Family members</td>
</tr>
<tr>
<td>Benefit Percentage Payable</td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100 %</td>
</tr>
<tr>
<td>Basic Services</td>
<td>80 %</td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50%</td>
</tr>
</tbody>
</table>
SECTION VII - DENTAL EXPENSE BENEFITS

1. BENEFITS PAYABLE
If, because of an Accidental Bodily Injury, a Covered Person incurs Covered Expenses for services payable under this Policy, then Contractor will pay the applicable Benefit Percentage thereof. The foregoing obligation of Contractor is subject to the Deductible, the applicable Maximum Benefits limits and all other applicable limitations and conditions of this Policy. The Benefit Percentage, the Deductible, and the Maximum Benefits are shown in the "SCHEDULE OF BENEFITS".

2. DEDUCTIBLE
The deductible shown in the "Schedule of Benefits" is the dollar amount of benefits otherwise payable hereunder for Covered Expenses which must be assumed without reimbursement hereunder by the Covered Person before reimbursement for any additional Covered Expenses will commence under this Policy. The Deductible is common to all benefits for services payable under this plan as "Basic Services", "Major Services" and "Orthodontic Services." The Deductible shall not apply to benefits for services payable under this Policy as "Preventive Services." The Deductible applies separately to each Covered Person in each calendar year, subject to the following:
   a. Covered Expenses incurred by any Covered Person in the last three months of any calendar year, and applied to satisfy the Deductible for that calendar year, shall also be counted toward satisfaction of the Deductible in the next calendar year; and
   b. When three covered family members satisfy their individual Deductibles, the Deductible will be considered satisfied for all covered family members for the remainder of that calendar year.

3. BENEFIT PERCENTAGE
The percentages of payment applicable to Covered Expenses for the various categories of services payable under this Policy are shown in the "SCHEDULE OF BENEFITS". The Benefit Percentages will also be applied to expenses submitted for satisfaction of the Deductible, so that only that portion of the Covered Expenses which would have been payable but for the Deductible will be applied to the satisfaction of the Deductible.
4. **MAXIMUM BENEFITS**

Benefits paid to any Covered Person for dental expenses for Preventive, Basic, and Major Services in any one calendar year shall not exceed the Maximum Benefit therefor as specified in the "SCHEDULE OF BENEFITS". Orthodontic Services are also subject to a lifetime Maximum Benefit as specified in the "SCHEDULE OF BENEFITS".

5. **PRE-TREATMENT POLICY**

If a Covered Person will undergo dental treatment in an amount estimated to be two hundred dollars ($200) or more, he should submit a pre-treatment plan to Contractor prior to the commencement of treatment. This will enable the Covered Person to estimate in advance his share of the cost.

A pre-treatment plan is a written report prepared by the Dentist showing the recommended programs and the estimated cost. A pre-treatment plan approved by Contractor will be subject to amendments to this Policy and eligibility of the Covered Person. It is only applicable for six months from its approval date.

6. **COVERED EXPENSES**

The services payable under this Policy shall include those listed in this Subsection to the extent that they are Covered Expenses as that term is defined in Section I, entitled "DEFINITIONS". No other services are payable under this Policy.

a. Preventive Services covers the usual and customary fees for the following Expenses:

   i. two dental examinations per calendar year regardless of when they occur in the year;

   ii. two prophylaxis (cleaning of teeth) treatments per calendar year regardless of when they occur in the year;

   iii. one series of bitewing x-rays per calendar year;

   iv. topical application of fluoride solutions up to the age of nineteen (19) years as follows:

      a. topical application of sodium fluoride, four treatments (excluding prophylaxis);

      b. topical application of stannous fluoride, one treatment (excluding prophylaxis) per calendar year, or
c. topical application of acid fluoride phosphate, one treatment (excluding prophylaxis) per calendar year;

v. space maintainers for missing primary teeth; and

vi Emergency Palliative Treatment.

b. Basic Services covers the usual and customary fees for the following expenses:

i. extractions;

ii. root canals;

iii. oral surgery - apicoectomies, impactions, and extractions (including alveolectomy, alveoplasty, and tori removal in connection with extractions);

iv. local anesthesia or I.V. sedation for covered oral surgery;

v. general anesthesia when medically indicated and administered in connection with oral surgery by a physician other than the operating Dentist;

vi. restorative services (fillings) other than gold;

vii. periodontal scaling, treatment, diagnosis, and surgery;

viii. diagnostic x-ray and full mouth series of x-rays;

ix. antibiotic injections;

x. repair of damaged crowns, inlays, onlays, bridgework or dentures - every three (3) years;

xi. endodontic treatment, and

d. Major Services covers the usual and customary fees for the following expenses:

i. charges relating to initial fixed bridgework and dentures except for extractions;

ii. replacement of bridgework or partial dentures when additional teeth must be replaced;

iii. Initial inlays, onlays, gold fillings or any crown, other than a crown for which benefits are payable as a Basic Service under Subsection 6(b)(xii), above; and
iv. replacement or modification of existing bridgework or dentures which cannot be made serviceable, and which were installed more than (5) years prior to replacement or modification.

d. Orthodontic Services. Orthodontic Services are payable monthly over the course of treatment and cease upon termination of coverage. Treatment may not exceed two (2) years from the beginning date of such treatment.

