CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

GROUP DENTAL SERVICES CONTRACT

This Contract is made this _____ day of _____, 20_____, and is between CareFirst BlueChoice, Inc. (hereinafter referred to as "PLAN"), and _____ (hereinafter referred to as "GROUP").

Plan Number: _____ Effective Date: _____
Annual Termination Date: _____

Group Service Area: the cities of Alexandria and Falls Church, the county of Arlington, and the portions of Fairfax and Prince William counties east of Route 123 including the incorporated limits of Fairfax City and the town of Vienna. The Eligible Employee must reside or work in the PLAN Enrollment Service Area listed in the Group Certificate of Coverage.

Term: This Contract will have a Term of one (1) year (the "**Term**") and will be automatically renewed under identical terms from year-to-year, unless this Contract is terminated in accordance with the terms of this Contract prior to any anniversary of this Contract (the "**Annual Termination Date**").

Cost for Services:

Plan is: ___ **Contributory** ___ **Non-Contributory**

Tiers:

Covered Employee Only:	$ _____ / month
Covered Employee and Child:	$ _____ / month
Covered Employee and Spouse/Partner:	$ _____ / month
Covered Employee and Family:	$ _____ / month

In consideration of the application of the GROUP and of the payment of the Cost for Services as provided herein, the PLAN accepts such application and agrees to provide benefits under the terms of this Contract.

1. DEFINITIONS

A. "Group" shall mean the organization or employing unit with which the Covered Employee is associated and which has executed the Group Dental Services Contract.

B. A "Covered Employee" shall mean an Eligible Employee of the GROUP, who has enrolled for this coverage and who has paid the Cost for Services of the PLAN prior to the period of coverage, including payment for Dependents as hereinafter defined.

C. An "Eligible Employee" shall mean an employee or participant of the GROUP who satisfies the requirements in the Group Application form.

D. "Dependents" shall mean the lawful spouse of a Covered Employee and/or unmarried children of the Covered Employee from and after birth to age twenty-three (23). A legally adopted child of the Covered Employee and/or his spouse shall be treated as a child of the Covered Employee and/or his spouse for purposes of this Contract, and the effective date of coverage for a newly adopted child is the date of adoptive or parental placement with the Covered Employee and/or his spouse. An unmarried child who is at least twenty-three (23) years of age, but less than twenty-five (25) years of age, and whose time is principally devoted to attending school, and who is dependent upon Covered Employee for primary support, is eligible to be covered as a Dependent. Upon the attainment of age twenty-three (23) or age twenty-five (25), as the case may be (the "PLAN Termination Age"), coverage as a Dependent shall be extended if the child is and continues to be both (I) incapable of self-sustaining employment by reason of mental or physical incapacity and (2) chiefly dependent upon the Covered Employee for support and maintenance, provided proof of such incapacity and dependency is furnished to PLAN by Covered Employee within thirty-one (31) days of the child's attainment of PLAN Termination Age and subsequently as may be required by the PLAN, but not more often than annually after the two (2) year period following the child's attainment of PLAN Termination Age. The Cost for Services for continuation of coverage of the incapacitated child shall be at the Dependent child rate, until such time as the coverage of the Covered Employee upon whom the child is dependent terminates. The PLAN will provide coverage for an eligible Dependent child who is age nineteen (19) or older, but less than the PLAN Termination Age stated in this Certificate, and who is enrolled as a full-time student and is unable to continue as a full-time student because of a medical condition. Coverage will continue for a period of twelve (12) months from the date the Dependent child ceases to be a full-time student or until the Dependent child attains the PLAN Termination Age as stated in this Certificate, whichever occurs first. The PLAN may request certification from the Dependent child's treating provider that the child's absence is and/or was medically necessary. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.

