TDAHP

Total Dental Administrators Health Plan, Inc.

TOTAL DENTAL ADMINISTRATORS HEALTH PLAN, INC.

GROUP DENTAL MEMBERSHIP AGREEMENT

TDAHP Plan # A500S

This Group Dental Membership Agreement, hereinafter referred to as the "Agreement" is made by and between Total Dental Administrators Health Plan, Inc., (TDAHP), 2111 East Highland Avenue, Suite 250, Phoenix, Arizona 85016, hereinafter referred to as the "Plan", and, _____ hereinafter referred to as the "Group".

This Agreement shall become effective on the _____ day of _____ 200___ at 12:01 a.m. and shall remain in effect for an initial term of _____ year(s), subject to the terms and conditions set forth in this Agreement.

In consideration of the payment of Membership Dues and the Monthly Group Administrative Fee in the amount and manner herein provided, the Plan agrees to provide dental benefits to eligible Subscribers and said Subscriber's Dependents, if the dependent coverage option has been exercised. Persons receiving coverage, whether as Subscribers or Dependents, may be referred to herein as "Members".

Monthly Membership Dues shall be as follows:

2 – Tier ☐	**3 – Tier ☐**	**4 - Tier ☐**	
Employee	**Employee**	**Employee**	**_____per month**
Employee & Family	**Employee & 1 Dep.**	**Employee & Spouse**	**_____ per month**
	Employee & Family	**Employee & Child(ren)**	**_____ per month**
		Family	**_____ per month**

Subject to the provisions contained herein, the above Membership Dues are guaranteed for a period of year(s) from the effective date of this Agreement. Dues shall be paid by the Group to the Plan no later than the fifteenth (15th) day of the month prior to the month services are to be provided. The Group shall remit to the Plan the total dues amount including the following Monthly Group Administrative Fee;

$ _____ Monthly Group Administrative Fee

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ARTICLE I
DEFINITIONS

Agreement - This document, the TDAHP Plan Schedule of Benefits and Co-payments, and any endorsements and riders issued hereunder.

Benefits - The dental services offered, for the co-payments stated, as set forth is this Agreement.

Co-payment - The amount a Member is required to pay at the time he or she receives specified dental care services from a Plan Provider. Co-payment amounts are specified in the Plan Schedule of Benefits and Co-payments.

Dentist - A person who is licensed, by the state which has jurisdiction over said person, to practice dentistry. For the purposes of this Agreement, Dentist shall also mean a physician with respect to the performance of oral surgery, who is properly licensed by the state which has jurisdiction over said physician.

Dental Care - Any care, treatment, services or supplies which are provided or ordered by a Dentist.

Dental Center - A dental practice with one or more Dentists under contract with the Plan to provide covered dental services in accordance with the provisions of this Agreement.

Dependent

1. The Subscriber's lawful spouse except in the case of court ordered separate maintenance.

2. The Subscriber's and/or his/her spouse's unmarried child(ren) by birth or legal adoption, from the date of placement for adoption, to age nineteen (19) or to age twenty-three (23) if unmarried and a full-time student at an accredited school; or

3. The Subscriber's and/or his/her spouse's children who are age nineteen (19) or older, who have been continuously covered under this Agreement, and who, before age nineteen (19), have been certified by a physician to be incapable of self-support because of a physical handicap or mental retardation. Subsequent written proof of the continuance of such incapacity must be furnished at such intervals as the Plan may reasonably require.

Elective Dentistry - Dental procedures which are unnecessary to the dental health of a Member, as determined by the Plan Provider.

Emergency Care - Those dental services necessary to control bleeding, relieve pain,including local anesthesia, or eliminate acute infection. Medications which may be prescribed by the dentist but must be obtained through a pharmacy are excluded.

Exclusion - Any provision of this Agreement which eliminates coverage for a dental care service.

Group - The organization that makes benefits available to its Members by entering into this Agreement.

Limitations - Any provision, other than an Exclusion, which restricts coverage.

Member - Any Subscriber or Dependent of a Subscriber who is enrolled under this Agreement and from whom the Membership Fee required by this Agreement has been paid.

Open Enrollment - A period of at least thirty (30) days prior to the anniversary date of this Agreement, during which all eligible persons in the Group may enroll as Members.