7. LIMITATIONS

The following are not covered by this Policy:

a. charges or services furnished or paid by reason of past or present service in the armed forces of any government, including, without limitation, any dental treatment which is provided in a veteran's hospital, military hospital, or other institution operated by the United States government or by any foreign government;

b. dental treatment received from a dental or medical department maintained by the Policyholder, a mutual benefit association, labor union, trustee, or similar type of group;

c. dental treatment required as a result of intentionally self-inflicted injury, war or engaging in a riot or insurrection;

d. broken appointments or the completion of claim forms or pre-treatment forms required by Contractor;

e. dietary planning, plaque control, oral hygiene instruction, congenital or developmental malformation existing when the person became covered under this Policy, or sealants;

f. the replacement of lost, missing, or stolen prosthetic devices;

g. any dental treatment which could have been rendered at a lower cost by means of any reasonable substitute that constitutes a generally accepted dental practice shall be included only to the extent of the cost of the lower cost substitute;

h. installation of an initial prosthodontics appliance when such charges are incurred for replacement of a congenitally missing tooth or teeth or replacement of a tooth or teeth all or any of which were lost while the individual was not covered by the Policy;

i. replacement of an existing prosthodontics appliance unless:
i. necessitated by the extraction of additional natural teeth while covered under this Policy, or

ii. the existing appliance is at least five (5) years old and cannot be made serviceable and twelve (12) months have elapsed since the effective date of coverage, or

iii. the replacement appliance is made necessary as the result of an initial placement of an opposing denture while covered;

j. any expenses incurred for treatment rendered after the date of termination of an individual's coverage, except as specified in Subsection 5 of Section IV, above;

k. any expenses incurred for treatment rendered for any occupational disease or accident;

l. any care, services, supplies or treatment rendered on an experimental or research basis not recognized as a generally accepted dental practice;

m. any expenses in excess of the usual and customary charge for the service or supply;

n. treatment other than by a duly licensed dentist, physician, dental hygienist, technician or laboratory unless performed by or under the direction of a dentist or physician;

o. any supply or service that is not reasonably necessary for the dental care of the Covered Person;

p. any care or services for which the provider customarily makes no charge;

q. any care or service rendered by a member of the Covered Person's family or close relative, including a person related by blood or marriage to the Covered Person;

r. any care or services covered in whole or in part under the Policyholder's medical plans, regardless of whether the Covered Person holds coverage thereunder, or not;

s. temporary restorations; however, if temporary restoration is part of a course of treatment, the maximum benefit for a permanent restoration shall include the fee for temporary restoration;

t. any duplicate prosthetic device or any other duplicate appliance;

u. implantology;
v. treatment except as orthodontic services, for placement of bands and regular maintenance of braces, the result of:
   i. mandibular or maxillofacial surgery to correct growth defects, jaw disproportions or malocclusions, except for correction of a congenital anomaly in a Child who was covered under this Policy from birth,
   ii. appliances or restorations used solely to increase vertical dimension, reconstruct occlusion or correct or treat temporomandibular joint dysfunction or TMJ pain syndromes, or
   iii. any changes due to temporomandibular joint disorder or dysfunction (TMJ),
   iv. diagnostic x-rays, exams and any other course of treatment to relieve TMJ pain syndrome;

w. charges for care or treatment of occlusion by adjustment, appliance, or restorations, except for orthodontics,

x. any expense incurred prior to becoming covered or any dental work in progress at the time a patient becomes covered under this Policy;

y. any charges in excess of the charge customarily made when alternate services or supplies are customarily available for such treatment, beyond the charge for the least expensive service or supply resulting in professionally adequate treatment;

z. services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures; without limitation, facings on crowns and pontics posterior to the second bicuspid shall always be considered cosmetic;

aa. periodontal splinting; or

bb. charges for drugs or their administration, except as specifically allowed under Subsection 7, above; or

cc. Hospitalization for any procedure.

8. PARTICIPATING DENTAL PROVIDER NETWORK
   Contractor shall offer and maintain a network of general dentists and dental specialists who are available for voluntary selection by Policy Members. This network shall be known as the Participating Dental Provider Network ("PDP"). Contractor shall ensure that participating dentists in the PDP network charge Policy Members no more than the
reasonable charges that are considered Covered Expenses under this Policy for that region for any covered procedure, excluding orthodontia.

Contractor shall ensure that participating dentists are located around the Houston area so as to meet the following geographical standard: Ninety-four percent (94%) of participating Members who reside in the Houston area shall have access to at least one participating PDP dentist within ten (10) miles of their home zip code.

Contractor agrees to publish and maintain a directory of participating PDP dentists for Members, to be distributed at least annually with annual enrollment materials. Contractor agrees that Policy Members will still have coverage according to the Policy Schedule of Benefits even if such Members choose not to utilize a PDP network dentist.

SECTION VIII – CLAIMS

1. CLAIMS PROCEDURE. The procedure outlined below must be followed by Covered Persons to obtain payment of benefits under this Policy for themselves and for their covered Dependents:
   a. NOTICE OF CLAIM. Within twenty (20) days after the date a loss occurs or commences, written notice must be submitted to Contractor which identifies the Covered Person whose condition, sickness, or Injury is the basis of a claim.
   b. CLAIM FORMS. Claim forms for submitting proof of loss will be furnished by Contractor upon receipt of notice of a claim. If such forms are not furnished within fifteen (15) days after receipt of notice of a claim, a Covered Person may use any written form as a claim form to submit a proof of loss which includes information indicating the date of service, the name and birthdate of the person receiving service, the service received, the person or entity providing the service, detailed charges for the service(s), and the name, social security number, and birthdate of the Covered Person. Any information included in the bill need not be included in the claim form. However, the bill must be attached to the claim form. HCFA Form 1500 may be used to submit a claim. Claim forms are also available from the claimant's Benefits Offices.
If claimant needs additional forms, he can call Contractor and forms will be sent to him.

c. **PROOF OF LOSS.** A completed claim form together with the original bills for expenses incurred and a statement from the attending Dentist must be submitted to Contractor within ninety (90) days after the date a loss occurs or commences.

d. **LIMITATION OF LIABILITY.** Contractor shall not be obligated to pay any benefits under the Policy for any claim if proof of loss for such claim was not submitted within the period provided in Item "c" above unless it is shown that (1) it was not reasonably possible to have submitted the proof of loss within such period and (2) the proof of loss was submitted as soon as it was reasonably possible. The provisions of items "a" and "b", and "c" of this Subsection (1) may be extended by Contractor in each individual case, provided that in so doing Contractor acts in a manner that precludes individual selection. However, in no event will Contractor be obligated to pay benefits for any claim if the proof of loss for such claim is not submitted to Contractor within one (1) year after the end of the ninety (90) day period provided in item "c" above except in the case of legal incapacity of the covered Employee.

e. **DENTAL EXAMINATION.** Contractor reserves the right to have a dentist of its own choosing perform a dental examination of any Covered Person whose condition is the basis of a claim. All such examinations shall be at the expense of Contractor. This right may be exercised when and as often as Contractor may reasonably require during the pendency of a claim. The opportunity to exercise this right shall be a condition for obtaining payment of benefits for the claim.