E. "Participating DENTISTS" shall mean those licensed DENTISTS who have contracted with The Dental Network to provide dental services to Covered Employees and Dependents under the PLAN and whose names appear on the list of Participating DENTISTS. The Participating DENTISTS are independent contractors, and are not employees or agents of the PLAN. The Dental Network is a separate corporate entity that has contracted with the PLAN, to provide administrative services only to the PLAN, the underwriting entity of this dental benefits plan.

F. "Personal Participating DENTIST'' shall mean the one Participating DENTIST selected by the Covered Employee and Dependents from the list of Participating DENTISTS, indicated on the completed Employee Dental Enrollment Form, and whose name appears on the Covered Employee's Membership Identification Card.

G. ''Approved Specialist" shall be a licensed specialized dentist who is board eligible, board qualified, or board certified in one of the specialty areas of periodontics, oral surgery, orthodontics, endodontics, and pedodontics and whose office has executed a contract with the PLAN.

H. "Cost for Services" shall mean amounts payable on a regular prepayment basis by or for the Covered Employee to the PLAN.

I. "Covered Employee Copayments" shall mean the cost of dental services to be paid by the covered Employee directly to the Participating DENTIST. See enclosed Schedule of Benefits and Copayments.

J. "Coverage Period" shall mean the month for which the Cost for Services has been prepaid by the GROUP for each Covered Employee and Dependent.

2. ELIGIBILITY FOR BENEFITS

A. Eligibility requirements are the Covered Employee must have been employed with the Group for at least (____) months and work a minimum of (____) hours per week. If the Eligibility requirements referenced above are blank, please refer to the Group Application or request a copy of the Group Application from the PLAN administrative office. To enroll as a Covered Employee, the individual must reside or work in the PLAN Enrollment Service Area.

B. All Eligible Employees who have enrolled in the PLAN and paid the appropriate Cost for Services on or before the twentieth (20^{th}) day of the month shall be eligible for benefits commencing on the first (1^{st}) day of the following month, subject to the terms of Section 4, B below.

C. All Covered Employees become eligible for services on the Effective Date indicated on their Membership Identification Card, which will be the date determined from the terms of Section 2, A or B above.

D. A newly eligible spouse and/or a newly eligible child of the Covered Employee or Dependent spouse may be added to the Covered Employee's coverage if the Covered Employee notifies the GROUP and the PLAN within thirty-one (31) days of the qualifying event by submitting a signed Change in Coverage Form. The effective date of the addition will be determined by the GROUP's enrollment procedures, and the additional Cost for Services (if any) must be paid to the PLAN.

3. TERMINATION OR CANCELLATION

Coverage shall cease as follows:

A. On the date of expiration of the Coverage Period for which the last payment of Cost for Services was made, but in no event shall coverage cease earlier than the last day of the grace period. Coverage will remain in force during a thirty-one (31) day grace period allowed for late payment of Cost for Services. If payment is not received within the thirty-one (31) days, coverage may be cancelled after the thirty-first (31^{st}) day. The PLAN must provide the GROUP with a written or printed notice of termination, including a specific date, not less than fifteen (15) days from the date of such notice, by which coverage will terminate if overdue Cost for Services is not paid to the PLAN.

B. For Dependents, upon attaining the age of twenty-three (23) years or the date of any marriage of the Dependent. Coverage shall not cease at age twenty-three (23) for a Dependent who is unmarried, dependent upon his or her parents for primary support, and whose time is principally devoted to attending school. Coverage for such Dependents beyond age twenty-three (23) will terminate upon the earliest of:

1. attainment of age twenty-five (25),

2. ceasing to be a student,

3. ceasing to be dependent upon the Covered Employee-parent or,

4. marriage of the Dependent.

Coverage for the Dependent will cease at the end of the Coverage Period during which the event occurs.

The Dependent who is a student will be insured during all scholastic vacations if the Dependent is enrolled as a student at school on the day immediately preceding such vacation. There is no coverage for the vacation following the term during which the Dependent-student is graduated from school, unless be or she is enrolled at that time for further study.