Plan - Means Total Dental Administrators Health Plan, Inc. (TDAHP).

Participating Specialist - A Doctor trained and licensed in orthodontics, endodontics, periodontics, and/or oral surgery who has contracted with TDAHP to provide specialty care to eligible Members in accordance with the provisions of this Agreement.

Plan Provider - A provider of dental care who is licensed by the state which has jurisdiction over said person and has a contract with the Plan to furnish dental care to Members in accordance with the provisions of this Agreement.

ARTICLE I
DEFINITIONS

Membership Dues - Those amounts required to be paid on a regular prepayment basis by the Group or a Member (or both) each month for the Member to be eligible for benefits the following month.

Schedule of Benefits and Co-payments - The listing of covered dental procedures and applicable Co-payments for a specified TDAHP Dental Plan.

Subscriber - a person:

1. Who the Group has determined is eligible;
2. Who has enrolled in the Plan as required by this Agreement; and
3. For whom all Membership Fees have been paid.

ARTICLE II
GENERAL TERMS AND CONDITIONS

Plan Providers

A. Benefits Obtained from Plan Providers - Except for emergency care, Benefits are available only from Plan Providers.

B. List of Providers - A Member may obtain a current list of Plan Providers by making written request to the Plan, TDAHP, located at 2111 East Highland Avenue, Suite #B-250, Phoenix, Arizona 85016, or by telephoning TDAHP, at (602) 266-1995 or toll free at 1-888-422-1995.

C. Choosing a Plan Provider

1. A Subscriber may choose any Plan Provider on the current Plan Provider list. Upon request, the Plan will assist a Subscriber in selecting a Plan Provider; but may not recommend any particular provider.

2. All Members in the same family must go to the same Plan Provider.

3. Each Subscriber is encouraged to choose a Plan Provider at the time of enrollment for coverage and is required to choose a Plan Provider before obtaining benefits.

D. Changing Plan Providers - A Subscriber may change Plan Providers if the Subscriber notifies the Plan, in writing, by the twentieth (20th) day of the month prior to the month that the change is to take place. Provided that notice is given as herein set forth, the change will be effective on the first day of the following month. Should the Subscriber's Plan Provider stop participating in the Plan, the Plan reserves the right to transfer the Subscriber to another Plan Provider of the Subscriber's choosing.

Eligibility

A. Initial enrollment must be made within thirty (30) days following the date of hire or the Group's period of probation. An application card must be filled out and returned to the Group, who will then send it to TDAHP so that coverage can begin in accordance with the effective date of coverage as contained herein.

B. A spouse and child(ren) newly acquired through marriage must make application within thirty (30) days of marriage.

C. Natural child(ren) of the Subscriber and spouse born while the Subscriber is covered under this Agreement are automatically covered from the date of birth. However, the Subscriber must make application for coverage of a newborn child within sixty (60) days from the child's date of birth for coverage to continue if coverage for said child results in additional Membership Dues becoming due.

Eligibility (Cont.)

D. Newly acquired adopted children or children required to be covered under a court or administrative order are automatically covered from the date they are placed with the Subscriber for adoption or the date of the court/administrative order. However, the Subscriber must make application within sixty (60) days from the date of placement for coverage to continue if coverage for said child results in additional Membership Dues becoming due.

E. Eligible Dependents include the lawful spouse of the Subscriber and the unmarried dependent children of the Subscriber and/or Subscriber's spouse, including children placed for adoption with Subscriber,or children required to be covered under a court or administrative order, to age nineteen (19). Eligible family Dependents who do no enroll during the initial enrollment period, and or in accordance with paragraphs B, C, or D above, cannot enroll until the next open enrollment period, except as set forth below. Dependents in military service are not eligible.

F. A Dependent child may continue coverage under this Agreement upon reaching nineteen (19) years of age, if the child continues to meet the Number 3 definition of Dependent, see Definitions, page 1, and the Subscriber remains covered under this Agreement and the appropriate Membership Dues are paid.

Effective Date of Coverage

All Subscribers, who are eligible for coverage under this Agreement, who have paid the appropriate Membership Dues prior to the fifteenth (15th) day of the prior month, shall be eligible for Benefits commencing on the first day of the following month. Membership Dues received between the fifteenth (15th) day of the month and the last day of the month shall be eligible for Benefits commencing the first day of the second month thereafter.