2. **PAYMENT OF CLAIMS.**

   a. **TIME OF PAYMENT**

   i. **DENTAL EXPENSE REIMBURSEMENT.** Benefits for incurred dental expenses which are covered under this Policy, other than orthodontics, will be paid after receipt of proper written proof of loss by Contractor.

   ii. **ORTHODONTIC PAYMENTS.** Payment of orthodontic expenses which are covered under this Policy will be made monthly over the course of the treatment.
iii. All payments are payable to the Covered Person unless assigned and submitted by attending dentist.

b. PAYMENT OF BENEFITS

i. TO EMPLOYEE. All benefits under this Policy are payable to the Covered Person whose sickness or Injury is the basis of a claim.

ii. DEATH OR INCAPACITY OF EMPLOYEE. In the event of the death or incapacity of a Covered Person and in the absence of written evidence to Contractor of the qualification of a guardian for this estate, Contractor may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of Contractor, is or was providing the care and support of such Covered Person.

iii. ASSIGNMENTS. Benefits for Covered Expenses under this Policy may be assigned by the Covered Person to the person or institution rendering the services for which the expenses were incurred. No such assignment will bind Contractor unless it is in writing and unless it has been received by Contractor prior to the payment of the benefit assigned. Contractor will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless written cancellation of the assignment, signed by the Covered Person and the assignee, is received by Contractor prior to the payment of the benefit assigned. In the event that Contractor is notified in writing of any dispute as to the validity of an assignment, then Contractor may withhold payment of the benefits covered thereby, pending resolution of the dispute by legal action or settlement.

iv. RECOVERY OF BENEFITS. Warrants issued in payment of claims shall be mailed to the address of the Claimant as stated on the claim form. If the warrant is returned in the U.S. Mail or is not timely presented for payment by its expiration date, the Policyholder and Contractor, shall make a reasonable effort to locate the claimant and reissue the warrant. However, the right to claim any benefit hereunder shall terminate, and all rights shall revert to Contractor, unless the claimant contacts the Policyholder or
Contractor and obtains a replacement warrant within one year from the original date of issuance of the claim warrant.

v. **TEXAS DEPARTMENT OF HUMAN SERVICES.** Benefits paid on behalf of a Dependent Child will be paid to the Texas Department of Human Services ("Department") after written notice to Contractor at Contractor's home office, if all of the following requirements are met.

a. The parent who is a member of the group:
   i. is a possessory conservator of the child due to an order issued by a court in this state; or
   ii. does not have the right to possession of or access to the child; and
   iii. is required by a court order or an agreement approved by the court to pay child support.

b. The Department pays benefits on behalf of the child under Chapter 31 or Chapter 32 of the Human Resources Code.

c. A notice is attached to the claim form when the claim is first submitted to Contractor which states that the benefits must be paid directly to the Texas Department of Human Services.

d. Contractor will pay the Department the actual cost of covered dental expenses of an Insured which are paid by the Department through medical assistance to the coverage limits of this Policy. Contractor may pay the managing conservator for claims filed for a Dependent Child if Contractor is given:
   i. written notice that the person is a managing conservator of the Dependent Child; and
   ii. a certified copy of the court order which made that person the managing conservator.

c. **DISCHARGE OF LIABILITY.** Any payment made in accordance with the provisions of this Section shall fully discharge the liability of Contractor to the extent of such payment.

d. **SUBROGATION.** Contractor shall be subrogated to any and all rights of Covered Persons for recovery against any third party because of a condition, sickness, or
Injury caused by such third party or for which such party may otherwise be liable. This right of subrogation is limited to the extent of benefits payable under this Policy for such condition, sickness, or Injury. Upon payment of such benefits:

i. Contractor shall be entitled to institute an action in the name of such Covered Person or to join in an action brought by such Covered Person against such third party and to participate in any judgment, award or settlement to the extent of its interests; and

ii. such Covered Person shall execute such instruments which are necessary for Contractor to perfect its rights of subrogation and shall refrain from taking any action which may prejudice Contractor's successful exercise of its right of subrogation.

e. **RECOVERY OF PAYMENTS.** Contractor reserves the right to deduct from any benefits properly payable under this Policy the amount of any prior payment which has been made:

i. in error; or

ii. pursuant to a misstatement contained in a proof of loss; or

iii. pursuant to a misstatement made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or

iv. with respect to an ineligible person; or

v. in anticipation of obtaining a recovery in subrogation if a Covered Person fails to comply with the provisions of Subsection 2, item "d" above or

vi. pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require Contractor to pay benefits under the Policy in any such instance.

Such deduction may be made against any claim for benefits under this Policy by a Covered Person if such payment is made with respect to such Covered Person.

f. **APPEAL OF CLAIMS DENIED.**

If a claim for benefits is wholly or partially denied, notice of the decision will be furnished to the Covered Person. This written notice will:
i. give the specific reason(s) for the denial;

ii. make specific reference to the policy provisions on which the denial is based;

iii. Provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and

iv. provide an explanation of the review procedure.

On any denied claim, a Covered Person or his representative may appeal to Contractor for a full and fair review.

The claimant may:

i. request a review upon written application within sixty (60) days of receipt of claim denial;

ii. review pertinent documents; and

iii. submit issues and comments in writing.

A decision will be made by Contractor no more than sixty (60) days after the receipt of the request, except in special circumstances such as the need to review an appeal by a panel consisting of two persons designated by the Policyholder and three non-participating dental professionals designated by Contractor, provided however, that the two persons designated by the Policyholder shall only serve in an advisory capacity. In no event, will this be more than 120 days after the request for review is received.