Notwithstanding any limiting age stated in this Section 3, any unmarried child covered under the Contract as a Dependent of a Covered Employee who is chiefly dependent for support upon the Covered Employee, and who, at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that commenced prior to the child's attaining the limiting age, shall continue to be covered under the Contract while remaining so dependent, unmarried, and mentally or physically incapacitated, until the coverage on the Covered Employee upon whom the child is dependent terminates.

C. Upon the date on which the Group Dental Services Contract is terminated by either PLAN or by the GROUP, coverage for all Covered Employees and Dependents terminates after the end of the Term unless the contract is renewed as described under the "Term" clause above. The PLAN will notify Covered Employees and their Dependents at least thirty (30) days prior to the termination of coverage.

D. For Dependent spouses, upon becoming divorced or legally separated from Covered Employee, coverage will cease at the end of the Coverage Period during which the event occurs.

E. If, after reasonable efforts to establish and maintain a satisfactory dentist-patient relationship, the "Personal Participating DENTIST" is unable to do so, PLAN reserves the right to transfer the Covered Employee and/or a Dependent, as the case may be, to a second "Personal Participating DENTIST" of their choice. If the second "Personal Participating DENTIST" is also unable to establish a satisfactory dentist-patient relationship, PLAN reserves the right to terminate the membership of said Covered Employee and/or Dependent(s), as the case may be; provided, however, that only the coverage of the actual person involved may be terminated. A thirty-one (31) day written notice of termination and a pro-rata refund of unearned Cost for Services will be given to the Covered Employee or credited to the GROUP.

F. For Covered Employees, if the Covered Employee no longer resides or works in the PLAN Enrollment Service Area, the PLAN coverage will cease at the end of the Coverage Period during which the event occurs.

G. The GROUP may terminate the Group Dental Services Contract by notifying the PLAN in writing at least thirty-one (31) days prior to the Annual Termination Date.

4. COST FOR SERVICES AND COVERED EMPLOYEE COPAYMENTS

A. All Cost for Services are payable on or before the 15th day of the month preceding Coverage Period in which services may be rendered. A grace period of thirty-one (31) days will be granted for the payment by the GROUP of each monthly payment of Cost for Services (exclusive of the first monthly Cost for Services), during which grace period this Contract shall continue in force. Failure to pay the Cost for Services within the grace period shall cause the termination of the Contract as respects the Covered Employee as of the end of the grace period.

B. Cost for Services are to be paid by the GROUP to the PLAN Administrative Office each

month. The GROUP receives the Cost for Services from their employees by means of payroll deductions. No coverage under this Contract shall commence until the total Cost for Services for the GROUP for one (1) month is received by the PLAN Administrative Office.

C. Covered Employee Copayments (as listed in the enclosed Schedule of Benefits and Copayments) are payable to the Participating DENTIST at the time service is rendered.

5. DUTIES PERFORMED BY GROUP

GROUP distributes PLAN brochures to all Covered Employees. Upon obtaining applications from employees, GROUP will initiate payroll deductions to collect monthly Cost for Services. GROUP will forward application forms and total Cost for Services Payments received from employees to the PLAN Administrative Office by the 15th of each month. The PLAN will deliver to each Covered Employee upon Effective Date of coverage a Membership Identification Card, Schedule of Benefits and Copayments, and a Group Certificate of Coverage that explains the essential features of the plan.

6. BENEFITS AND COVERAGE

A. All dental procedures listed under the attached Schedule of Benefits and Copayments will be provided, if, in the opinion of the Participating DENTIST, they are necessary for the patient's dental health. PLAN exclusions and limitations are listed in the attached Group Certificate of Coverage for Covered Employees.

B. COORDINATION OF BENEFITS (COB). The PLAN's COB policy is based on the "ADA Guidelines on Coordination of Benefits" resolved by the American Dental Association.