Payment of Membership Dues

All Membership Dues are payable on or before the 15th day of the month preceding the month in which services may be rendered. Under this Agreement, the Group shall pay the Membership Dues on behalf of the Subscriber and/or the Subscriber's Dependents. Any arrangements between the Group and the Subscriber under which the Subscriber is to reimburse the Group for any portion of the Membership Dues are entirely between the Group and the Subscriber. The Plan looks solely to the Group for payment of Membership Dues. The Group is solely responsible for notification to Subscribers of Termination of this Agreement for non-payment of Membership Dues.

Continuation of Dental Coverage

A. Subscriber or Subscriber and Dependents may continue dental coverage should eligibility under this Agreement cease. Subscriber must send a written request for continuation of coverage with appropriate Membership Dues to TDAHP within sixty (60) days of the date eligibility ceases under this Agreement. Note: The continuation coverage herein offered, may provide a different benefits and/or a different level of Benefits than those offered by the Plan.

B. Under Federal and State laws, Subscribers and/or Subscriber's Dependents may be eligible to continue coverage under the Plan for a limited period after such coverage would otherwise terminate. Events after which this type of continuation may be available are:

1. The Subscriber's termination of employment or reduction in working hours;
2. The Subscriber's death;
3. The Subscriber's divorce or legal separation;
4. The Subscriber's entitlement to Medicare benefits; and
5. The Subscriber's child's loss of eligibility as a dependent of Subscriber.

The Group shall provide notification and details for continuation of Group coverage to Subscribers and their Dependents as required under the COBRA Act.

ARTICLE II
GENERAL PROVISIONS

Termination

A. Dental coverage provided under this Agreement will cease at the end of the period for which Membership Dues were paid when the following occurs:

1. The Subscriber and all Dependents when:

   a. The Subscriber's employment or connection with the Group ceases; or

   b. This Agreement is terminated; or

   c. The Group fails to submit the Membership Dues for any covered Member.

2. The Dependent children when they:

   a. Reach age nineteen (19) or age twenty-three (23), as the case may be, unless said child meets the Number 3 definitions of Dependent , see Definitions, page 1; or

   b. Marry; or

   c. Are no longer dependent upon the Subscriber for Support.

3. The spouse when his or her marriage is dissolved, annulled, or otherwise terminated.

B. Notice to the Plan of termination by the Group and/or Subscriber. The Plan must be notified in writing within thirty (30) days of a covered Member's termination. Requests for retroactive adjustment of Membership Dues beyond the thirty (30) day limit will not be considered.

C. Notice to the Subscriber of termination by the Group and/or the Plan. In the event of termination of this Agreement by either TDAHP and/or the Group, the Group shall give thirty (30) days prior written notice of termination to each Group Member and shall notify each Group Member of his/her rights to continue coverage upon termination.

Grievance Procedure

A complaint is any oral or written expression of concern or dissatisfaction regarding a Plan service or procedure, whether dental or non-dental in nature. If the Group or Member has a complaint, an initial attempt should be made to resolve it by communicating with TDAHP=s Customer Service Department. In most cases, a satisfactory resolution can be reached in this manner. However, if a resolution cannot be reached in this manner, a more formal grievance process can be used. This formal process will operate as follows:

A. The Group or Member may file a written complaint/grievance with the Plan, TDAHP, at:

Total Dental Administrators Health Plan, Inc. (TDAHP)
2111 East Highland Avenue, Suite #B-250
Phoenix, Arizona 85016

This written request for action on the grievance must be received by TDAHP within thirty (30) days of the occurrence which generates the complaint or grievance.

B. Required information in the written request for action shall include the name of the Group and Subscriber's name, address, telephone number, the nature of the complaint/grievance, the facts upon which the issue is based and the resolution sought. Necessary facts include dates of services, place of service, providers involved, and types of service/procedure received if applicable. In addition, TDAHP may request any further information it deems necessary.

C. Final written or verbal resolution by TDAHP shall be made no later than thirty (30) calendar days following initial receipt of the written complaint/grievance in TDAHP's office.