The written decision will include specific reference(s) to the Policy provisions on which the decision is based.

g. HOW TO FILE A CLAIM FOR BENEFITS.

Obtain a claim form from the Policyholder and have the Dentist complete the required information or include a copy of an approved American Dental Association (ADA) bill suitable for insurance submission that the claimant received from the Dentist. Payment of the amount provided by the Policy will be sent directly to the Covered Person or to the Dentist, if the benefit payment has been assigned to him.
SECTION IX - COORDINATION OF BENEFITS

1. **Benefits Subject To This Provision.** All of the benefits provided under this Policy are subject to this Section.

2. **Definitions.** For the purposes of this Section:

   "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insurance coverage, (ii) any coverage under labor-management trustee plans, union welfare plans, or employee benefit organization plans, (iii) any coverage under governmental programs, and (iv) any coverage required or provided by any statute. The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement under which is reserved the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion that does not.

   "This Plan" means that portion of this Policy that provides the benefits that are subject to this Provision.

   "Allowable Expenses" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be an Allowable Expense and a benefit paid.

   "Claim Determination Period" means the calendar year.

3. **Effect on Benefits**

   a. This provision shall apply in determination of the benefits as to a Member covered under this Plan for any Claim Determination Period, if, for the Allowable Expenses incurred as to such person during such period, the sum of

      i. The benefits that would be payable under this Plan in the absence of this provision, and

      ii. The benefits that would be payable under all other Plans in the absence therein of provisions similar to this provision would exceed such Allowable Expenses.
b. As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits payable for such Allowable Expenses under all other Plans, except as provided in item (c) of this Section 3 shall not exceed the total of such Allowable Expenses. Benefits payable under Plan include the benefits that would have been payable had claim been duly made therefor.

c. If:
   i. Another Plan that is involved in item (b) of this Section 3 and that contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
   ii. The rules set forth in item (e)(iii) of this Section 3 would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

d. If another Plan that is involved in item (b) of this Section 3 does not contain a provision coordinating its benefits with those of this Plan, then the benefits of such other Plan shall be determined before the benefits of this Plan.

e. For the purpose of item (c) of this Section 3, the rules establishing the order of benefit determination are:
   i. The benefits of a Plan that covers the person on whose expenses claim is to be based other than as a Dependent shall be determined before the benefits of a Plan that covers such person as a Dependent;
   ii. (A) Except for cases of a person for whom claim is made as a Dependent Child whose parents are separated or divorced, the benefits of a plan that covers the person on whose expenses claim is based as a Dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan that covers such person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If the other Plan does not have the provisions of this paragraph (ii) (A) regarding
Dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph (ii) (A) shall not apply, and the rule set forth in the Plan that does not have the provisions of this paragraph ii (A) shall determine the order of benefits;

(B) In the case of a person for whom claim is made as a Dependent Child whose parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of a Plan that covers the Child as a Dependent of the parent with custody of the Child will be determined before the benefits of a Plan that covers the Child as a Dependent of the parent without custody.

(C) In the case of a person for whom claim is made as a Dependent Child whose parents are divorced and the parent with custody of the Child has remarried, the benefits of a Plan that covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a Plan that covers that Child as a Dependent of the stepparent, and the benefits of a Plan that covers that Child as a Dependent of the stepparent will be determined before the benefits of a Plan that covers that Child as a Dependent of the parent without custody.

(D) In the case of a person for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree that would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the Child, then, notwithstanding paragraphs (B) and (C) above, the benefits of a Plan that covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan that covers the Child as a Dependent Child.

iii. When rule(s) (i) and (ii) as set out above do not establish an order of benefit determination, the benefits of a Plan that has covered such person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan that has covered such person the shorter period of time, provided that:
(A) The benefits of a Plan covering the person as an employee other than a laid-off or retired employee, or as a Dependent of a laid-off or retired employee, shall be determined before the benefits of any other Plan covering such person as a laid-off or retired employee, or as a Dependent of a laid-off or retired employee; and
(B) If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of (A) above shall not apply.

f. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately and such reduced amount shall be charged against any applicable benefit limit of this Plan.

4. **Right to Receive and Release Necessary Information.** For the purpose of determining the applicability of and implementing the terms of this Section or procedures promulgated hereunder or any provision of similar purpose of any other plan, Contractor may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or individual, any information, with respect to any person, that Contractor deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to Contractor such information as may be necessary to implement this Section.

5. **Facility of Payment.** Whenever payments that should have been made under this Plan in accordance with this provision have been made under any other Plan(s), Contractor shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, Contractor shall be fully discharged from liability under this Plan.

6. **Right of Recovery.** Whenever payments have been made by Contractor with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, Contractor shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as Contractor shall determine: any persons to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.
7. **Responsibility of Member.** Any Member claiming benefits under this Agreement must furnish to Contractor all information deemed necessary by it to implement this provision.

8. **Direct Services.** None of the above rules as to coordination of benefits will serve as a barrier to the Member first receiving direct health services from Contractor that are covered under this Agreement.

9. **Subrogation.** Contractor shall have all rights of recovery acquired by a Member against any person or organization for negligence or any willful act resulting in illness or Injury covered by Contractor benefits, but only to the extent of such the Allowable Expense for benefits. Upon receiving such benefits from Contractor, the Member is considered to have assigned such rights of recovery to Contractor and to have agreed to give Contractor any reasonable help required to secure the recovery.