1. For the purposes of this COB section, the following term is defined.

   Dental Plan means any dental insurance policy, issued on a group basis, including those of nonprofit health service plan, and those of commercial group, or self-insured group and blanket policies, any group subscriber contracts issued by health maintenance organizations, and any other established group programs under which the insured may make a claim. The term Dental Plan includes coverage under a governmental plan, or coverage required or provided by law. This does not include a State plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

2. When a patient has coverage under two or more group Dental Plans the following rules should apply:

   a. The coverage from those Dental Plans should be coordinated so that the patient receives the maximum allowable benefit from each Dental Plan.

   b. The aggregate benefit should be more than that offered by any of the Dental Plans individually, but not such that the patient receives more than the total charges for the dental services received.

3. In determining order of payment for care, the following rules should apply to group Dental Plans:

   a. The Dental Plan covering the patient other than as a dependent is the primary Dental Plan.

   b. When both Dental Plans cover the patient as a dependent child, the Dental Plan of the parent whose birthday occurs first in a calendar year should be considered as primary.

c. When a determination cannot be made in accordance with the above, the Dental Plan that has covered the patient for the longer time should be considered as primary.

d. When one of the plans is a medical plan and the other is a Dental Plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as primary.

4. In coordinating care with a group Dental Plan which contractually reduces the fees for services which participating dentists accept as payment in full, the following rules should apply:

a. When the reduced fee Dental Plan is primary and treatment is provided by a participating dentist, the reduced fee is that dentist's full fee unless the dentist has contractually arranged that the reduced-fee Dental Plan should provide its allowed amount for participating dentists and the secondary Dental Plan should pay the lesser of: its allowed benefit for the service or the difference between the primary Dental Plan care and the dentist's full fee. The secondary Dental Plan should pay the lesser of: its allowed benefit or the difference between the primary Dental Plan's benefit and the reduced fee.

b. When the reduced fee Dental Plan is primary and treatment is provided by a nonparticipating dentist, the reduced fee Dental Plan should provide its allowed amount for nonparticipating dentists and the secondary Dental Plan should pay the lesser of: its allowed benefit for the service or the difference between the primary Dental Plan care and the dentist's full fee.

c. When a full fee Dental Plan is primary and a reduced fee Dental Plan is secondary, the full fee Dental Plan should provide its allowed amount for the service and the secondary Dental Plan should pay the lesser of: its allowed benefit for the service or the difference between the primary Dental Plan care and the dentist's full fee.

5. In coordinating care between a group indemnity Dental Plan and a capitation Dental Plan, the following rules should apply:

a. When the capitation Dental Plan is primary, the capitation payments to the treating dentist remain the capitation Dental Plan's usual care. The indemnity Dental Plan should pay benefits for the patient's surcharges or copayments up to the indemnity Dental Plan's allowable benefit.

b. When the indemnity Dental Plan is primary, and treatment is received from a capitation-participating dentist, the indemnity Dental Plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation Dental Plan's allowable amount.

c. When the indemnity Dental Plan is primary, and treatment is received from a non-capitation participating dentist, the indemnity Dental Plan should pay its allowable benefit. The capitation Dental Plan will pay care, in keeping with the capitation Dental Plan's allowed amount for treatment by nonparticipating dentists.

d. No Dental Plan should contractually direct a dentist to charge a secondary carrier for more than the amount which would be charged to the patient absent secondary coverage.

C. The fees charged will be the fees listed under “Covered Employee Copayments” for each procedure completed. Services listed as “NO CHARGE” in the Schedule of Benefits and Copayments will be performed by the “Personal Participating DENTIST” at no cost to the Covered Employee or Dependent. Any charges for laboratory services or other specialized dental services which are not set forth in the Schedule of Benefits and Copayments shall not exceed the DENTIST's charges for such services, and the Covered Employee or Dependent shall be informed of such charges prior to treatment by the “Personal Participating DENTIST.”

