BOS AGREEMENT # 21-178

COUNTY OF MENDOCINO
STANDARD SERVICES AGREEMENT

This Agreement is by and between the COUNTY OF MENDOCINO, hereinafter referred to as the "COUNTY", and Regional Government Services Joint Powers Authority (RGS), hereinafter referred to as the "CONTRACTOR".

WITNESSETH

WHEREAS, the Regional Government Services Joint Powers Authority ("RGS" or "CONTRACTOR") is a public agency created by the City of Dublin, the City of Larkspur, the City of Walnut Creek, and the Town of Yountville pursuant to Government Code section 6500 et seq. under their agreement entered into on or about March 1, 2001 as amended and restated effective August 25, 2016 (a copy of which is attached hereto as Attachment 1); and,

WHEREAS, pursuant to the August 25, 2016 agreement, RGS has the ability to accept other public entities as associate members via contract, which associate members are not entitled to appoint a representative to RGS' Board of Directors; and,

WHEREAS, pursuant to Article II, section 2 of the August 25, 2016 agreement, RGS' Executive Committee has the ability to establish the rights, privileges, duties and obligations of associate members; and,

WHEREAS, RGS has adopted rules through its Executive Committee (a copy of which are attached hereto as Attachment 3), governing the admission, rights, privileges, duties and obligations of associate members for the purposes of participating in RGS' Municipal Dental Pool ("MDP); and

WHEREAS, RGS has provided a form (attached hereto as Attachment 2), for public entities to become associate members through agreement to be bound by those rules set forth in Attachment 2; and,

WHEREAS, RGS currently contracts with Delta Dental of California, for the provision of certain administrative services in connection with a MDP (a copy of which agreement is attached hereto as Attachment 4); and,

WHEREAS, COUNTY desires to obtain an associate membership in RGS so that COUNTY can become a member of the RGS Municipal Dental Pool, and

WHEREAS, CONTRACTOR is willing to approve the associate membership to the County with the terms and conditions set forth in this AGREEMENT; and

WHEREAS, COUNTY will become a participating member of the RGS Municipal Dental Pool, effective when Agreement is fully executed; and

WHEREAS, the premium for employee dental benefits is calculated Per Employee Per Month (PEPM) for an estimated annual cost of Eight Hundred Forty Thousand Dollars ($840,000), paid directly to the RGS Municipal Dental Pool through Keenan's Service Enhancement Technologies (SETECH) division.

NOW, THEREFORE it is agreed that:

1. COUNTY does hereby agree to join as an associate member of the Joint Power's Association, pursuant to those terms and conditions set forth in Attachment 2.

2. COUNTY does hereby agree to become a participating member of the RGS Municipal Dental Pool, at an estimated annual amount of $840,000 for employee dental benefits.

Attachment 1	Amended and Restated Joint Powers Agreement Creating the Regional Government Services Authority.
Attachment 2	Agreement and Acceptance of Municipal Dental Pool Services Agreement.
Attachment 3	Municipal Dental Pool Rules and Regulations.
Attachment 4	Delta Dental Administrative Services Contract.
Attachment 5	Regional Government Services Authority Municipal Dental Pool monthly premium rates.

The term of this Agreement shall be from the date this Agreement becomes fully executed by all parties and shall continue through December 31, 2023.

The Agreement will automatically renew for subsequent three (3) year periods unless either party gives the other sixty (60) days written notice of its intent not to renew.

IN WITNESS WHEREOF

DEPARTMENT FISCAL REVIEW:

09/07/2021

CARMEL J. ANGELO, CEO DATE

Budgeted: ☒ Yes ☐ No

Budget Unit: 0715

Line Item: 862239

Grant: ☐ Yes ☒ No

Grant No.: _____

COUNTY OF MENDOCINO

By: _____

DAN GJERDE, Chair
BOARD OF SUPERVISORS

Date: OCT 20 2021

ATTEST:
CARMEL J. ANGELO, Clerk of said Board

By: _____
Deputy

OCT 20 2021

I hereby certify that according to the provisions of Government Code section 25103, delivery of this document has been made.

CARMEL J. ANGELO, Clerk of said Board

By: _____
Deputy

OCT 20 2021

INSURANCE REVIEW:

By: _____
Risk Management

Date: 09/07/2021

CONTRACTOR/COMPANY NAME

By: _____ Digitally signed by Richard H. Averett Date: 2021.09.10 14:43:32 -07'00'

Date: _____

NAME AND ADDRESS OF CONTRACTOR:

Regional Government Services Authority Municipal Dental Pool

PO Box 1350

Carmel Valley, CA. 93924

By signing above, signatory warrants and represents that he/she executed this Agreement in his/her authorized capacity and that by his/her signature on this Agreement, he/she or the entity upon behalf of which he/she acted, executed this Agreement

COUNTY COUNSEL REVIEW:

APPROVED AS TO FORM:

CHRISTIAN M. CURTIS,
County Counsel

By: _____
Deputy

Date: 09/07/2021

EXECUTIVE OFFICE/FISCAL REVIEW:

By: _____
Deputy CEO

Date: 09/07/2021

Signatory Authority: $0-25,000 Department; $25,001- 50,000 Purchasing Agent; **$50,001+ Board of Supervisors**
Exception to Bid Process Required/Completed ☐ _____
Mendocino County Business License: Valid ☐
Exempt Pursuant to MCC Section: _____

ATTACHMENT 1

AMENDED AND RESTATED JOINT POWERS AGREEMENT CREATING THE REGIONAL GOVERNMENT SERVICES AUTHORITY

An agreement entitled "Joint Powers Agreement Creating the Regional Government Services Authority" was entered into as of March 1, 2001 (as amended and restated from time to time, the "Agreement"), by and between participating public entities (collectively called the "Members"), currently comprised of the City of Dublin, the City of Larkspur, the City of Walnut Creek and the Town of Yountville. This Amended and Restated Joint Powers Agreement Creating the Regional Government Services Authority is made and effective August 25, 2016, by the Members.

RECITALS

The Members have determined that it is more efficient, effective, and economical to provide certain management, administrative, special or general services for Members and other public agencies through a joint powers authority ("JPA") than by each agency directly employing separate staff;

The Members have determined that state law allows for a joint powers authority to provide such services;

The Members further have determined that state law allows for certain such Member functions to be provided by contract with the JPA;

The Members also wish to be able to offer expertise to other public and private entities serving public agencies through the provision of services by this JPA;

Each Member is a public agency as defined by Government Code Section 6500 *et seq.*, and is authorized and empowered to contract for the joint exercise of powers common to each Member;

The Members seek to provide through the JPA, an entity that will directly employ staff and consultants for local and regional entities;

The Members have determined there exists a need for a public agency to operate services on a regional basis or to operate services outside the routine operations of Members, in order to achieve greater efficiency, effectiveness and/or economy;

The Members have determined there exists a need for a public agency to provide shared, collaborative services to public agencies that enable partner agencies to achieve their goals cost-effectively;

The Members now wish to exercise jointly their powers to provide services by establishment of the Regional Government Services Authority ("RGS"), a public agency; and

RGS is established to maximize the efficiency and effectiveness of service delivery of government programs benefiting the local and regional public interest. Many of the services provided by RGS will be those typically beyond the scope or capacity of an individual local government entity because of funding and other constraints .RGS can efficiently and effectively provide these services through consolidation and coordination

NOW, THEREFORE, in consideration of the mutual promises set out, the parties agree as follows:

AGREEMENT
ARTICLE I.
POWERS AND PURPOSES

1. **RGS Created.** RGS is formed by this Agreement pursuant to the provisions of Article 1, Chapter 5, Division 7, Title 1(commencing with Section 6500) of the Government Code of the State of California. RGS shall be a public entity separate from the parties hereto and its debts, liabilities and obligations shall not be the debts, liabilities and obligations of its Members.

2. **Purpose of the Agreement; Common Powers to be Exercised.** Each Member individually has the statutory ability to provide services for the operation of a public agency. The purpose of this Agreement is to jointly exercise the foregoing common powers in the manner set forth herein.

3. **Effective Date of Formation.** RGS was formed as of the date referred to in the first paragraph of the Joint Powers Agreement Creating the Regional Government Services Authority, which was March 1, 2001 (the "Effective Date").

4. **Powers.** Pursuant to and to the extent required by Government Code Section 6509, RGS shall be restricted in the exercise of its powers in the same manner as is a general law city. RGS shall have the power to do any of the following in its own name:

   (a) To exercise the common powers of its Members in providing services for the operation of a public agency or other entity, including related and incidental services.

   (b) To make, assume and enter into contracts, including contracts with its Members, associate members, partner agencies, consultants and vendors.

   (c) To negotiate contracts with represented and unrepresented employees.

   (d) To maintain, assume and employ such agents, employees, consultants, and other persons as it deems necessary to accomplish its purpose.

   (e) To lease, acquire, hold and dispose of property of any kind.

   (f) To invest surplus funds.

   (g) To incur debts, liabilities, or obligations.

   (h) To sue and be sued in its own name.

   (i) To apply for grants, loans, or other assistance from persons, firms, corporations, and/or governmental entities.

   (j) To prepare and support legislation related to the purposes of this Agreement.

   (k) To collect payments and fees for services, as relevant law may allow.

(l) To purchase insurance or to self-insure.

(m) To enter into joint powers agreements with other public agencies when necessary or beneficial for RGS to carry out its mission.

(n) To adopt rules, regulations, policies, by laws and procedures governing its operation.

5 **Indemnification of Members.** RGS shall indemnify, defend and hold harmless the Members from and against any and all loses, liability, claims, suits, actions, damages, causes of actions, and costs, including but not limited to reasonable attorneys' fees, (collectively, "Liability") arising out of the operation of RGS, except when such Liability arises due to the sole negligence or willful misconduct of the Member.

Whenever RGS provides services to a Member pursuant to a separate agreement between RGS and the Member, the indemnification provisions of that agreement shall apply as to the services that RGS provides pursuant to the agreement.

ARTICLE II.
ORGANIZATION

1. **Membership.** The Members of RGS shall be the parties hereto, and such other public entities as may join RGS after execution of this Agreement, and shall exclude any current or future Members who later withdraw. Public entities may join if approved by two-thirds of the members of the Executive Committee of the RGS Board on terms and conditions approved by the Executive Committee. New members shall be included within the term "Members" following execution of an Addendum to this Agreement executed by the new member and the Chair of the Executive Committee. Following execution of such an Addendum, the new member shall be subject to the provisions of this Amended and Restated Agreement, and shall have the same power to appoint a representative to the RGS Board of Directors as existing Members. Any Member that withdraws from RGS, pursuant to Article V of this Agreement, shall no longer be a Member.

2. **Associate Membership.** Public entities may join RGS as associate members, by virtue of contracting for services with RGS, which contract shall include an addendum to this Agreement and must be approved by the Executive Committee, or by other means as approved by the Executive Committee Associate membership shall be on terms and conditions approved by the Executive Committee, and the Executive Committee shall establish the rights, privileges, duties and obligations of associate members consistent with this Agreement. Associate members shall not have the right to appoint a representative to the Board of Directors, nor shall they have a right to any of RGS' assets upon dissolution. The debts, liabilities and obligations of ROS shall not be the debts, liabilities and obligations of its associate members.