ARTICLE III
WORKERS' COMPENSATION EXCLUSION

Workers' Compensation Exclusion

Expenses for which payment is required under applicable Workers' Compensation statutes are not eligible for payment under this Agreement. This Agreement is not in lieu of and does not affect any requirement for coverage by Workers' compensation insurance.

ARTICLE IV
COVERED DENTAL SERVICES AND CO-PAYMENTS

Schedule of Benefits and Co-payments

A Schedule of Benefits and Co-payments applicable to this Plan and under this Agreement is attached hereto. The Schedule of Benefits and Co-payments lists all covered dental services. All Co-payments shall be payable by the Subscriber or Subscriber's covered Dependents directly to the designated Plan Provider and neither the Plan nor the Group shall have any liability for the collection thereof.

Specialty Care

Should a Member require dental care from a specialist, the Plan Provider will, depending on the plan of coverage (as provided in the Schedule of Benefits and Co-payments), refer the Member to a participating specialist or will initiate Plan authorization for Member referral to a participating specialty. Specialty care benefits are available only from participating specialists and eligible dental care services from a specialist are those services specifically listed under the specialist category of the Schedule of Benefits and Co-payments.

Emergency Care

A. A Member should always **FIRST** attempt to obtain emergency care from their designated Plan Provider when the Member is within the area served by their designated Plan Provider.

B. If the Member is seeking emergency care during normal business hours and the Member's selected Plan Provider is not accessible, the Member may contact the Plan for assistance at (602) 266-1995 or 1-888-422-1995.

C. When a Member's Plan Provider is not accessible or when the emergency occurs outside the area served by the Member=s Plan Provider, then the Member should seek emergency dental care from a licensed dental health professional to control bleeding, relieve pain, including local anesthesia, or eliminate acute infection. Medications which may be prescribed by the dentist but must be obtained through a pharmacy are excluded. A written, itemized statement for these services must be presented to TDAHP for reimbursement. If it is necessary to have additional treatment, it must be done by the Member's Plan Provider in order for benefits under this Agreement to be applicable.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

Principal Exclusions and Limitations of Benefits

1. Sealants are covered to the age of seventeen (17) and are limited to permanent molars only.
2. Periodontal treatments (sub-gingival curettage and root planing) are limited to five quadrants in any twelve (12) months.
3. Replacement of a restoration is covered only when it is dentally necessary.
4. Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
5. Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
6. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

Principal Exclusions and Limitations of Benefits (Cont.)

7. Full upper and/or lower dentures are not to exceed one each in any five (5) year period. Replacement will be provided by the Plan for an existing full or partial denture onlay if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
8. Denture relines are limited to two (2) in any year.
9. Services for injuries or conditions which are covered under Workers' Compensation or Employers' Liability laws.
10. Services which, in the opinion of the attending Dentist, are not necessary for the patient's dental health.
11. Temporomandibular joint treatment (TMJ) (except as provided herein).
12. Elective or cosmetic dentistry (except as provided herein).
13. Oral surgery requiring the setting of fractures or dislocations. Orthonognathic surgery or extractions solely for orthodontic purposes.
14. Treatment of malignancies, cysts or neoplasms or congenital malformations, except congenital anomaly of a tooth or teeth covered from birth.
15. Dispensing of drugs.
16. Hospital charges of any kind.
17. Loss or theft of dentures or bridgework.
18. Any procedure of implantation or of an experimental nature.
19. General anesthesia of IV/conscious sedation (except as provided herein).
20. Fees incurred for broken or missed appointments (without 24 hours notice) are the Member's responsibility.
21. Dental expenses incurred in connection with any dental procedure started prior to the effective date of coverage.
22. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
23. Any procedure performed for the purpose of correcting contour, contact or occlusion. Any procedure to correct tooth structure lost due to attrition, erosion, or abrasion.
24. Any procedure that is not specifically listed as a covered benefit.
25. Provider may refuse treatment to any patient who continually fails to follow a prescribed course of treatment.
26. Any dental treatment which, in the opinion of the Plan dental consultant, has a poor prognosis.
27. Nightguard (occlusal guard) limited to one each twelve (12) months.
28. Services performed by a Dentist who is not a participating Dentist (except for Emergency Care as provided herein).