**SECTION X - TERMINATION OF MEMBER COVERAGE**

1. **Termination of Member Coverage.** No Member's coverage shall be terminated by Contractor due to his health status or his dental care needs. No eligible person shall be refused enrollment or reenrollment because of his health status or dental care needs. Coverage under this Policy for a Member will terminate if any of the following occurs:
   a. A Member uses another Member's identification card or allows someone else to use a Member's identification card. Contractor will provide a fifteen (15) days written notice of termination to the Member. Contractor is entitled to collect payment from the Member for the benefits that were falsely obtained.
   b. An Employee gives fraudulent information on an application or commits any other fraudulent act related to this Policy. The coverage will be terminated immediately.
   c. A Member at any time threatens the physical safety of a Dentist or any person in the participating Dentist's office or threatens to cause physical damage to furniture, fixtures, appliances, or the physical office of a participating Dentist. The coverage will be terminated immediately.
   d. A Member repeatedly refuses to follow the recommended treatment of a Dentist. Contractor will provide at least thirty-one (31) days written notice of termination to the Member.
   e. The Employee fails to make the monthly Contribution for a Member's coverage. However, an Employee shall have a thirty (30) day grace period during which the Employee may
make payment of non-payroll deducted premiums. Employees will be held liable for the cost of services received during the grace period.

f. A Member fails to sign or submit any consents, releases, assignments, or other documents or to turn over any payments due under this Agreement. Contractor will provide sixty (60) days written notice of termination to the Member. Coverage may be continued provided that the required documents or payments are signed and submitted to Contractor within the sixty (60) day period.

g. The Policyholder commits fraud and this Policy is terminated in accordance with Section XI herein.

2. Continuation of Benefits. Upon the expiration or termination of this Policy or the termination of eligibility of a Member, benefits payable under this Policy shall apply for purposes of completing any dental procedures initiated prior to said expiration or termination as though this Policy remained in effect for such procedure.

3. Termination of Policy. The Policyholder reserves the right to terminate the Policy at any time after the termination of the Policy. Benefits payable under the Policy in connection with any claim that arose prior to the date of termination shall be paid in accordance with the terms of the Policy as in existence at the time of termination.

4. Incontestability. In the absence of fraud, all statements made by an Employee are considered representations and not warranties. During the first two years, coverage can be voided for a material misrepresentation, as defined by the TEXAS INSURANCE CODE and 28 TEXAS ADMINISTRATIVE CODE, contained in the written application. Coverage can be voided at any time in the event of a fraudulent misstatement contained in the written application. A copy of the written application must have been furnished to the Employee if the terms of the application or enrollment form are to be applied.

SECTION XI - TERM AND TERMINATION OF POLICY

1. Initial Term. This Policy shall be in effect for an initial period of three (3) years beginning at 12:01 a.m. on May 1, 2016, and ending at 11:59 p.m. on April 30, 2019.

2. Renewal Term(s). This Policy is renewable for two additional one-year terms at the sole option of the Director, provided that the Director gives written notice of such renewal to Contractor no later than sixty (60) days before the end of the Initial Term or before the anniversary of any Renewal period.
3. The Policyholder may terminate this Policy for its convenience during the Initial Term or any Renewal Term by providing Contractor at least ninety (90) days written notice of such termination.

4. Contractor shall cooperate with Policyholder upon termination of this Policy to provide any records and data that will assist with the smooth transition of Policyholder's Members to a succeeding provider.

5. **Events of Default.** Contractor cannot terminate the Policy during the Initial Term unless a default has occurred as defined hereafter: The following are events of default under this Policy:
   
a. The commission of any materially fraudulent act by the Policyholder;

b. Failure to pay sums contracted for;

c. Breach of any terms of this Policy that materially interfere with Contractor's ability to perform its duties under this Policy:

Notwithstanding any provisions to the contrary, the Policyholder shall have the opportunity to cure any event of default within thirty days after Contractor notifies the City in writing of event of default Number a. or c. and within ten days after notice for event of default Number b.

**SECTION XII – MISCELLANEOUS**

1. **Inspections, Audits and Enforcement.** Representatives of the Policyholder or Contractor shall have the right to perform, or cause to be performed, (1) audits of each others' books and records, and (2) inspect all places where services are undertaken in connection with this Policy. Contractor shall be required to keep such books and records available for such purpose for at least five (5) years after the ceasing of its performance under this Policy. Nothing in this provision shall affect the time for bringing a cause of action nor the applicable statute of limitations.

   The Policyholder's City Attorney or his or her designee shall have the right to enforce all legal rights and obligations under this Policy without further authorization. Contractor covenants to provide to the City Attorney all documents and records that the City Attorney deems necessary to assist in determining Contractor's compliance with this Policy, with the exception of those documents made confidential by federal or State law or regulation.

2. **Amendments.** The provisions of this Agreement may be amended at any time, and from time to time, by either party, upon concurrence of the Policyholder’s Mayor, Human Resources Director and City Attorney in order to comply with state, federal, or local law; provided,
however, that no amendment shall deprive any Employee of any benefits to which he or she became entitled in connection with any claim incurred before the date of the amendment.

3. **Notice.** Any notice, consent or other communication permitted or required by, or to be given pursuant to the Policy, shall be in writing and delivered to the intended recipient thereof. A notice shall be deemed delivered if mailed to the intended recipient by registered or certified mail, return receipt requested, postage prepaid, to the following address (subject to change of such address by prior written notice)

   To Policyholder: City of Houston
   Director of Human Resources
   P.O. Box 248
   Houston, Texas 77001-9931

   To Contractor: ______________________
   ______________________
   ______________________
   ______________________

   With copy to: ______________________
   ______________________
   ______________________
   ______________________

4. **Headings.** The headings for the Sections of this Policy are inserted solely for the convenience of reference and form no substantive part of this Policy, nor shall they be used in any interpretation or construction of any substantive provision of this Policy.

5. **Assignability.** This Policy shall bind, and inure to the benefit of the parties hereto, their respective successors and assigns. However, no assignment may be made without the consent of both parties.