3. **Designation of RGS Board of Directors.** The ROS Board of Directors (the "Board") shall consist of the chief executive or the chief executive's designee of each Member, who shall serve at the pleasure of the governing board of the Member and may be removed at any time, without cause, in the sole discretion of that Member. Each representative shall serve as a director and shall be entitled to place any matter reasonably related to the business of RGS on the agenda for any meeting of the Board. No additional compensation shall be provided for such service, although directors' expenses shall be reimbursable. A meeting of the Board of Directors shall be called at least once per fiscal year for the purpose of selecting Executive Committee members, amending Authority Bylaws, approving the budget, and other

such business as appropriate. All voting power shall reside in the Board of Directors, with those powers necessary to carry out the day-to- day business of RGS delegated to the Executive Committee. Special meetings of the Board may be called in accordance with the provisions of Government Code section 54956, as that section may be amended from time to time.

4. **Executive Committee.** The regular management of the Authority shall be vested in an Executive Committee consisting of no more than seven individuals selected by the Board of Directors at the annual meeting, with up to two Alternate committee members also chosen by the Board of Directors. Members of the Executive Committee may, but need not, be on the Board of Directors. Members of the Executive Committee shall serve at the pleasure of the Board, and may be removed, without cause, in the sole discretion of the Board. No additional compensation shall be provided for service on the Executive Committee, although expenses of members of the Executive Committee shall be reimbursable. The Executive Committee shall have power:

(a) To approve additional public entities as new members or associate members and terms and conditions of such membership;

(b) To employ and contract for personnel and consultants consistent with the purposes of the RGS.

(c) To expend funds of ROS and enter into contracts, whenever required, in the judgment of the Executive Committee consistent with the purposes of the ROS.

(d) To acquire and sell any personal property.

(e) To lease, acquire, hold and dispose of property of any kind.

(f) To approve payroll payments and other demands for payments by ROS.

(g) To review and recommend to the Board prior to July 1 of each year the annual budget for the next fiscal year referred to in Section II.3.

(h) To make all expenditures of ROS consistent with the ROS budget, authorized appropriations and approved agreements.

The Executive Committee shall perform such other duties as may be imposed on it by the Board and shall report to the Board at such times and concerning such matters as the Board may require.

5. **Principal Office.** The principal office of RGS shall be designated by the Board, which may move those offices should it choose to do so.

6. **Meetings.**

a. The Board shall meet at the principal office of RGS or at such other place as may be designated by the Board. The Board shall meet at least once per fiscal year.

b. All meetings of the Board or Executive Committee, including regular, adjourned and special meetings, shall be called, noticed and held in accordance with the Ralph M. Brown Act, Section 54950, et seq. of the Government Code (the "Brown Act") as it may be amended from

time to time.

7. **Quorum; Voting.** A majority of the members of the Board of Directors shall constitute a quorum for the purpose of the transaction of business relating to RGS. Each director shall be entitled to one vote. Unless otherwise provided herein, a vote of the majority of those present and qualified to vote shall be sufficient for the adoption of any motion, resolution or order or to take any other action deemed appropriate to carry forward the objectives of RGS.

8. **Officers.** At its first meeting, the Board shall elect a Chair and Vice-Chair from among the Directors, and shall appoint a Secretary who may, but need not, be a Director. The officers shall perform the duties normal to such offices. The Chair shall preside at all meetings of the Board and shall sign all routine contracts that do not require Board award on behalf of RGS, and shall perform such other duties as may be imposed by the Board. The Vice-Chair shall act, sign contracts and perform all of the Chair's duties in the absence of the Chair. The Board may also designate an employee of RGS to sign contracts that do not require Board award and contracts for which Board award has been granted.

9. **Secretary; Minutes.** The Board shall have the authority to appoint a Secretary of RGS, or may delegate such power to the Executive Committee. The Secretary of RGS shall provide notice of, prepare and post agendas for and keep minutes of regular, adjourned regular, and special meetings of the Board or Executive Committee, and shall cause a copy of the minutes to be forwarded to each director. The Secretary will otherwise perform the duties necessary to ensure compliance with the Brown Act and other applicable rules or regulations, and shall perform such other duties as may be imposed by the Board or Executive Committee. The Secretary shall cause a copy of this Agreement to be filed with the Secretary of State pursuant to the Act.

10. **Rules.** The Board from time to time may adopt such bylaws, rules and regulations for the conduct of its affairs that are not in conflict with this Agreement. The Board may also adopt bylaws, rules and regulations for the conduct of the Executive Committee, or may delegate such authority to the Executive Committee itself.

11. **Fiscal Year.** RGS's fiscal year shall be July 1 of each year, to and including the following June 30.

12. **Treasurer/Controller.** The Board shall have the power to appoint a Finance Director of RGS Pursuant to Section 6505.6 of the Act, the Finance Director of RGS serves as the Auditor, Controller and Treasurer of RGS. The Treasurer shall be the depositary, shall have custody of all of the accounts, funds and money of RGS from whatever source, shall have the duties and obligations set forth in Sections 6505 and 6505.5 of the Act and shall assure that there shall be strict accountability of all funds and reporting of all receipts and disbursements of RGS.

13. **Officers in Charge of Records. Funds. and Accounts.** Pursuant to Section 6505.1 of the Act, the Treasurer shall have charge of, handle and have access to all accounts, funds and money of RGS and all records of RGS relating thereto; and the Secretary shall have charge of, handle and have access to all other records of RGS.

14. **Bonding Persons Having Access to Public Records.** From time to time, the Board may designate persons, in addition to the Executive Director, Secretary and the Treasurer, having charge of handling or having access to any records, funds or accounts of RGS, who shall be required to post performance bonds. The respective costs of the official bonds of such persons designated by the Board pursuant to Section 6505.1 of the Act shall be paid by RGS. The Executive Director, Secretary and the Treasurer may be employees of, or contracting to, any Member or public agency affiliated with RGS.

15. **Legal Advisor.** The Board shall have the power, or may delegate such power to the Executive Committee, to appoint the legal advisor of RGS who shall perform such duties as may be prescribed by the Board, and to retain other legal counsel as the Executive Committee deems necessary. The Legal Advisor may be an employee of, or have a contractual relationship with, any Member, but such relationship is not required.

16. **Executive Director Appointment; Employees.** The Executive Committee shall have the power to appoint and employ an Executive Director, and to establish the duties and responsibilities of the Executive Director. The Executive Director shall have the power to appoint and employ such other employees, consultants, and independent contractors as may be necessary for the purposes of this Agreement, and to establish the duties and responsibilities of such employees. Such employees, consultants, or independent contractors may be employees of, or have a contractual relationship with, any Member. The Executive Committee may also contract with a Member to provide administrative services to RGS.

All of the privileges and immunities from liability, exemption from laws, ordinances and rules, and all other benefits which apply to the activities of officers, agents, or employees of a public agency when performing their respective functions shall apply to the officers, agents and employees of RGS to the same degree and extent while engaged in the performance of any of the functions and other duties under this Agreement.

None of the officers, agents, or employees directly employed by RGS shall be deemed, by reason of their employment by RGS, to be employed by a Member or, by reason of their employment by RGS, to be subject to any of the requirements of a Member.

17. **Assistant Officers.** The Board may appoint or delegate to the Executive Committee the authority to appoint, such assistants to act in the place of the Executive Director, Treasurer, Secretary or other officers of RGS (other than a member of the Board of Directors) as the Board shall from time to time deem appropriate.

ARTICLE III.
MEMBER CONTRACTING WITH RGS

Any Member may contract with RGS for services on terms to be negotiated by the parties.

ARTICLE IV.
ACCOUNTS AND REPORTS; FUNDS

1. **Accounts and Reports**. The Treasurer shall establish and maintain such funds and accounts as may be required by good accounting practice. The books and records of RGS shall be open to inspection at all reasonable times by representatives of Member Agencies. The Treasurer will make independently audited financial statements available to Members each fiscal year.

2. **Funds**. The Treasurer of RGS shall receive, have the custody of and disburse RGS funds as nearly as possible in accordance with generally accepted accounting practices, shall make the disbursements required by these Agreements or to carry out any of the provisions or purposes of these Agreements.

ARTICLE V.
TERM

1. **Term**. This Restated and Amended Agreement for Regional Government Services Authority shall become effective when signed by all of the Members and shall continue in full force and effect so long as there are at least two Members.

2. **Dissolution & Withdrawal**. All Members may mutually agree to dissolve RGS at any time. Individual Members may terminate their membership by providing three months' advance notice to the RGS Board Chair, with the date of termination coinciding with the beginning of a fiscal quarter. Any terminating Member shall pay all amounts owed to the JPA prior to the date of termination. A terminating Member shall not be entitled to receive a share of RGS' assets, except upon dissolution as provided for in Section V.3.

3. **Disposition of Assets**. Upon dissolution of RGS, after satisfaction of all debts, liabilities or obligations incurred by RGS, any and all remaining property of RGS, both real and personal, and all other assets of any kind shall be divided among the Members active as of the act of dissolution, in such manner as shall be agreed upon by those Members. In the event RGS has outstanding debt, liability or obligation at the time of dissolution, the Members shall have no obligation or responsibility for such debt, pursuant to Section 1.1 of this Agreement.

ARTICLE VI.
MISCELLANEOUS PROVISIONS

1. **Notices**. Notices hereunder shall be in writing and shall be sufficient if delivered to the notice address of each party hereto for legal notices or as otherwise provided by a party hereto in writing to each of the other parties hereto.

2. **Section Headings.** All section headings in this Agreement are for convenience of reference only and are not to be construed as modifying or governing the language in the section referred to or to define or limit the scope of any provision of this Agreement.

3. **Consent**. Whenever in this Agreement any consent or approval is required, the same shall not be unreasonably withheld.

4. **Law Governing.** This Agreement is made in the State of California under the constitution and laws of the State of California, and is to be so construed.

5. **Amendments.** This Amended and Restated Agreement may be amended at any time, or from time to time, by a written amendment executed by the

Members. Additional public entities may become Members of RGS by execution of an Addendum as provided in Article II, section **1.** Following the addition of a new Member, any amendment of this Amended and Restated Agreement shall require approval of all Members, including any such new Members.

6. **Enforcement by RGS.** RGS is hereby authorized to take any or all legal or equitable actions, including but not limited to injunction and specific performance, necessary or permitted by law to enforce this Agreement.

7. **Severability.** Should any part, term or provision of this Agreement be decided by any court of competent jurisdiction to be illegal or in conflict with any law of the State of California, or otherwise be rendered unenforceable or ineffectual, the validity of the remaining portions or provisions shall not be affected thereby.

8. **Successors.** This Agreement shall be binding upon and shall inure to the benefit of the successors of the Members respectively. No Member may assign any right or obligation hereunder without the written consent of other Member(s).

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized on the day and year set opposite the name of each of the parties

CITY OF DUBLIN

By: _____
Chris Foss, City Manager

Date: 8/25/16

Attest: _____
Caroline Soto, City Clerk

Approved as to Form:

_____
John Bakker, City Attorney

CITY OF WALNUT CREEK

By: _____
Ken Nordhoff, City Manager

Date: _____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

CITY OF LARKSPUR

By: _____
Dan Schwarz, City Manager

Date: _____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

TOWN OF YOUNTVILLE

By: _____
Steven Rogers, City Manager

Date: _____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized on the day and year set opposite the name of each of the parties.

CITY OF DUBLIN

By:_____
Chris Foss, City Manager

Date:_____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

CITY OF WALNUT CREEK

By:_____
Ken Nordhoff, City Manager

Date:_____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

CITY OF LARKSPUR

By:_____
Dan Schwarz, City Manager

Date: 6/27/16

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

TOWN OF YOUNTVILLE

By:_____
Steven Rogers, Town Manager

Date:_____

Attest:

_____
Town Clerk

Approved as to Form:

_____
Town Attorney

2653448.6

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized on the day and year set opposite the name of each of the parties.