Orthodontic Plan Exclusions and Limitations

1. No benefits will apply for a treatment program which began before the Subscriber enrolled in the Orthodontic Plan.
2. No benefits will apply for lost or broken appliances.
3. Extractions are not included as a benefit.
4. No benefit will apply for the following:
    a. Care required in excess of twenty-four (24) months from the time of banding.
    b. Cross non-cooperation.
    c. Accidents occurring during the period of treatment.
    d. Cases involving surgical orthodontics.
    e. Cases involving myofunctional therapy or TMJ.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

Orthodontic Plan Exclusions and Limitations (Cont.)

5. If the Subscriber relocates to an area and is unable to receive treatment from a participating Orthodontist, coverage under this Agreement ceases and it becomes the obligation of the Subscriber to pay the usual and customary fee of the Orthodontist where the treatment is completed.
6. Choice of Orthodontist, initially, after treatment begins or upon change of residence is limited to Orthodontists participating in this Plan or who would accept the fees outlined under this Plan.
7. If the Subscriber becomes ineligible during the course of treatment, coverage under this Agreement ceases and it becomes the obligation of the Subscriber to pay for all treatment rendered after the Subscriber becomes ineligible for coverage under this Plan.

ARTICLE VI
GENERAL PROVISIONS

A. Any notice that the Plan is required to submit to the Group will be considered delivered if mailed to the Group at the address appearing on the records of the Plan. The Plan may submit notices, including individual identification cards and booklets or notifications of modification thereto, to Members by the same means. The Group agrees to receive and deliver all notices on behalf of the Members.

B. No person other than an enrolled Member shall be entitled to receive any benefits under this Agreement. Such right to receive benefits may not be transferred or assigned.

C. The services provided under this Agreement are at all times governed by the terms and conditions of the Member Dentist Agreement between TDAHP and the Plan Provider Dentist. The Plan assumes no liability for conditions beyond its control which makes it impossible for services provided under this Agreement to be obtained, such as:

   1. Epidemics:
   2. Natural disasters;
   3. Civil disorders;
   4. War; or
   5. Labor disputes.

D. All Plan Providers (Dentists) furnishing services to a Member do so as independent contractors. TDAHP shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by a member while receiving such services.

E. All Co-payments and any additional fees or charges provided hereunder are due to the Plan Provider or dental center immediately upon commencement of extended treatments or upon performance of services for which such fees or charges are specified under the Schedule of Benefits and Co-payments attached hereto. Termination of the Agreement shall in no way affect or limit any liability or obligation of the Subscriber to the Plan Provider or dental center for any such fees or charges owing.

F. If a Subscriber fails to indicate a preference for a Plan Provider or dental center within ten (10) days prior to the effective date of coverage, TDAHP may assign the Subscriber and any enrolled Dependents to a Plan Provider or dental center.

G. The Subscriber is solely responsible for payment of eligible dental services received by the Subscriber or the Subscriber's Dependents from a Plan Provider or dental center that was not selected in writing by the Subscriber or for which a prior written referral by the selected Plan Provider has not been made.

ARTICLE VI
GENERAL PROVISIONS

General Provisions (Cont.)

H. The Group shall furnish the Plan with a complete list of all eligible Subscribers and Dependents together with completed application forms therefor, at least fifteen (15) days prior to the effective date of this Agreement. Thereafter, the Group shall notify the Plan of all additions and deletions on a monthly basis no later than fifteen (15) days prior to the first of the following month.

I. This Agreement, including any endorsements and riders issued hereunder, constitutes the entire contract between the parties. In the event of any inconsistency between the terms of this Agreement and the Member's Booklet/Certificate, the terms of this Agreement shall prevail.

J. The Group and Plan may modify this Agreement by a written amendment. Consent of the Employees to any such modification shall not be required.

GROUP:	**BROKER/CONSULTANT:**
_____	_____
Group Name	Broker/Agency Company Name
_____	_____
Authorized Signature	Broker Name
_____	_____
Print Name and Title of Authorized Signature	Signature
_____	_____
Date	Date

Please return to: Total Dental Administrators Health Plan, Inc.
2111 East Highland Avenue, Suite 250
Phoenix, Arizona 85016

This Agreement is not in force until signed by an Officer of Total Dental Administrators Health Plan, Inc.

TOTAL DENTAL ADMINISTRATORS HEALTH PLAN, INC.
an Arizona corporation

By:_____

_____
Title