6. **Continuing Membership.**

   a. Members may elect a continuation of coverage option. A Member may elect to continue coverage if he or she no longer meets eligibility requirements and has not been terminated for any reason as stated in this Policy, or for gross misconduct. The coverage will be the same as that for Active Employees.

   b. Effective Date. The Member's coverage will begin on the date he or she is no longer eligible for the coverage, complies with Contractor's required notice and election rules, and pays any applicable contributions, as required by law.
c. Period of Coverage. The Member's coverage shall continue for either:
   i. Eighteen (18) months when Active Employee quits, retires, is laid off or fired, or when Active Employee's hours are reduced such that he no longer is eligible for the Policyholder; or
   ii. Thirty-six (36) months for Dependents in the event of divorce from or death of Active Employee or when Dependent children cease to be eligible under this Policy; or
   iii. Twenty-nine (29) months if Member becomes disabled, as defined by the Social Security Administration.

   d. Coverage under this Subsection 6 is intended to comply with Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

7. Converting Membership.
   a. Members may convert to an Individual Dental Policy without presenting evidence of insurability when their membership ends because they no longer meet the eligibility requirements of this Policy or at the end of the continuation period described above.
   b. Contractor shall send a Member Enrollment Application to all Members eligible for conversion within fifteen (15) days of such eligibility. The Member must then submit the Member Enrollment Application to __________________________ and pay the applicable Contribution to Contractor within thirty-one (31) days of the expiration of coverage. The Contribution is the amount established by Contractor for conversion membership. The Member may cover only those Dependents who were covered under this Policy prior to conversion.
      i. Election Period. The Member must convert within thirty-one (31) days of the date coverage ends. If the Member does not convert, the Member must pay for the cost of any services received after the coverage ended.
      ii. Effective date. The conversion goes into effect on the date Policy coverage ends.
   c. Any Member or former Member that no longer meets Policy eligibility requirements for any reason other than termination for any reason stated in this Policy may request a Member Enrollment Application from____________________. Contractor must then provide the Member Enrollment Application together with any other forms required to obtain conversion and information regarding converted coverage within ten (10) days of receipt of the written request.
8. **Compliance with Laws.** Contractor shall comply with all applicable state and federal laws and regulations and all provisions of the City of Houston Charter and Code of Ordinances. Venue for any litigation for purposes of this Policy shall be in Houston, Harris County, Texas.
EXHIBIT "B"

PERFORMANCE GUARANTEE

FULLY INSURED INDEMNITY/DPPO

Contractor shall provide the performance guarantees set out below to ensure smooth initial and ongoing enrollment, adequate access, contract turnaround, production of administration materials, claims handling, customer service standards and employee satisfaction surveys.

<table>
<thead>
<tr>
<th>If average claim payment time on 98% of dental claims is:</th>
<th>Liquidated damages due are:</th>
<th>Maximum Annual Amount at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.00 to 13.50 days</td>
<td>$2,000/quarter</td>
<td>$40,000 maximum per year</td>
</tr>
<tr>
<td>13.51 to 14.50 days</td>
<td>$4,000/quarter</td>
<td></td>
</tr>
<tr>
<td>14.51 to 15.50 days</td>
<td>$6,000/quarter</td>
<td></td>
</tr>
<tr>
<td>Greater than 15.50 days</td>
<td>$10,000/quarter</td>
<td>$10,000 per year</td>
</tr>
</tbody>
</table>

Contractor shall agree to be in compliance at all times with the following geographical access standard: 94% of city employees who reside in the thirteen county service area will have access to two participating dentists within 10 miles of their home zip code. GeoAccess will be measured quarterly.

Contractor shall agree to pay $2,500 in liquidated damages for each quarter they are below 94%.

Service Center shall be ready to respond to inquiries as of 5/1/2016, with City dedicated toll-free number operational by April 1, 2016.

$10,000 (one time only for new vendor)

Contractor shall process 99% of transitions from Active to Retiree status within 5 business days of receipt of status change from the City

$500 per pay period (24)

TOTAL ANNUAL

$166,000 per year

NOTE: All references to “quarter” and “year” mean contract quarter and contract year.
EXHIBIT "C"

DRUG DETECTION AND DETERRENCE POLICY

(1) It is the policy of the City to achieve a drug-free workforce and workplace. The manufacture, distribution, dispensation, possession, sale, or use of illegal drugs or alcohol by contractors while on City Premises is prohibited. Contractor shall comply with all the requirements and procedures set forth in the Mayor's Drug Abuse Detection and Deterrence Procedures for Contractors, Executive Order No. 1-31 ("Executive Order"), which is incorporated into this Agreement and is on file in the City Secretary's Office.

(2) Before the City signs this Agreement, Contractor shall file with the Contract Compliance Officer for Drug Testing ("CCODT"):

(a) a copy of its drug-free workplace policy,

(b) the Drug Policy Compliance Agreement substantially in the form set forth in Exhibit “C-1,” together with a written designation of all safety impact positions and,

(c) if applicable (e.g. no safety impact positions), the Certification of No Safety Impact Positions, substantially in the form set forth in Exhibit "C-2."

If Contractor files a written designation of safety impact positions with its Drug Policy Compliance Agreement, it also shall file every 6 months during the performance of this Agreement or on completion of this Agreement if performance is less than 6 months, a Drug Policy Compliance Declaration in a form substantially similar to Exhibit "C-3." Contractor shall submit the Drug Policy Compliance Declaration to the CCODT within 30 days of the expiration of each 6-month period of performance and within 30 days of completion of this Agreement.
The first 6-month period begins to run on the date the City issues its Notice to Proceed or if no Notice to Proceed is issued, on the first day Contractor begins work under this Agreement.

(3) Contractor also shall file updated designations of safety impact positions with the CCODT if additional safety impact positions are added to Contractor's employee work force.

(4) Contractor shall require that its subcontractors comply with the Executive Order, and Contractor shall secure and maintain the required documents for City inspection.
EXHIBIT "C-1"

DRUG POLICY COMPLIANCE AGREEMENT

I, _______________________________ as an owner or officer of
(Name) (Print/Type) (Title)
(Name of Company) (Contractor)

have authority to bind Contractor with respect to its bid, offer or performance of any and all
contracts it may enter into with the City of Houston; and that by making this Agreement, I affirm
that the Contractor is aware of and by the time the contract is awarded will be bound by and
agree to designate appropriate safety impact positions for company employee positions, and to
comply with the following requirements before the City issues a notice to proceed:

1. Develop and implement a written Drug Free Workplace Policy and related drug
testing procedures for the Contractor that meet the criteria and requirements
established by the Mayor's Amended Policy on Drug Detection and Deterrence
(Mayor's Drug Policy) and the Mayor's Drug Detection and Deterrence
Procedures for Contractors (Executive Order No. 1-31).