CITY OF DUBLIN

By:_____
Chris Foss, City Manager

Date:_____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

CITY OF WALNUT CREEK

By: Ken Nordhoff
Ken Nordhoff, City Manager

Date: 8/5/16

Attest:

_____
City Clerk

Approved as to Form:

_____
For City Attorney

CITY OF LARKSPUR

By:_____
Dan Schwarz, City Manager

Date:_____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

TOWN OF YOUNTVILLE

By:_____
Steven Rogers, Town Manager

Date:_____

Attest:

_____
Town Clerk

Approved as to Form:

_____
Town Attorney

2653448.6

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized on the day and year set opposite the name of each of the parties.

CITY OF DUBLIN

By:_____
Chris Foss, City Manager

Date:_____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

CITY OF WALNUT CREEK

By:_____
Ken Nordhoff, City Manager

Date:_____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

CITY OF LARKSPUR

By:_____
Dan Schwarz, City Manager

Date:_____

Attest:

_____
City Clerk

Approved as to Form:

_____
City Attorney

TOWN OF YOUNTVILLE

By:_____
Steven Rogers, Town Manager

Date: 7/21/16

Attest:

_____
Town Clerk - Michelle Dahme

Approved as to Form:

_____
Town Attorney

2653448.6

ATTACHMENT 2

AGREEMENT AND ACCEPTANCE OF THE MUNICIPAL DENTAL POOL SERVICES AGREEMENT

WHEREAS, the undersigned public agency ("Agency") seeks to become a member of the Regional Government Services Authority Municipal Dental Pool (the "Dental Pool"); and

WHEREAS, membership in the Dental Pool is offered to full and associate members of the Regional Government Services Joint Powers Authority (RGS); and

WHEREAS, Agency seeks associate membership in RGS for the purpose of joining the Dental Pool and RGS desires to grant such membership.

NOW, THEREFORE, it is agreed

1. As of the Effective Date noted below, Agency is granted associate membership in RGS as such membership is defined in the Amended and Restated Joint Powers Agreement Creating the Regional Government Services Authority.

2. Associate membership does not confer a right to any of RGS' assets upon dissolution nor does it oblige associate member to any of the debts, liabilities or obligations of RGS.

3. Agency hereby elects to become a Participating Employer in the MDP Administrative Services Agreement, as defined therein.

4. As a Participating Member, Agency agrees that it shall be bound by all terms and conditions of the MDP Administrative Services Agreement attached hereto as Exhibit A, as if the Agency had been an original signatory thereto.

County of Mendocino

BY: _____

Name: **Dan Gjerde**

Title: **Chair, Board of Supervisors**

Effective Date: **From the date this Agreement becomes fully executed by all parties.**

REGIONAL GOVERNMENT SERVICES

BY: _____

Name: Richard H. Averett

Title: Executive Director

Date: _____

EXHIBIT A

DENTAL PROGRAM SERVICES AGREEMENT

This **MDP Services Agreement** ("Agreement") is made and entered into by and between **Regional Government Services Authority** ("Client") and **Keenan & Associates** ("Keenan"), as of ("Effective Date").

RECITALS

A. Client has established the Municipal Dental Pool (hereinafter referred to as "MDP") serving the Client's members ("Client Members") and desires to have Keenan assist in the negotiation, implementation and operation of the MDP;

B. Client desires to have Keenan provide the services outlined in this Agreement with respect to the MDP and Keenan desires to provide such services subject to the terms and conditions of this Agreement.

The parties agree as follows:

AGREEMENT

1. TERM

The term of this Agreement is from December 1, 2018 ("Effective Date") through **December 31, 2023** ("Termination Date") and shall automatically renew for subsequent three (3) year periods unless either party gives the other at least sixty (60) days written notice of its intent not to renew, or unless the Agreement is otherwise terminated pursuant to Section 11.

2. KEENAN RESPONSIBILITIES AND SCOPE OF SERVICES

A. Keenan shall perform its obligations hereunder as an independent contractor and Keenan shall at all times remain responsible for its own operational and personnel expenses. Under no circumstance shall any employee of one party look to the other party for any payment or the provision of any benefit, including without exception, workers' compensation coverage.

B. Keenan's services are limited to the specific obligations described herein and Keenan is authorized to act on behalf of Client in connection with the MDP only as expressly stated in this Agreement. Except for Keenan's responsibilities with respect to funds obtained from or held on behalf of Client, Keenan shall not be a fiduciary of Client or any Client Member.

C. Keenan agrees to comply with all applicable laws and regulations applying to the protection and security of any data obtained by Keenan pursuant to this Agreement and to take all commercially reasonable efforts to ensure the security of program data, in whatever form stored or used by the MDP. Keenan shall promptly notify Client if it

becomes aware of a breach of the security measures established that results in the inappropriate disclosure of information.

D. It is anticipated that Keenan will obtain access to "Protected Health Information" as such term is defined by the Healthcare Information Portability and Privacy Act of 1996 ("HIPAA"). Keenan will execute a BAA pursuant to its HIPAA obligations.

E. Keenan shall perform the following specific services:
   (a) General Administration Services as described in Appendix A.
   (b) Underwriting Administration Services as described in Appendix B.
   (c) Funding and Payment Services as described in Exhibit C
   (d) Brokerage and benefits consulting services as described in Appendix D.
   (e) Financial services, provided through Keenan's SETECH division, as described in Appendix E

F. Keenan shall work with and coordinate with the claims processing administrator selected by MDP and shall forward eligibility data received from MDP and/or its Client Members and such other data as may be necessary for the efficient payment of claims.

3. CLIENT'S DUTIES AND RESPONSIBILITIE

A. Client shall retain final authority and responsibility for its MDP and is responsible for all other aspects of the MDP, except for the functions expressly delegated to Keenan under this Agreement.

B. Client hereby acknowledges and agrees that Delta Dental, or such other network/claims administrator that Client may later select ("Administrator") shall process MDP's claims for dental benefits as such responsibilities are outlined in the applicable claim administration agreement.

C. Client shall provide Keenan with timely access to such information and individuals, including its outside advisors and consultants, as may be necessary for Keenan to perform the Services. Keenan shall not be responsible for any delay in its performance that results from the failure of Client, or any person acting on behalf of Client, to make available any information or individual in a timely manner. Client shall cause its Client Members who participate in the MDP ("MDP Participants), as applicable, to provide such information to Keenan.

D. To the extent Keenan requires the assistance of Client's staff or any third parties who are assisting, advising or representing Client to fulfill its obligations hereunder, Client shall have its staff and these third parties assist Keenan.

E. Client shall consult its own attorney on all legal issues, and its own tax and accounting experts on all tax, accounting, and financial matters relating to its operations, including without limitation, the establishment and/or operation of the Plan. Keenan shall not

provide any legal, tax, or accounting service, advice, or opinion, and the Services shall not be interpreted as representing any such service, advice or opinion.

F. Client or MDP Participants, as applicable, will report eligibility changes (additions, terminations, and transfers) to Keenan on an eligibility list as mutually approved by Keenan and Client. A copy of the eligibility list must be received by Keenan no later than the 10th day of the month. Any eligibility changes received after the 10th day of the month may not be included in that month's eligibility data to the Administrator. Client will inform the MDP Participants submit the eligibility changes to Keenan as they occur.

G. Client will require MDP Participants to reimburse the Administrator within thirty (30) days after notice is given for any erroneous payments made by the Administrator as a result of incorrect eligibility reported by an MDP Participant to Keenan.

H. Upon termination of this Agreement, Keenan will return all information provided by Client in such reasonable form as Client designates. If Client requests to receive the information in a form that is deemed by Keenan to be non-standard, Client will pay Keenan reasonable costs associated with Keenan's conversion of the information to Client's requested form.

I. Client authorizes Keenan to acquire such information as may be reasonably required by Keenan to provide the Services from any entity or individual acting on behalf of Client.

4. COMPENSATION

The fees and funding amounts shall be as set forth in Appendix F attached to and incorporated into this Agreement. Appendix F may be modified from time to time, and, once signed by both parties, each new Appendix F shall become a part of this Agreement.

5. INSURANCE

Keenan shall procure and maintain during the term of this Agreement the following insurance coverages and shall provide certificates of insurance to Client upon Client's request.

A. Workers' Compensation: Coverage in conformance with the laws of the State of California and applicable federal laws;

B. General Liability: Coverage (including motor vehicle operation) with a Two Million Dollar ($2,000,000) limit of liability for each occurrence and a Two Million Dollar ($2,000,000) aggregate limit of liability; and

C. Errors and Omissions: Coverage with a Two Million Dollar ($2,000,000) limit of liability for each occurrence and a Two Million Dollar ($2,000,000) aggregate limit of liability.

D. Cyber Liability/Privacy: Coverage with a Two Million Dollar ($2,000,000) limit of liability for each occurrence and a Two Million Dollar ($2,000,000) aggregate limit of liability.

6. INDEMNIFICATION

If either party breaches this Agreement, then the breaching party shall defend, indemnify and hold harmless the non-breaching party, its officers, agents and employees against all claims, losses, demands, actions, liabilities, and costs (including, without limitation, reasonable attorneys' fees and expenses) arising from such breach. In addition, if Keenan (i) becomes the subject of a subpoena or is otherwise compelled to testify, or (ii) becomes the subject of a claim, demand, action or liability brought or asserted by an MDP Participant or one of an MDP Participant's employees, Plan beneficiaries, or Plan vendors ("Third-Party Demand") relating to the Services and such Third-Party Demand is not a direct result of Keenan's negligence or willful misconduct, then Client shall defend, indemnify and hold Keenan harmless from all losses, payments, and expenses incurred by Keenan in resolving such Third-Party Demand.

7. LIMITATION OF LIABILITY

Notwithstanding anything to the contrary in this Agreement, in no event shall either party be liable for any punitive damages, fines, penalties, taxes or any indirect, incidental, or special damages incurred by the other party, its officers, employees, agents, contractors or consultants whether or not foreseeable and whether or not based in contract or tort claims or otherwise, arising out of or in connection with this Agreement even if advised of the possibility of such damage. Keenan's liability under this Agreement shall further be limited to, and shall not exceed, the amount of its available insurance coverage, up to the limits of coverage outlined in Section 5.

8. DISPUTE RESOLUTION

A. In the event of any dispute arising out of or relating to this Agreement that cannot be settled through informal discussion or mediation, such dispute shall be resolved by submission to binding arbitration before Judicial Arbitration & Mediation Services ("JAMS") or ADR Services, at the claimant's choice, in Los Angeles County, California, before a retired judge or justice. If the parties are unable to agree on a retired judge or justice, the selected arbitration service (JAMS or ADR Services) will select the arbitrator.

B. In any such arbitration, the parties shall be entitled to take discovery in accordance with the provisions of the California Code of Civil Procedure, but either party may request that the arbitrator limit the amount or scope of such discovery, and in determining whether to do so, the arbitrator shall balance the need for the discovery against the parties' mutual desire to resolve disputes expeditiously and inexpensively.

C. The prevailing party in any action, arbitration, or proceeding arising out of or to enforce any provision of this Agreement will be awarded reasonable attorneys' fees and costs incurred in that action, arbitration of proceeding, or in the enforcement of any judgment or award rendered.

9. TERMINATION

A. Either party may terminate this Agreement upon the occurrence of any of the following events:

(1) The breach of this Agreement by either party if the alleged breach is not cured within thirty (30) days of receiving notice of the breach from the non-breaching party;

(2) The dissolution or insolvency of either party;

(3) The filing of a bankruptcy petition by or against either party (if the petition is not dismissed within sixty (60) days in the case of an involuntary bankruptcy petition); or

(4) If either party reasonably interprets the application of any applicable law, rule, regulation, or court or administrative decision to prohibit the continuation of this Agreement or cause a penalty to either party if the Agreement is continued.

B. If Client requests that Keenan continue to provide services under this Agreement after its expiration, Keenan may agree to provide services, and upon Keenan's written agreement, this Agreement shall be extended on a month-to-month basis until terminated by either party.

C. The termination of this Agreement with respect to any Participating Agency member shall have no effect on the Agreement with respect to the Client and the remaining Participating Agencies.

10. SOLICITATION OF EMPLOYEES

During the Term, and for a period of twelve (12) months following any termination or expiration of the Agreement, neither party shall solicit the employment or engagement of any employee or agent of the other party that interacted directly with the soliciting party; provided, however, the foregoing provision shall not prevent either party from soliciting for employment or employing an employee who responds to general solicitations or advertisements in periodicals including newspapers and trade publications, so long as such solicitations or advertisements are not specifically directed at the employee(s) of the other party.

11. MARKETING

Keenan may use Client's name in its representative client list.

12. OTHER RELATIONSHIPS

A. Keenan or its affiliates may provide Client or others with other services or insurance coverage not provided for in this Agreement and may receive compensation related to such other services which may include, without limitation, loss control services, joint powers administration, insurance brokerage services, securing reinsurance, claims administration, investigative services, financial processing and other related services.

B. Keenan and/or its affiliate may provide services for certain Client Members that also participate in and/or contract with the MDP and to the extent that such services are provided, Keenan will be separately compensated for those services.

C. The Services provided to Client are non-exclusive and Keenan may provide the same or similar services to other clients who may be in the same industry, business, or service as Client.

13. GENERAL

A. This Agreement, its recitals and all attached exhibits constitute the entire understanding of the parties related to the subject matter of the Agreement, and supersede all prior and collateral statements, presentations, communications, reports, agreements or understandings, if any, related to such matter(s).

B. All terms of this Agreement (other than Keenan's obligation to perform services and Client's obligation to pay for such services) shall survive the expiration or termination of this Agreement.

C. This Agreement is made for the benefit of the parties and is not intended to confer any third-party benefit or right. The enforcement of any remedy for a breach of this Agreement or claim related to the Services may only be pursued by the parties to this Agreement.

D. No modification or amendment to this Agreement shall be binding unless in writing and signed by authorized representatives of both parties. Any waiver or delay by a party in enforcing this Agreement shall not deprive that party of the right to take appropriate action at a later time or due to another breach. This Agreement shall be interpreted as if written jointly by the parties.

E. Any provision determined by a court of competent jurisdiction to be partially or wholly invalid or unenforceable shall be severed from this Agreement and replaced by a valid and enforceable provision that most closely expresses the intention of the invalid or unenforceable provision. The severance of any such provision shall not affect the validity of the remaining provisions of this Agreement.

F. Neither party shall be liable or deemed to be in default for any delay or failure in performance under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions,

earthquakes, floods, power outages, failure of computer systems, machinery or supplies, vandalism, strikes, or other work interruptions, or any similar or other cause that is beyond the reasonable control of either party. Each party shall make a good faith effort to perform under this Agreement in the event of any such circumstances and shall resume full performance of its contract duties once the cause of the delay has abated.

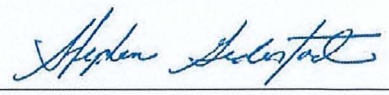
G. All notices hereunder shall be in writing and shall be sent to the parties at the addresses as set forth below, or to such other individual or address as a party may later designate. Notices shall be sent via personal delivery, courier service, United States mail (postage pre-paid, return receipt requested), express mail service, electronic mail, or fax. Notice shall be effective when delivered, or if refused, when delivery is attempted. Notices delivered during non-working hours shall be deemed to be effective as of the next business day.

   If the notice relates to a legal matter or dispute, a copy shall be sent to:

   Keenan & Associates
   2355 Crenshaw Blvd., Ste. 200
   Torrance, CA 90501
   Attn: Legal Department
   Fax: (310) 533-0573

H. This Agreement may be executed in counterparts and by fax signatures and each shall be deemed to be an original.

I. Each person signing this Agreement on behalf of a party represents and warrants that he or she has the necessary authority to bind such party and that this Agreement is binding on and enforceable against such party.

Regional Government Services Authority			**Keenan & Associates**	
Signature:			**Signature:**	
By:	**Richard H. Averett**		**By:**	**Stephen Gedestad**
Title:	**Executive Director**		**Title:**	**Municipality Practice Leader**
Address:	**PO Box 1350**		**Address:**	**1111 Broadway, Suite 2000**
	Carmel Valley, CA 93923			
Telephone:	**831.308.1508**		**Telephone:**	**(510) 986-6750**
Fax:			**Fax:**	**(510) 986-0440**
Attention:	**Richard Averett**		**Attention:**	**Peter McNamara**

APPENDIX A- GENERAL ADMINISTRATION SERVICES

1. Actuarial Reports. Facilitate independent actuarial services and annual certification of reserves report to the Board of Directors and appropriate committees for rate study and reserve contingency certification.

2. MDP Participant Rates and Contributions. Annually prepare and submit the established MDP rate for each upcoming year to the MDP Participants so that they can calculate their respective contributions to MDP. Follow-up with the MDP Participants, as necessary, to facilitate payment on a timely basis and compliance with MDP's late payment policy.

3. MDP Administrative Guide. Provide each MDP Participant a guide with details and responsibilities of Keenan, MDP, and the MDP Participant. Include a listing of Keenan personnel involved in the management and day-to-day operations of MDP in order that Members have access to those professionals as necessary. Update and revise annually as necessary and provide to the Board Members.

4. Program Structure Outline. Provide each MDP Participant, at the beginning of each fiscal year, a synopsis of its coverage under the various options provided by MDP. Distribute to each Member a copy of the coverage outlines within 90 days, after January 1 of each program year.

5. New Participant Orientation. Provide personnel as necessary to meet with new MDP Participants to review the various policies, procedures and documentation that are utilized in the operation of the Program.

6. Policies and Procedures. At the direction of Client, develop policies and procedures to facilitate the smooth operations of MDP.

7. Coordination of Providers. Oversee independent service providers contracted with by MDP.

8. Legislation. Keep the Board or the appropriate committee(s) apprised of legislation pending or otherwise that affects MDP's Program.

9. Strategic Planning. At least every two years, Keenan shall meet with Client to review and update the Strategic Plan for MDP.

10. Client Interface. Keenan will respond to all inquiries by Client and MDP Participants, as applicable regarding eligibility, renewals, funding of benefits, and administrative expenses.

APPENDIX B - UNDERWRITING ADMINISTRATION SERVICES

1. Underwriting Policies. Develop and recommend underwriting policies to MDP as necessary.

2. New Participant Marketing. Provide professional personnel to market MDP to public agencies for membership in MDP through the use of presentations and literature.

3. New Participant Proposals. Review prospective MDP Participant proposals to assess eligibility for participation in MDP and provide a synopsis of new business proposals together with a recommendation. Provide such additional information as requested by MDP so that MDP can make its decision on admission of new MDP Participants.

4. Renewals. Collect, collate and coordinate information from each Member for programs of MDP. Disseminate appropriate information to MDP Participants.

5. Independent Actuary.
   I. Keenan shall engage an independent actuarial firm to provide such advice as may be necessary to ensure the fiscal stability of the self-insured program, rate and reserve adequacy.
   II. Keenan will pay the costs of the actuarial firm, but the actuary will be an independent contractor with sole responsibility for its advice and services.

6. Rate Setting
   I. Keenan shall recommend self-funded rates for the Program options for each plan year.
   II. Keenan shall prepare and distribute spreadsheets to MDP Participants detailing the rates
   III. MDP shall provide such additional information as may be requested by Keenan to develop the rates.

EXHIBIT C - FUNDING AND PAYMENT

1. Keenan Fee. MDP shall pay Keenan a fee and as described in Exhibit F. If there are insufficient funds in the MDP account, Client shall pay Keenan directly.

2. Administrator Fee. Client shall also pay Administrator in accordance with the terms of the applicable agreement with the Administrator.

3. Monthly Rate. At the beginning of the plan year, Keenan shall provide each MDP Participant with a monthly rate for their participation in MDP ("Monthly Rate.") MDP Participants will submit payment each month based upon the Monthly Rate provided. Payment will be made to Keenan's SETECH division who will deposit the payments into a claim payment account ("Account") established for MDP. The funds in the Account will be used to: (i) fund the MDP Participants' claims payment obligations, (ii) pay the Administrator's fee, and (iii) pay Keenan's fee. Funds shall be allocated in the order specified in the previous sentence.

4. Advancement of Funds. Neither Keenan nor Delta shall be required to advance any of its own funds for the payment of any claim, fee or expense that is the responsibility of the MDP. Client shall reimburse Delta and/or Keenan, as applicable, for any expense incurred in the collection of any amount due from MDP or an MDP Participant

APPENDIX D - BROKERAGE SERVICES

Additional Coverages. At the request of Client, Keenan will obtain proposals for insurance coverage for the operational risks and exposures of MDP and obtain additional insurance/reinsurance coverages as may be Required. In such case Keenan shall provide:

1. Summary of Coverage Terms. To the extent that Keenan obtains quotes for coverage in response to a Client Request, it shall prepare a summary of the terms of the Coverages that are being offered. Respond to Client requests for additional information concerning the Coverages that arc offered. Client shall be responsible for the final approval and acceptance of terms of all Additional Coverages.

2. Credit Information on Coverage Providers. Provide Client with the most recent available

3. Best Rating. Keenan shall advise client of the A.M. Best (or similar rating agency) rating report for each insurer/reinsurer that may be offering coverages, along with such additional information that Client may request, so that MDP can make its decision on whether to purchase a Coverage.

4. Additional Services. Keenan agrees to provide the additional services that will be required in connection with obtaining and administering the Coverages, including preparation of submissions, brokerage, claims administration, financial processing and reporting ("additional Services").

5. Option. As part of its ongoing assistance with the strategic planning for MDP, Keenan shall also advise Client as program options for MDP and shall take such steps as directed by Client to establish and implement such options.

APPENDIX E - SETECH SERVICES

Keenan, through its SETECH division, shall provide the following accounting and consulting services:

1. Maintain an accounting system with appropriate internal controls and proper segregation of duties which will include the following:

   I. Receive contributions from the MDP Participants on behalf of MDP and transfer them into an operating checking account set up for the MDP
   II. Make payments on behalf of MDP for its obligations to the Administrator.
   III. Maintain and reconcile MDP's operating checking for the approval of the Client.
   IV. Monitor and control cash flow of MDP for approval of the Client

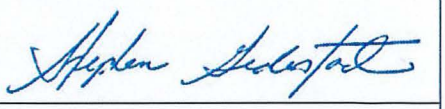
2. Prepare at a minimum, quarterly financial reports for MDP, which will present the financial position and compare actual results versus the adopted budget.

3. Coordinate, accumulate and prepare the annual budget

4. Prepare calculations for return of MDP's net position or MDP Participant assessments, upon request

APPENDIX F
COMPENSATION

Keenan Fee: There will be a per employee per month (PEPM) fee ("Keenan Fee") equal to 10% of fully insured rate equivalent premiums except when mutually agreed to be different on a case by case basis. The Keenan Fee will not be reviewed or adjusted prior to 2022. Thereafter, the Keenan Fee will be reviewed annually and may be adjusted upon the mutual agreement of the parties.