2. Obtain a facility to collect urine samples consistent with Health and Human
Services (HHS) guidelines and a HHS certified drug testing laboratory to perform
the drug tests.

3. Monitor and keep records of drug tests given and the results; and upon request
from the City of Houston, provide confirmation of such testing and results.


I affirm on behalf of the Contractor that full compliance with the Mayor's Drug Policy and
Executive Order No. 1-31 is a material condition of the contract with the City of Houston.

I further acknowledge that falsification, failure to comply with or failure to timely submit
declarations and/or documentation in compliance with the Mayor's Drug Policy and/or Executive
Order No. 1-31 will be considered a breach of the contract with the City and may result in non-
award or termination of the contract by the City of Houston.

__________________________  
Date  Contractor Name

__________________________
Signature

__________________________
Title
EXHIBIT "C-2"

CONTRACTOR'S CERTIFICATION
OF NO SAFETY IMPACT POSITIONS
IN PERFORMANCE OF A CITY CONTRACT

(Name)       (Title)

as an owner or officer of__________________________ (Contractor)

(Name of Company)

have authority to bind the Contractor with respect to its bid, and hereby certify that Contractor
has no employee safety impact positions, as defined in §5.18 of Executive Order No. 1-31, that
will be involved in performing

(Project)

Contractor agrees and covenants that it shall immediately notify the City of Houston Director of
Human Resources if any safety impact positions are established to provide services in performing this City Contract.

(Date)       (Typed or Printed Name)

(Signature)

>Title)
EXHIBIT "C-3"
DRUG POLICY COMPLIANCE DECLARATION

I, ______________________ (Name) ____________________ (Print/Type), as an owner or officer of (Engineer) ______________________ (Name of Company) ____________________, have personal knowledge and full authority to make the following declarations:

This reporting period covers the preceding 6 months from _____________ to ___________, 20   _.

_______ Initials A written Drug Free Workplace Policy has been implemented and employees notified.

The policy meets the criteria established by the Mayor's Amended Policy on Drug Detection and Deterrence (Mayor's Policy).

_______ Initials Written drug testing procedures have been implemented in conformity with the Mayor's Drug Detection and Deterrence Procedures for Engineers, Executive Order No. 1-31. Employees have been notified of such procedures.

_______ Initials Collection/testing has been conducted in compliance with federal Health and Human Services (HHS) guidelines.

_______ Initials Appropriate safety impact positions have been designated for employee positions performing on the City of Houston contract. The number of employees in safety impact positions during this reporting period is ________________.

From _____________ to _____________ the following test has occurred
(Start date) (End date)

<table>
<thead>
<tr>
<th>Random</th>
<th>Reasonable Suspicion</th>
<th>Post Accident</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>________</td>
<td>________</td>
<td>______</td>
</tr>
</tbody>
</table>

Number Employees Tested

Number Employees Positive

Percent Employees Positive

Any employee who tested positive was immediately removed from the City worksite consistent with the Mayor's Policy and Executive Order No. 1-31.

I affirm that falsification or failure to submit this declaration timely in accordance with established guidelines will be considered a breach of contract.

I declare under penalty of perjury that the affirmations made herein and all information contained in this declaration are within my personal knowledge and are true and correct.

_______________  (Typed or Printed Name)  
_______________  (Signature)  
_______________  (Title)  

G:\CONTRACT\LPN\HEALTH BENEFITS\RFP Sample_GROUP DENTAL INDEMNITY AGREEMENT-DPPO_2015.doc 9/2/2015 58
EXHIBIT "D"

MINORITY AND WOMEN BUSINESS ENTERPRISES

It is the City's policy to encourage participation of certified local minority and women business enterprises (MWBEs) in City contracts. Vendors will be required to make a good-faith effort to meet annual MWBE goals.

- **Dental indemnity goal:** Contractors shall make good faith efforts to award 15% of the portion of total annual premium (plan cost) that is attributable to the administrative services portion of the plan to city-certified MWBE. Proposers will be required to set the percentage of administrative services upon which the goal will be based each year. The administrative services percentage (not the goal) may be modified annually, upon written request by the contractor 30 days in advance of May 1 each year.

Items that are eligible for satisfaction of the goal include dental services, printing costs, laboratories, translation services, and any others listed in the current City of Houston MWBE directory. However, good faith efforts must include solicitations to firms that provide dental and directly related services.

The City's policy does not require contractors or administrators to in fact meet or exceed goals, but it does require them to objectively demonstrate that it has made good faith efforts to do so. To this end, they shall maintain records showing:

1. subcontracts and supply agreements with Minority Business Enterprises,
2. subcontracts and supply agreements with Women's Business Enterprises, and
3. specific efforts to identify and award subcontracts and supply agreements to MWBEs.

Administrator shall submit periodic reports of its efforts under this Section to the Office of Business Opportunity ("OBO") Director in the form and at the times the Director prescribes.