Regional Government Services Authority			**Keenan & Associates**	
Signature:			**Signature:**	
Title:	**Executive Director**		**Title:**	**Municipality Practice Leader**

ATTACHMENT 3

Municipal Dental Pool
Rules and Regulations

PREAMBLE

The Municipal Dental Pool ("MDP") is created for the purpose of the establishment, operation, and maintenance of a Dental Program, and such other coverages and associated services as Regional Government Services Authority (RGS) may later determine, and to provide a forum for discussion, study, development, and implementation of programs regarding employee benefits, insurance, and self-insurance MDP is sponsored by a Joint Powers Authority entitled Regional Government Services Authority ("RGS" or "Board").

ARTICLE I
MEMBERSHIP

A. Membership in MDP is open to any California public agency, and trust or non-profit serving public agencies, if legally permissible. Membership shall be deemed to be effective when the prospective Participating Agency or "Agencies" has:
    1. Been approved by the Executive Director and Program Manager;
    2. Has executed the Agreement; and
    3. Agreed in writing to be bound by these Rules and Regulations.

B. For purposes of Section A above, "public agency" means any city, state, county, or local government or an agency of city, state, county, other public entity such as a joint powers authority.
C. A representative of the Participating Agency may participate in Advisory Committee meetings with the Executive Director to provide input on all matters affecting the program. Participation is voluntary but helps ensure the program best meets the needs of Participating Agencies.

ARTICLE II
EXECUTIVE DIRECTOR

Duties of Executive Director

A. The Executive Director refers to the RGS Executive Director and is appointed and can be removed by the RGS Board.
B. Executive Director duties with respect to MDP include:
    1. Establish an Insurance Advisory Committee (IAC) for MDP Agencies to provide input into the program's administration;
    2. Provide Treasurer services for the program;
    3. Provide program oversight;
    4. Assist the vendor in strengthening the program through outreach, coordination, and management; and
    5. Keep the RGS Board/Executive Committee informed about the program's status (e.g. membership, IOC/member input, lives covered, claims volume and account balance).

6. The Executive Director has the authority to contract for services as appropriate.

ARTICLE III
PROGRAM MANAGER

A Program Manager shall oversee the day-to-day operations and administrative functions of MDP. The Program Manager shall also act as MDP's benefits consultant and insurance broker for the organization, supporting the IAC, Executive Director and RGS Board/Executive Committee. Given its extensive experience as an insurance broker/consultant and in the management of pooled insurance programs and joint powers authorities, Keenan shall serve as MDP's Program Manager. Keenan shall serve at the pleasure of the Executive Director and may be removed as the Program Manager by the Executive Director with the advice and consent of the majority of the Participating Agencies and RGS Board or Executive Committee. The compensation of the Program Manager will be set by agreement with RGS.

ARTICLE IV
INSURANCE ADVISORY COMMITTEE

A. There shall be created an Insurance Advisory Committee ("IAC") whose purpose shall be to advise and consult with the RGS Executive Director and Program Manager with respect to the interests and concerns of the MDP Agencies. Each Participating Agency can designate one individual from the organization to serve on the IAC. Individuals shall serve on the IAC at the pleasure of the appointing Agency and any individual so serving may be removed and replaced by the appointing Agency at any time for any reason.

B. The IAC may select one individual to serve as its Chair. If selected, the Chair shall preside over all meetings of the IAC.

C. The IAC shall function only in an advisory capacity and shall have no authority to take any action or make any decision on behalf of the RGS Board with respect to the MDP.

D. All meetings of the IAC will be called, held and conducted in compliance with the provisions of the Brown Act.

E. The IAC members shall not receive compensation for their service on the Committee. Expenses incurred by an IAC member at the direction or request of the Executive Director shall be eligible for reimbursement from the program only if approved in advance.

F. The IAC shall meet telephonically or in-person at least once annually. Additional meetings may be convened upon request of the Chair or any IAC member, or at the request or direction of the Executive Director.

G. The IAC may establish rules governing its own conduct and procedure and have such expressed or implied, as is not inconsistent with or contrary to the laws of the State of

California, these Rules and Regulations, the Agreement, or any rule, policy, procedure, action, or directive of the Board.

H. The powers of the IAC include:

1. Review contracts to which MDP is a party.
2. Recommend benefits insurance and insurance-related programs to be offered to the Agencies;
3. Work with the Program Manager, as appropriate, to provide input regarding MDP's insurance programs and day-to-day operations
4. Review the renewal and other financial related aspects of MDP

ARTICLE V
FINANCE

A. MDP shall operate on a program year from January 1st through December 31st.

B. No less than 90 days before the end of the program year, the Executive Director shall propose an operating budget ("Operating Budget") for the following program year for review and recommendation by the IAC. A copy of the Operating Budget shall be transmitted to each of the Participating Agencies.

C. As necessary, an Operating Account shall be established and maintained by the Program Manager for monies that may be received by MDP for the benefit of the Program. Funds from the Operating Account shall be used for the payment of the operating expenses of MDP.

D. Each Member shall be responsible for the payment of its own insurance premiums. A 2% late fee will be charged for premiums received thirty (30) days after the due date, and a 5% late fee will be charged for premiums received sixty (60) days after the due date.

E. Request made to provide a timeline for annual renewal process, advising when the preliminary renewal will be available, when renewal rates are presented to the Board, and when and rates are released to Agencies.

ARTICLE VI
INSURANCE COVERAGE AND OTHER SERVICES

A. The Program Manager shall solicit and obtain quotes from insurance carriers for presentation to the Participating Agencies and Executive Director.

B. The Board or their designee shall determine the carrier(s) and insurance options that will be made available to the Participating Agencies.

C. MDP will make available the third-party administration (TPA) services to its self-insured Agencies.

D. Self-insured Participating Agencies will be required to accept the terms and conditions of the TPA service agreement entered into by MDP's Executive Director

ARTICLE VII
ACCOUNTS AND RECORDS

A. MDP is accountable for all funds received by the pool and dispersed by it and, to that end, MDP shall establish and maintain such funds and accounts as may be required by good accounting practice or by any provision of law or any resolution of MDP. Accounting duties may be provided by a third party, such as SETECH, under contract. Books and records of MDP in the hands of the Program Manager shall be open to inspection at all reasonable times by representatives of the Agencies. As soon as practical after the close of each program year, MDP shall give, or cause to be given, a complete written report of all financial activities for such program year to each Agency.

B. RGS may make, or contract with a Certified Public Accountant to make, for an appropriate review of the accounts, records, and financial affairs of MDP.

ARTICLE VIII
TERMINATION OF MEMBERSHIP

A. Any Member who has been a member of MDP for at least two (2) years may terminate its membership and its participation in the MDP by providing notice in the manner prescribed in Section B below. Termination will be effective as of the last day of the then-current program year.

B. Notice must be given at least 60 days before the end of the program year. Notice must be in writing signed by the chief executive of the Agency, addressed to the Program Manager and/or Executive Director. If an Agency submits notice of an intent to terminate, but subsequently decides to remain in MDP, the Agency shall not be permitted to submit another termination notice for two years. The Executive Director has the right to impose a termination fee upon any Agency who fails to provide notice in the manner required by these Rules and Regulations.

C. Any Agency withdrawing from MDP shall not be eligible to reapply for membership for a period of two (2) years.

D. An Agency may be involuntarily terminated from MDP upon agreement by both the Executive Director and Program Manager at any IAC meeting at which a quorum is present.

E. Grounds for involuntary termination include, but are not limited to, the following:

1. Failure or refusal to abide by the Agreement or Bylaw, and/or any amendment thereto;
2. Any action which in the opinion of the Executive Director and Program Manager is contrary to best the interests, goals and/or objectives of MDP and its Agencies.
3. Failure of an Agency to disclose a material fact to MDP or its Program Manager which, in the opinion of the Executive Director, constitutes fraud, misrepresentation or concealment for the purposes of obtaining coverage with
5. Failure for more than 60 days to pay any of its share of the Program Manager's fees;
6. The cancellation of insurance obtained through MDP for non-payment of plan premiums, or
7. Failure for more than 60 days to make any payment due for TPA services secured through MDP.

Involuntary termination shall have the effect of eliminating the Agency as a Participating Agency of MDP. Termination shall be effective upon such other date as the Executive Director may specify, but in no case less than thirty (30) days after notice of involuntary termination is given. If termination occurs before the last day of the program year, any insurance obtained by the terminated Agency through MDP shall continue until the first day of the month following the termination date, but in no way relieves the terminating Agency from any financial obligation to pay for premiums.

ARTICLE IX
DISPOSITION OF PROPERTY AND FUNDS

In the event of the dissolution of MDP, the complete rescission, or other final termination of the Program by all Participating Agencies then a party to the Agreement, any property interest remaining in MDP following a discharge of all obligations shall be disposed of pursuant to each Participating Agency's pro rata share of the remaining interest, less five (5) percent for RGS to oversee dissolution. The pro rata share shall be distributed to participants who have been members for at least 24 months and are participants on the date of termination.

ARTICLE X
INVESTMENT OF FUNDS

A. MDP shall have the power to invest or cause to be invested, in compliance with Section 6509.5 of the California Government Code, such funds as are not necessary for the immediate operation of MDP as allowed by Section 53601 of the California Government Code. Another section that references codes that was requested to be reviewed.

B. The level of cash to be retained for the actual operation of MDP shall be determined by the by Executive Director, with the advice and concurrency of the Program Manager and Participating Agencies.

ARTICLE XI
AMENDMENT

A. Amendment to these Rules and Regulations may be proposed by any Participating Agency.

B. Except as otherwise provided in these Rules and Regulations, amendments to these Rules and Regulations must be adopted by a two-thirds (2/3) majority of Participating Agencies and approval by RGS. Any amendments duly adopted by the Board shall be binding upon all Participating Agencies of MDP. Any amendment that would alter the rights of the Agencies or would fundamentally change the purpose of the MDP as established in the Preamble to these Rules and Regulations, must be approved by a 2/3rds majority of all Participating Agencies and by the RGS Board or Executive Committee. The effective date of any amendment will be on the first day of the next month following adoption, unless otherwise stated.

ARTICLE XI
SEVERABILITY

Should any portion, term, condition, or provision of these Rules and Regulations be decided by a court of competent jurisdiction to be illegal or in conflict with any law of the State of California, or be otherwise rendered unenforceable or ineffectual, the validity of the remaining portions, terms, conditions, and provisions shall not be affected thereby.

ARTICLE XII
EFFECTIVE DATE

These Rules and Regulations shall become effective immediately upon their adoption by the RGS Board or Executive Committee.

Approved: TBD

DENTAL ADMINISTRATIVE SERVICES CONTRACT

This Contract is entered into between **Regional Government Services Authority Municipal Dental Pool** (Contractholder) and **Delta Dental of California** (hereinafter referred to as Delta Dental).

Whereas, Contractholder has adopted an employee dental benefit plan (the Plan), which is set forth in the employee benefit booklet, as shown in Section 7, mutually agreed upon by Contractholder and Delta Dental, and for which Contractholder retains all liabilities;

Whereas, Contractholder has requested Delta Dental to provide certain administrative services to the Plan and Delta Dental has agreed to provide such services in accordance with this Contract and, without assuming any liability of the Contractholder under the Plan;

Now therefore, in consideration of the mutual promises and covenants contained in this Contract, it is hereby agreed as follows:

SECTION 1. DEFINITIONS

Terms with capital letters appearing in this Agreement shall have the meaning given to them in the Plan attached hereto as shown in Section 7. In addition, the following terms shall have these meanings:

1.01 **Contract** means this agreement between Delta Dental and Contractholder including the attached appendices, endorsements and riders, if any. This Contract constitutes the entire agreement between the parties.

1.02 **Contract Term** means the period during which this Contract is in effect. The Contract Term is shown in Appendix A.

1.03 **Keenan & Associates** is authorized to act on behalf of the Contractholder and it's Participating Employers in the collecting and submitting of funds to pay for claims and administration.

1.04 **Participating Employers** means Public Agency groups (excluding schools and school district) that are full or associate members of the Regional Government Services Authority and will receive Employee Benefit Booklets.

1.05 **Plan** means the self-funded dental benefits program for Contractholder's employees or members and their eligible dependents as set forth in Section 7.

SECTION 2. DUTIES OF DELTA DENTAL

For the administrative charge set forth in Appendix A, Delta Dental will provide Contractholder with the following services for the administration and operation of the Plan:

2.01 **Claims Services**
Delta Dental shall provide the following claim services:

a) Evaluate and process claims presented for Benefits described in the employee dental benefit booklet approved by Delta Dental and Contractholder. Claims shall be processed in accordance with Delta Dental's standard processing policies and the employee dental plan booklet as shown in Section 7 of this Contract. Services shall not be covered when received by a patient who is not an Enrollee at the time of treatment except for Single Procedures started while the patient was covered. Proof of loss must be furnished to Delta Dental within 12 months after care is received. Failure to furnish proof of loss within this time period shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss within such time and that such proof of loss was furnished as soon as reasonably possible. Proof of loss must be given no later than one (1) year from such time (unless the claimant was legally incapacitated). All written proof of loss must be given to Delta Dental within 12 months of the termination of the Contract.

b) Predetermine the amount of Benefits payable under the Contract. Pre-Treatment Estimate will be valid for 365 days from the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:
- the date this Contract terminates;
- the date the Enrollee's coverage ends; or

- the date the Delta Dental Premier® Provider's (Premier Provider) or Delta Dental PPO Provider's (PPO Provider) agreement with Delta Dental ends.

c) Investigate claims when appropriate. This includes, but is not limited to, referring claims to professional consultants. In addition, Delta Dental may obtain to the extent permitted by California law, from any Provider or from hospitals in which a Provider's care is provided, such information and records relating to an Enrollee as Delta Dental may require to determine the claim, or Delta Dental may require that an Enrollee be examined by a dental consultant retained by Delta Dental in or near his community or residence. Such information and records will be kept confidential.

d) Coordinate Benefit coverage when Benefits are being provided under two (2) or more group benefit plans or group health care programs as described in the employee benefit booklet prepared by Delta Dental and approved by Contractholder.

e) Delta Dental may suspend claims for Enrollees if it does not receive all amounts due, in the amount and manner required by Section 3 and Appendix A. Also, Delta Dental shall not pay claims for any person unless included on the monthly eligibility list when the dental services are performed. However, a child shall be covered if notice of birth and payment are received within 31 days after birth. All payments for services performed by a PPO or Premier Provider will be made directly to the Provider. With regard to services performed by a Non-Delta Dental Provider, the Primary Enrollee may request in writing when filing proof of loss to have the payment made to the Provider. All other payments shall be payable to the Primary Enrollee, or to the estate, except that if the person is a minor or otherwise not competent to give a valid release, payment may be made payable to his parent, guardian or other person actually supporting him, unless otherwise specified by a valid court order.

f) Document claim payments to providers for the purpose of reporting to the Internal Revenue Service.

g) Furnish to any Provider or any Enrollee, on request, a Claim Form to make a claim for payment for services under the Plan.

h) Notify the Primary Enrollee if any Benefits are denied for services submitted on a Claim Form. An Enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta Dental giving reason why the denial is disputed. The Enrollee may also ask Delta Dental to examine any records to aid an appeal. Delta Dental will review the denial in accordance with the Plan and render a decision. Should the Primary Enrollee further appeal Delta Dental's decision to Contractholder, Delta Dental shall assist Contractholder by providing information necessary to conduct its review.

i) Provide Contractholder with an annual projection of paid claims.

j) Provide Contractholder with standard claim activity reports.

2.02 **Dental Care Booklet**
Delta Dental shall be responsible for drafting an employee dental care booklet, for each Participating Employer, which summarizes the Benefits and to whom Benefits are payable. Delta Dental is also responsible for providing this booklet to the Contractholder, oh behalf of each Participating Employer, in an electronic format. The booklet is non-assignable and the Benefits are non-assignable prior to a claim. If any amendment to this Contract shall materially affect any Benefits described in such booklet, new booklets and amendments showing the change shall be issued.

2.03 **Identification Card**
Delta Dental will make a non-transferable identification card available for each Primary Enrollees to download from Delta Dental's website (deltadentalins.com).

2.04 **PPO Providers and Premier Providers**
Delta Dental will provide access to PPO Provider and Premier Provider network listings on the Internet. Delta Dental's website address is deltadentalins.com.

a) Contractholder understands and agrees that any agreement between Delta Dental and a network dentist is that of an independent contractor. Delta Dental shall not be responsible for any care rendered or not rendered. Delta Dental shall provide Contractholder with an electronic version of the PPO Provider Directory.

b) Any information relating to PPO Providers and Premier Providers will be considered the sole property of Delta Dental and shall not be distributed to third parties or for any purpose other than one which is reasonably necessary to carry out the terms of the Contract.

c) Delta Dental does not guarantee the availability of any Provider nor is it required that dental services be provided by any specific Provider.

SECTION 3. DUTIES OF CONTRACTHOLDER

3.01 **Eligibility**
On or before the Effective Date, Contractholder, on behalf of all Participating Employers, will furnish to Delta Dental, in writing or in electronic media format agreed by Delta Dental and the Contractholder, a listing of eligible Primary Enrollees and Dependent Enrollees. The listing must show the names, Enrollee ID numbers, dates of hire, dates of birth, dependent status and location codes, if any. The eligibility list shall include all active employees unless the employee waives coverage in writing or the Eligible Employee enrolls in an alternate dental plan offered by Contractholder. The eligibility list may also include retired employees.

Thereafter, before the 10th of each month, Contractholder must furnish to Delta Dental in the format agreed to above, a listing indicating specific additions, changes or terminations made during the prior month.

Contractholder will notify Delta Dental in writing of any requests for administrative fee adjustments for Enrollees who should have been terminated in the event Delta Dental was not previously notified of the termination(s). Said termination date will be adjusted retroactively to the immediately preceding 3 months plus the current month, provided:
a) no claims were submitted to be processed on said Enrollee subsequent to the date of retroactive termination; and
b) The administrative fees were actually paid for the Enrollee subsequent to the date of retroactive termination.
Delta Dental will notify the Contractholder in writing of the revised termination date and administrative fees will be adjusted accordingly.

Delta Dental will not pay any Benefits for an Enrollee or Dependent Enrollee if proof of eligibility is not submitted. Also, Delta Dental will not pay Benefits for an Enrollee if the administrative fees are not paid for the month in which dental services are rendered.

3.02 **Audits**
Contractholder shall permit Delta Dental to audit its records to determine whether the lists of Primary Enrollees are correct and to verify the monthly payments match the administrative charges. Delta Dental shall give Contractholder written notice within a reasonable time before the audit date.

3.03 **Printing and Distribution**
Contractholder agrees to consult with Delta Dental to the extent reasonably practical concerning any material published or distributed relating to the Contract. No such material shall be published or distributed which is contrary to the terms of the Contract.

Contractholder will make the dental booklet(s) drafted by Delta Dental available to each Primary Enrollee of a Participating Employer, via its internal computer network or through its website. Contractholder will neither change nor revise these booklets without the prior written approval of Delta Dental.

3.04 **Electronic Transfer of Funds**
Delta Dental will produce a weekly summary of claims paid. This information will be transmitted weekly by fax or email to the Keenan & Associates on behalf of the Contractholder and it's Participating Employers. Delta Dental will initiate the Automatic Clearing House Debit against the designated bank account within one (1) business day of sending the weekly notification.

Delta Dental may suspend claims payments at any time if the requested electronic funds transfer is not received within the allotted time frame.

SECTION 4. RELATIONSHIP OF THE PARTIES

4.01 Delta Dental is an independent contractor with Contractholder.

4.02 Delta Dental shall be responsible for fulfilling all administrative duties and obligations set forth in this Agreement. Notwithstanding the foregoing, Delta Dental may, in its discretion, delegate one or more functions or tasks to one or more subsidiaries or affiliated companies (companies under common control with or by Delta Dental), however, such delegation shall not in any way affect Delta Dental's continuing obligation to perform its stated duties and obligations.

4.03 **Indemnification**
Contractholder shall indemnify, defend and hold harmless Delta Dental, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Contract.

Delta Dental shall indemnify, defend and hold harmless the Contractholder, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Delta Dental's negligent performance or non-performance of its obligations under this Contract.

4.04 **Impossibility of Performance**
Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

SECTION 5. GENERAL PROVISIONS

5.01 If during the Contract Term any new or increased tax, assessment, or fee is imposed on the amounts payable to, or by, Delta Dental under this Contract or any immediately preceding contract between Delta Dental and the Contractholder, the amount stated in Appendix A will be increased by the amount of any such new or increased tax, assessment, or fee by written notice to Contractholder, and the Contract shall thereby be modified on the date set forth in the notice.

5.02 The parties agree that all questions regarding interpretation or enforcement of the Contract shall be governed by the laws of the State of California, where the Contract was entered into and is to be performed. Any provision of the Contract which, on its Effective Date, is in conflict with statutes of said state is hereby amended to conform to minimum requirements of such statutes.

5.03 Delta Dental is a member of the Delta Dental of California Holding Company System (the "Enterprise"). There are service agreements between and among the controlled member companies of the Enterprise. Delta Dental is a party to some of these service agreements, and it is expected that the services, which include certain ministerial tasks, will continue to be performed by these controlled member companies, which operate under strict confidentiality and/or business associate agreements. All such service agreements have been approved by the respective regulatory agencies.

5.04 Delta Dental will not be responsible or liable for any incorrect, obsolete or unreadable data or information supplied to Delta Dental including, but not limited to, eligibility and enrollment information.

5.05 All formal notices required under the Contract must be in writing and sent by first-class United States Mail, overnight delivery service or personal delivery. Notice by first class United States Mail shall be effective forty-eight (48) hours after mailing.

Notice to Delta Dental shall be to:
Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

Notice to Contractholder shall be to:
Regional Government Services Authority
Municipal Dental Pool
1111 Broadway #200
Oakland, CA 94607

5.06 Both parties to the Contract agree to permit and encourage the professional relationship between Provider and patient to be maintained without interference.

5.07 The Contract may not be amended, except in writing by mutual consent of Delta Dental and Contractholder.

5.08 If any portion of the Contract or any amendment thereto shall be determined by a court or other competent authority to be illegal, void or unenforceable, such determination shall not abrogate the Contract or any portion thereof other than such portion determined to be illegal, void or unenforceable, and all other portions of the Contract shall remain in full force and effect.

5.09 Contractholder shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Enrollee information. The Contractholder agrees that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

5.10 Absent fraud, each statement made by the Contractholder or Enrollee is considered to be a representation and not a warranty.

SECTION 6. TERMINATION AND RENEWAL

6.01 The term of the Contract shall be for the period set forth in Appendix A.

6.02 The Contract may be terminated only for the following causes:

a) By Delta Dental, upon Contractholder's failure (i) to furnish Delta Dental with a list of all Primary Enrollees and Dependent Enrollees as required under Section 3.01; (ii) to permit the inspection of records as called for under Section 3.02; or (iii) to pay all amounts due, in the amount and manner required by Section 3 and Appendix A.

b) By either Contractholder or Delta Dental, upon expiration of a Contract Term.

c) By Delta Dental, in the event that the number of Primary Enrollees reported by Contractholder to Delta Dental shall be less than the minimum number of Primary Enrollees (shown in Appendix A) in each of three (3) consecutive months, but only upon written notice, given not more than 15 days after receipt of the list of Primary Enrollees which indicates that such grounds for termination exist, effective as of the last day of the month in which notice of termination is given.

d) By Delta Dental, in the event that the bank account for claim payment remains under funded as a result of insufficient funds for more than 15 days. The Contract shall terminate as of the last day of the month after the fifteen days under funding has occurred.