Administrators shall require written subcontracts with all MWBE subcontractors and suppliers and shall submit all disputes with MWBE subcontractors to mediation if directed to do so by the OBO Director.
EXHIBIT "E"

CITY OF HOUSTON GROUP DENTAL INDEMNITY CONTRIBUTIONS
Effective May 1, 2011

Monthly Group Dental Indemnity Contributions during the first three years of this Agreement are as follows:

(May 1, 2011 - April 30, 2014)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee/Retiree</td>
<td>$31.58</td>
</tr>
<tr>
<td>Employee/Retiree + One</td>
<td>$72.67</td>
</tr>
<tr>
<td>Employee/Retiree + Family</td>
<td>$99.50</td>
</tr>
</tbody>
</table>

For optional renewal year four (4), Group Dental Indemnity Contributions shall not exceed the following:

Year 4 (May 1, 2014 April 30, 2015)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Indemnity Rate Caps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee/Retiree</td>
<td>$34.42</td>
</tr>
<tr>
<td>Employee/Retiree + One</td>
<td>$79.21</td>
</tr>
<tr>
<td>Employee/Retiree + Family</td>
<td>$108.46</td>
</tr>
</tbody>
</table>

For optional renewal year five (5), Group Dental Indemnity Contributions shall not exceed the following:

Year 5 (May 1, 2015 April 30, 2016)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Indemnity Rate Caps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee/Retiree</td>
<td>$37.52</td>
</tr>
<tr>
<td>Employee/Retiree + One</td>
<td>$86.34</td>
</tr>
<tr>
<td>Employee/Retiree + Family</td>
<td>$118.22</td>
</tr>
</tbody>
</table>

If Policyholder elects to extend the term of this Policy, the rates for the period beginning 12:01 a.m. on May 1, 2014 and ending at 11:59 p.m. on April 30, 2016, the rates shall be increased based on the following formula; subject to the above rate caps.

a. For the period beginning at 12:01 a.m. on May 1, 2014 and ending at 11:59 p.m. on April 30, 2015, the rates shall be increased based on the following formula; subject to the above rate caps for Year 4.
1. Twelve months of dental claims for the period November 1, 2012 through October 31, 2013, plus the ending IBNR less the beginning IBNR;
2. Plus Dental CPI-U US City Average as defined by the Department of Labor Statistics for the period of November 1, 2012 through October 31, 2013;
3. Plus 5.5% of revenue for claims administration;
4. Plus 2% of revenue for premium tax;
5. Plus 3% for legal, overhead, marketing, and other administrative expenses;
6. Plus 4% Risk charge; and
7. Equals Total Projected Cost. Divided by 12 months of premium for the period of November 1, 2012 through October 31, 2013, adjusted to reflect current rate levels, minus one equals percentage rate increase.

However, this increase shall be capped as shown above.

For the fifth (5th) year of this Agreement, Group Dental Indemnity Contributions shall be calculated as follows:

b. For the period beginning at 12:01 a.m. on May 1, 2015 and ending at 11:59 p.m. on April 30, 2016, the rates shall be increased based on the following formula; subject to the above rate caps for Year 5.

1. Twelve months of dental claims for the period November 1, 2013 through October 31, 2014, plus the ending IBNR less the beginning IBNR;
2. Plus Dental CPI-U US City Average as defined by the Department of Labor Statistics for the period of November 1, 2013 through October 31, 2014;
3. Plus 5.5% of revenue for claims administration;
4. Plus 2% of revenue for premium tax;
5. Plus 3% for legal, overhead, marketing, and other administrative expenses;
6. Plus 4% Risk charge; and
7. Equals Total Projected Cost. Divided by 12 months of premium for the period of November 1, 2013 through October 31, 2014, adjusted to reflect current rate levels, minus one equals percentage rate increase.

However, this increase shall be capped as shown above.

Renewal rates are due to the City on or before February 1 of each renewal period.
EXHIBIT “F”

SCOPE OF SERVICES

Services specifically required in the management and administration of the Group Dental Indemnity Plan, as well as payment of dental claims submitted by or on behalf of covered City employees are listed below.

Contractor shall:

1. Provide and manage DPPO networks, ensuring they include sufficient credentialed dental providers to serve City participants. Ninety-four (94) percent of members should have two dentists within ten (10) miles of their home zip code.
2. Exclude actively at-work requirements for any participants covered by the prior carrier on the day before the effective date of the Agreement.
3. Accept City of Houston electronic eligibility data files on a bi-weekly basis. Ensure that all data transfers, storage and processing are confidential and HIPAA compliant.
4. Establish and maintain records of account for all claims submitted. All such records shall be accessible to City representatives and other authorized individuals.
5. Allow an annual third party dental claim audit at no charge for internal claims audit support.
6. Analyze claims submitted by or on behalf of providers and/or covered participants in accordance with the provisions of the dental plans, and determine the amount of benefits payable.
7. Provide timely payment of claims and/or capitation to dental providers.
8. In the event that a claim is denied in whole or in part, notify the claimant of such denial clearly describing:
   a. The specific reason for the denial;
   b. The specific reference to the dental plan provision on which the denial is based;
   c. Any additional materials or information needed for the claimant to appeal his claim;
   d. An explanation of the dental plan’s claims review procedure; and
   e. The time frame during which the appeal must be filed.
9. If a payment is made to or on behalf of an ineligible person or an overpayment is made, attempt to recover payment or overpayment from the person. The Director or his/her designee may direct in writing further action to be taken, as needed.
10. Establish effective communication to assist employees and the City.
11. Provide customer service to all members of the City’s dental plan, utilizing designated or dedicated customer service representatives.
12. Provide a dedicated toll free number for use by City dental plan members at no cost to the
13. Provide an onsite customer service representative at no cost to the City.
14. Assist with annual open enrollment activities, including attendance at open enrollment meetings.
15. Permit the City to review and approve all communication materials prior to distribution to members.
16. Provide an employee website and mobile applications as mutually agreed upon.
17. Mail ID cards to each covered member every year by May 1st at no cost to the City.
18. Conduct an annual member satisfaction survey for all plans.
19. Provide the quarterly reports indicated below for DPPO plan:
   A. Monthly Paid Claims vs. Premiums Paid Report;
   B. Enrollment Report by Month;
   C. Claims Detail Report by Month;
   D. Claim Loss Ratios by Month;
   E. Total Number of Complaints;
   F. Total Number of Appeals;
   G. Network Composition;
   H. Performance Guarantee Reports;
   I. MWBE Compliance Reports; and
   J. Ad Hoc Reports as requested by the City.
20. As plan provisions and rates change, provide information electronically and also printed booklets describing the changes.