6.03 In the event of termination by Delta Dental, all Benefits shall terminate and Delta Dental shall be released from all further obligations of the Contract, effective on the last day of the month in which written notice of termination is given. Contractholder shall remain liable for claims incurred, paid or otherwise discharged during the term of the Contract and during the 12-month claims run-out period.

6.04 The Contract may be terminated at the end of a Contract Term only by at least 60 days written notice.

6.05 Delta Dental will notify the Contractholder in writing within 120 days prior to the end of each Contract Term of the renewal information.

6.06 In the event of termination by the Contractholder, upon 30 days written notice by the terminating party to the other party of such termination in which event Delta Dental shall be paid its compensation for services performed to termination date, including all reimbursable expenses then due or incurred to the date of termination. Termination for cause shall include, but not be limited to, misuse of funds, fraud, lack of compliance with applicable rules, laws, regulations, and ordinances, and failure to perform in a timely manner any provision of this Agreement.

Delta Dental and the Contractholder understand and agree that at the expiration of this Agreement or any extension thereto, the Contractholder shall in no way be further obligated to Delta Dental and shall remain liable for claims incurred, paid or otherwise discharged during the term of the Contract and during the 12-month claims run-out period.

SECTION 7. ATTACHMENTS

The following documents are attached to this Contract and made a part hereof:

Appendix A Administrative Contract Variables

Appendix A-1 Participating Employers

Appendix B Employee Benefit Booklets

Appendix C RGSA MDP Guidelines

SECTION 8. SIGNATURES

The terms of this Contract are agreed to by:

DELTA DENTAL OF CALIFORNIA

Name of Officer: Michael G. Hankinson, Esq.

Title: EVP, Chief Legal Officer

Date: October 10, 2019

REGIONAL GOVERNMENT SERVICES AUTHORITY MUNICIPAL DENTAL POOL

Name of Officer: Richard H. Averett

Title: RGS Executive Director

Date: October 29, 2019

APPENDIX A

ADMINISTRATIVE CONTRACT VARIABLES

A. Contract Number: 19207*

B. The administrative services performed by Delta Dental under this Contract shall be effective commencing on July 1, 2019.

C. The Contract Term shall be for the period commencing on July 1, 2019 and concluding on December 31, 2020.

D. The monthly administrative charge is based on 1,000 covered employees and the composition of the Contractholder's group at the beginning of each Contract Term. Delta Dental may propose a choice of changes in administrative charges for a 15 percent change in composition during the Contract Term, such as an increase or decrease in enrollment, change in location, change in job classifications, change in mix of active versus retiree enrollment or other similar change in the Contractholder's group composition that lasts three (3) months in a row or longer and results in an increase in cost per person of the Contractholder's group. Within 31 days of receipt of the proposed change(s), Contractholder will select one of the choices by written notice to Delta Dental. If Contractholder fails to do so, Delta Dental may select one of the choices by written notice to Contractholder. This Contract will be modified for all dental services predetermined and incurred after notice.

E. Delta Dental on a weekly basis will reconcile and bill for the administration of the Plan. Keenan & Associates on behalf of the Contractholder and it's Participating Employers shall furnish to Delta Dental weekly payments of 10% of claims paid per week as compensation for administering the program. Any payment received after 90 days of the due date shall be subject to interest equal to one percentage point above the then current three month U.S. Treasury Bill rate.

F. Delta Dental may change the amounts charge whenever the Contract is amended or whenever the Contractholder requests a change in Benefits or eligibility or when applicable under 5.01. Any change in amounts due shall not be effective during a Contract Term unless Contractholder and Delta Dental agree in writing (except as provided in D and E above or when applicable under 5.01).

G. As the Contractholder has also entered into a DeltaCare® USA contract which is effective during the term of this Contract, this Contract will terminate if the combined enrollment under this Contract and the DeltaCare USA contract drops below 10 for three (3) consecutive months.

*Including all Participating Employers listed on Appendix A-1, below.

APPENDIX A-1

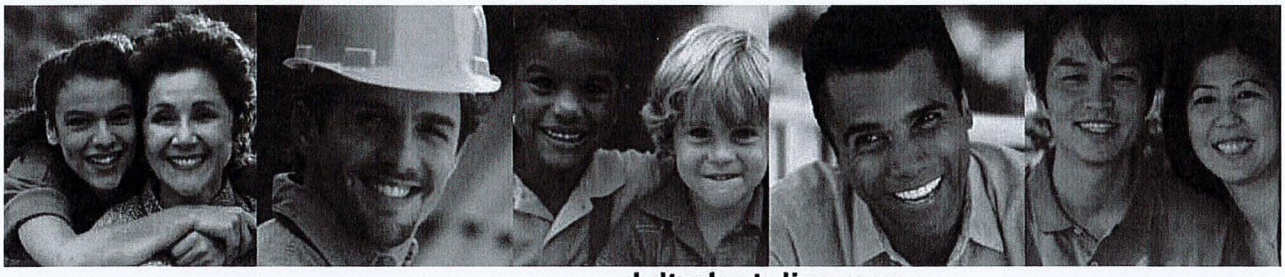
PARTICIPATING EMPLOYERS

Group Name	Group Number
City of Pico Rivera	18840
City of Claremont	19137
City of Azusa	19180
Regional Government Services	19207
City of Santa Ana	19209
City of Chino	19211
County of Mendocino	19212
Metropolitan Transportation Commission (MTC)	19213
City of Bishop	19214
Cit of Larkspur	19215
East Contra Costa Protection District	19216
City of Desert Hot Springs	19217
City of Alhambra	19223
City of Dana Point	19236
Town of Corte Madera	19243
Central Marin Fire Authority	19249
City of Bellflower	19294
City of Oxnard	19828
Town of Woodside	19947

APPENDIX B

EMPLOYEE BENEFIT BOOKLET

REGIONAL GOVERNMENT SERVICES



deltadentalins.com

Group No: 19207

Effective Date: July 1, 2019

CA-ENT-ASC-PPO-E(2019)

Table of Contents

Attachments

INTRODUCTION

We are pleased to welcome you to the group dental plan for Regional Government Services. Your plan is self-funded by your employer and your claims are administered by Delta Dental. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

This Employee Benefit Booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by Delta Dental of California ("Delta Dental") and cannot modify the Contract in any way.

Using This Employee Benefit Booklet

This Employee Benefit Booklet, which includes Attachment A, Deductibles, Maximums and Contract Benefit Levels (Attachment A) and Attachment B, Services, Limitations and Exclusions (Attachment B), discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer, trust fund, or other entity ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet. This booklet is *not* a Summary Plan Description to meet the requirements of ERISA.

Notice: *This booklet is a summary of your group dental plan and must be in effect at the time covered dental services are provided. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at deltadentalins.com or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 800-765-6003 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

DELTA DENTAL OF CALIFORNIA
560 Mission Street
Suite 1300
San Francisco, CA 94105

DEFINITIONS

Terms when capitalized in your Employee Benefit Booklet have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: covered dental services provided under the terms of the Contract.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim or request Pre-Treatment Estimate.

Contract: the agreement between Delta Dental and the Contractholder, including any attachments.

Contract Benefit Level: the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied as shown in Attachment A.

Contractholder: the employer, union or other organization or group as named herein contracting to obtain Benefits.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12-month period thereafter.

Deductible: a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.

Delta Dental Premier® Provider (Premier Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier Contracted Fee: the fee for a Single Procedure covered under the Contract that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental PPO℠ Provider (PPO Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee contracted fees as payment in full for covered services provided under a PPO dental plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental PPO Contracted Fee: the fee for a Single Procedure covered under the contract that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Dental Emergency: Dental screening, examination, and evaluation by a Provider, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Provider, to determine if an emergency dental condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency dental condition, within the capability of the facility.

Dental Emergency Condition: a dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in: 1) placing the Enrollee's health in serious jeopardy; 2) causing other serious dental or health consequences, and/or 3) causing serious impairment of dental functionality.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: the original date the Contract starts. This date is given on this booklet's cover and Attachment A.

Eligible Dependent: a dependent of an Eligible Employee eligible for Benefits.

Eligible Employee: any employee or retiree as eligible for Benefits.

Enrollee: an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Enrollee Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

Enrollee's Effective Date of Coverage: the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.

Maximum: is the maximum dollar amount ("Maximum Amount" or "Maximum") Delta Dental will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Delta Dental will pay the Maximum Amount(s), if applicable, shown in Attachment A for Benefits under the Contract.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Program Allowance.

Non-Delta Dental Provider: a Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period: the month of the year during which employees may change coverage for the next Contract Year.

Pre-Treatment Estimate: an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee: an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

Procedure Code: the Current Dental Terminology© (CDT) number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental sets the Program Allowance for each procedure through a review of proprietary data by geographic area. The Program Allowance may vary by the contracting status of the Provider and/or the Program Allowance selected by the Contractholder.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Qualifying Status Change: a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Enrollee or Eligible Dependent);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, dependent Spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Spouse: a person related to or a partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
- as may be recognized by the Contractholder.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

COST OF COVERAGE

You are not required to contribute towards the cost of your coverage.

You are not required to contribute towards the cost of your Dependent Enrollee's coverage.

We may cancel the Contract 30 days after written notice to the Contractholder if the cost of coverage is not paid when due.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

An employee becomes eligible on whichever is later, the Effective Date or on the first day of the month following date of hire.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

- Dependents are the Primary Enrollee's Spouse and dependent children from birth to age 26.
- Children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a Dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status.
- An overage dependent child may be eligible if:
  (1) he or she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
  (2) he or she is chiefly dependent on the eligible employee for support; and
  (3) proof of dependent child's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two (2)-year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the eligible employee for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental coverage provided by the military while they are on active duty.

Enrollment Requirements

If the Contractholder is paying all coverages for you and your dependents, everyone is automatically enrolled.

If you are paying all or a portion of the coverage for yourself or your dependents then:

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees for coverage.
- You must pay the cost of coverage in the manner elected by the Contractholder and approved by us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If you pay the cost of coverage for your Dependent Enrollees, you must pay in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you

choose to drop dependent coverage. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.

- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

Loss of Eligibility

Your coverage ends on the earlier of the last day of the month you stop working for the Contractholder, are no longer an Eligible Employee of the Contractholder or immediately when the Contract ends. Your Spouse loses coverage when your coverage ends or when dependent status is lost. Your dependent children lose coverage when your coverage ends or the last day of the month when dependent status is lost.

Continuation of Benefits

We will not pay for any services/treatment received after your coverage ends. However, we will pay for covered services incurred while you were eligible if the procedures were completed within 31 days of the date your coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same Calendar Year, Deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different Calendar Year, new Deductibles and maximums will apply.

Coverage will resume provided the Contractholder submits a request to Delta Dental that coverage be reactivated.

*Coverage for you and your dependents is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If you are currently paying any part of your cost of coverage, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act of 1993 does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

If you are rehired within the same Calendar Year, Deductibles and maximums will resume as if you were never gone.

Continued Coverage under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins, or;
- the date you fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the cost of coverage for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachment B. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed in accordance with our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards. Delta Dental will provide advance notice of such changes to the Contractholder who will then distribute to Primary Enrollees.

We will use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, are listed in Attachment A. If you receive dental services from a Provider outside the state of California, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in Attachment A and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that are discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the section titled "Selecting Your Provider" for more information.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in Attachment A. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

Most dental plans have a Maximum Amount. A Maximum Amount is the maximum dollar amount we will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable is shown in Attachment A. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under the Contract with your benefits under any other group or pre-paid plan designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits, but if this plan is the "secondary" plan, we determine Benefits after those of the primary plan and will pay the lesser of the amount that we would pay in the absence of any other dental benefit coverage or the Enrollee's total out-of-pocket cost under the primary plan for Benefits covered under the Contract.

- How do we determine which plan is the "primary" program?
  (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
  (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a) secondary to the plan covering the insured person as a dependent and
    b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

(3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:

a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but

b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).

(6) The Benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);

b) Second, the Benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(8) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.

(9) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider
You may see any Provider for your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. This plan is a PPO plan and the greatest benefits – including out-of-pocket savings – occur when you choose a PPO Provider. To take full advantage of your Benefits, we highly recommend you verify a Provider's participation status within a Delta Dental network with your dental office before each appointment. Review this section for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a PPO Provider
You may access information through our website at deltadentalins.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider
A PPO Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Choosing a Premier Provider
A Premier Provider is a Delta Dental Provider who has not agreed to the features of the PPO plan. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance. The amount charged by a Premier Provider may be above that accepted by PPO Providers but no more than the Delta Dental Premier Contracted Fee.

Choosing a Non-Delta Dental Provider
If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO or Premier Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.
Additional Obligations of PPO and Premier Providers

- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of the Deductible and Enrollee Coinsurance. The Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.
- PPO and Premier Providers accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and contracted fees.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

DELTA DENTAL OF CALIFORNIA
P.O. Box 997330
Sacramento, CA 95899-7339

Payment Guidelines

We do not pay PPO or Premier Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO Provider that you were covered under a Delta Dental Policy at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

Provider Relationships

Enrollees and Delta Dental agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to an Enrollee does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

CLAIMS APPEAL

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You and your Provider may also ask Delta Dental to examine any additional information provided that may support the appeal or grievance.

Send your appeal or grievance to us at the address shown below:

DELTA DENTAL OF CALIFORNIA
P.O. Box 997330
Sacramento, CA 95899-7339

We will send you a written acknowledgment within 5 days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send the Enrollee a decision within 30 days after receipt of the Enrollee's appeal or grievance.

If the Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Non-Discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Delta Dental's Customer Service Center at 800-471-0287.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 800-471-0287
Website Address: deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at our expense, in or near your community or residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All Benefits not paid to the Provider will be payable to you, the Primary Enrollee, or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

Misstatements on Application: Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same coverage rate. If any misstatement would materially affect the rates, we reserve the right to adjust the coverage rate to reflect your actual circumstances at enrollment.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.

Attachment A
Deductibles, Maximums and Contract Benefit Levels

Deductibles & Maximums		
	Delta Dental PPO Providers†	**Delta Dental Premier and Non-Delta Dental Providers†**
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year	
Deductibles waived for	Diagnostic & Preventive and Orthodontic Services	
Annual Maximum	$1,500 per Enrollee per Calendar Year	$1,000 per Enrollee per Calendar Year
	If an Enrollee switches among types of Providers during a Calendar Year the maximum amount payable for Benefits will be adjusted accordingly. The maximum amount payable each year for all services received from all Providers will not exceed the maximum amount payable for PPO Providers $1,500. However, if only Premier and Non-Delta Dental Providers are used, the maximum will not exceed $1,000. If an Enrollee meets the Calendar Year maximum for Premier and Non-Delta Dental Providers, an Enrollee may still utilize a PPO Provider for the balance of the applicable maximum.	
Lifetime Orthodontic Maximum	$1,000 per Enrollee	

Contract Benefit Levels		
Dental Service Category	**Delta Dental PPO Providers†**	**Delta Dental Premier and Non-Delta Dental Providers†**
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown below for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	70%
Major Services	60%	50%
Orthodontic Services	50%	50%

† Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

Attachment B
Services, Limitations and Exclusions

Description of Dental Services
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive: cleaning (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, which is considered to be a Diagnostic and Preventive Benefit, and periodontal maintenance, which is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
  - (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- **Basic Services**
  - (1) Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
  - (2) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
  - (3) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (4) Periodontics: treatment of gums and bones supporting teeth.
  - (5) Palliative: emergency treatment to relieve pain.
  - (6) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
  - (7) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
  - (8) Specialist Consultations: opinion or advice requested by a general dentist.
- **Major Services**
  - (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
  - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- **Orthodontic Services**
  Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

- **Note on additional Benefits during pregnancy**
  When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:
a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration;
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
e) an overdenture instead of denture.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Exam and cleaning limitations:
a) Delta Dental will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year.
b) A full mouth debridement is allowed once in a lifetime when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
c) Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit and that routine cleanings (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
d) Caries risk assessments are allowed once in 36 months.

(3) X-ray limitations:
a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(4) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.

(5) Space maintainer limitations:
   a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14. However, a distal shoe space maintainer-fixed-unilateral is limited to children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
   b) Recementation of space maintainer is limited to once per lifetime.
   c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(6) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(7) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

(8) Sealants are limited as follows:
   a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
   b) repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.

(9) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Delta Dental will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(12) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

(13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

(14) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(15) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(16) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(18) Periodontal limitations:
   a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. No more than two (2) quadrants of scaling and root planing will be covered on the same date of service.

b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Provider/Provider office.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Service and are limited to once in a 24-month period.

(19) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(20) The following Oral Surgery procedure is limited to age 19 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.

(21) The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.

(22) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60-month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(23) Core buildup, including any pins, are covered not more than once in any 60-month period.

(24) Post and core services are covered not more than once in any 60-month period.

(25) Crown repairs are covered not more than twice in any 60-month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.

(26) Denture Repairs are covered not more than once in any six (6)-month period except for fixed Denture Repairs which are covered not more than twice in any 60-month period.

(27) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.

(28) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(29) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6)

months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(30) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6)-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(31) Limitations on Orthodontic Services:
   a) The maximum amount payable for each Enrollee is shown in Attachment A.
   b) Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
   c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
   d) Benefits are not paid for orthodontic retreatment procedures.

Exclusions

Delta Dental does not pay Benefits for:

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal

surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) laboratory processed crowns for Enrollees under age 12.

(12) fixed bridges and removable partials for Enrollees under age 16.

(13) interim implants and endodontic endosseous implant.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening or tobacco counseling.

(18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(21) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.

(24) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.

(25) missed and/or cancelled appointments.

(26) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(27) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(28) dental case management motivational interviewing and patient education to improve oral health literacy.

(29) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(30) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

APPENDIX C

GROUP GUIDELINES FOR

Regional Government Services Authority Municipal Dental Pool

EFFECTIVE 7/1/2019

Underwriting Guidelines:

1) The Regional Government Services Authority Municipal Dental Pool (MDP) plans administered by Delta Dental of California are to only consist of Public Agency groups (excluding schools and school districts) that are full or associate members of the Regional Government Services Authority. Proof of membership with the Regional Government Services Authority must be provided with the group's enrollment application. Delta Dental defines Public Agency groups as county, city, municipal corporation, district, or any board, commission or agency thereof (excluding schools and school districts).

2) Delta Dental of California shall be the only dental carrier for the MDP.

3) A master agreement will be issued to the MDP. The conditions set forth in the master agreement are applicable to each Public Agency group participating in the MDP. Each group will also be provided with a subscriber agreement. In the event that a member group seeks to contract with Delta directly, their rates will be no lower than their existing rates within the MDP.

4) The Delta Dental PPO plan is available to MDP participating groups on a stand-alone basis. The DeltaCare USA plan is available to MDP participating groups on a stand-alone basis. Dual choice options may be offered to groups with a minimum of 25 primary enrollees with a minimum enrollment of 5 primary enrollees in the PPO plan and 5 primary enrollees in the DCUSA plan.

5) The MDP will ensure that each participating group with 5-99 primary enrollees receiving shelf plans will meet a minimum employer contribution requirement towards employee plan coverage under Delta Dental PPO. If employer contributes 100% of the cost, 100% of eligible employees must enroll. If employer contributes 75-99% of the cost, minimum 80% of eligible employees must enroll. Contributions for dependents may vary. Groups not meeting these minimum requirements will be reviewed on a case-by-case basis.

6) Fully Insured DeltaCare USA groups will be underwritten directly by Delta Dental and are referred to as individually rated groups in this document. For Self-Funded PPO groups over 100 primary enrollees, Delta Dental will review the current dental benefits and provide a suggested funding rate tier structure. If an existing Delta group seeks to join the MDP, Delta reserves the right to underwrite the case. Unless otherwise agreed to, standard Delta Dental processing policies, limitations and exclusions will be applied to all groups.

7) Payment of administration for the Self-Funded PPO groups will occur in conjunction with the weekly claims settlement addressed in item 11. Existing MDP groups will receive a new group number upon moving to the ASC arrangement in order to facilitate combined billing.

8) Administration charge will be subject to review should the MDP consist of more than 25 groups with enrollment below 100 primary enrollees. The MDP non-retention administrative charge for DeltaCare

USA groups will include applicable broker commission and costs associated with the Affordable Care Act. Delta Dental reserves the right to set minimum participation guidelines in the future for the MDP.

9) All groups within the MDP will have a common renewal date of January 1st each year. Any new group receiving shelf plans joining the MDP will have an initial contract ranging from 1 to 12 months, starting in any month and renewing January 1. Any new group that is individually rated joining the MDP will have an initial contract ranging from 12 to 23 months, starting in any month and renewing January 1. The MDP will use pooled experience for renewal purposes.

10) Each Public Agency group that enrolls must agree to remain in the program at the same benefit level for the term of the contract as described in item 9 above.

11) Groups new to Delta Dental with an ASC arrangement for the PPO program will be charged an administrative fee of 10% of claims. Claims payments and the percentage of claims administration fee will be charged to the MDP on a weekly basis.

12) Delta Dental's Conversion Policy.

a) In-force Delta Dental groups with risk rates pulling out of another Delta Dental pool will be assessed a 10% withdrawal penalty until at least 12 months have elapsed from the change of broker of record.

b) In-force Delta Dental groups with self-funded rates pulling out of another Delta Dental pool will pay an additional 1% in admin over the MDP administration rate until at least 12 months have elapsed from the change in broker of record.

c) In-force Delta Dental groups not currently in one of the Delta Dental pooled arrangements moving into MDP will not be eligible to receive an administration rate adjustment until at least 12 months have elapsed from the change of broker of record.

d) In-force Delta Dental groups that do not require a change of broker of record in order to move into MDP are eligible to receive an administration rate adjustment at their next renewal anniversary.

13) Groups with 5-99 enrollees will choose one FFS or one DeltaCare USA shelf plan. Groups with 25-99 enrollees will choose one FFS and/or one DCUSA shelf plan.

14) Delta Dental of California will adhere to each Public Agency group's eligibility requirement for their employees.

15) At renewal, a separate renewal letter will NOT be issued to each group in the MDP.

Keenan
Associates

County of Mendocino

Municipal Dental Pool (MDP) Renewal
Delta Dental PPO (Self-funded) Plan
Effective: January 1, 2021

Rate Tier	Subscribers*	2021 Rates
EE Only	543	$44.42
EE + Spouse	163	$74.66
EE + Child(ren)	149	$91.10
EE + Family	160	$124.32
Estimated Monthly Premium		**$69,754.74**
Estimated Annual Premium		**$837,056.88**

*Subscribers based on December 2020 enrollment