D. ALTERNATE TREATMENT. Frequently, several methods exist to treat a dental condition. The PLAN will authorize treatment based upon the allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of dental treatment. The PLAN’s decision does not commit the Covered Employee to the less expensive procedure. However, if the Covered Employee and the dentist choose the more expensive procedure, the Covered Employee is responsible for the additional charges beyond those authorized or allowed by the PLAN.

E. Only the Personal Participating DENTIST shall have the right to examine and to determine the professional services to be performed pursuant to the PLAN, except in the instance of out-of-area dental emergency care as specified under Section 13 or in the instance of referral to an Approved Specialist as defined in this Contract.

F. If a conflict arises regarding the quality and extent of work, the case in question will be submitted to the PLAN for resolution, as described in the attached Benefit Determinations and Appeals section of the Certificate of Coverage.

G. A ninety (90) day extension of benefits is applicable to all dental services begun while coverage was in effect, i.e., if a dental service was begun while coverage was in effect for the Covered Employee or Dependent, PLAN agrees that the Personal Participating DENTIST will complete such dental services within ninety (90) days with no change in or addition to the Covered Employee Copayments. Orthodontic coverage shall be provided, in accordance with the policy in effect at the time the Covered Individual or Dependent(s)’ coverage terminates, for ninety (90) days after the date the coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or until the later of ninety (90) days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

H. Coverage of Covered Employee or Dependent(s) will not be terminated or discontinued solely because of clerical error on the part of the GROUP or PLAN.

7. REFERRALS

Any covered specialty services received by Covered Employee or Dependent must be approved in writing by Covered Employee or Dependent’s “Personal Participating DENTIST.” Should the “Personal Participating DENTIST” wish to refer Covered Employee or Dependent to a non-approved specialist, the referral must be approved in writing by the PLAN to be eligible for coverage.

A standing specialist referral will be made if the “Personal Participating DENTIST,” in consultation with the specialist, determines that the patient needs continuing care from the specialist for conditions or diseases that are life threatening, degenerative, chronic, disabling, and require specialized care. The specialist shall have expertise in treating the life threatening, degenerative, chronic, or disabling disease or condition and be part of the PLAN’s provider panel. The standing referral shall be made in accordance with a written treatment plan for a covered service developed by the “Personal Participating DENTIST,” the specialist, and the Member. The treatment plan may limit the number of visits to the specialist, limit the period of time in which visits to the specialist are authorized, and require the specialist to communicate regularly with the “Personal Participating DENTIST” regarding the treatment and health status of the Covered Employee or Dependent.

A Covered Employee or Dependent may request a referral to a specialist who is not part of the PLAN's provider panel if the Covered Employee or Dependent is diagnosed with a condition or disease that requires specialist medical care and the PLAN does not have in its provider panel a specialist with the professional training and expertise to treat the condition or disease and the specialist agrees to accept the same reimbursement as would be provided to a specialist who is part of the PLAN's provider panel.

If a PLAN Dentist refers the Covered Employee or Dependent to a specialist who is not a PLAN dentist, the PLAN shall be responsible for payment of the specialist's charges to the extent the charges exceed the copayment specified in the enclosed Schedule of Benefits.

8. RENEWAL

The PLAN will provide GROUP with a written notification of any changes to Schedule of Benefits and Copayments and/or Cost for Services (monthly premium) at least sixty (60) days prior to the effective date of Group Renewal. If the GROUP does not reject the proposed renewal changes, in writing, at least thirty (30) days prior to the renewal date, the Group Dental Services Contract will be amended to include the changes to Schedule of Benefits and Copayments and/or Cost for Services.

9. DENTAL RECORDS

The dental records of all Covered Employees and Dependents concerning services performed hereunder shall remain the property of the "Personal Participating DENTIST." The Covered Employee and/or Dependent(s) may be subject to a charge for the duplication of dental records and radiographs in accordance with Virginia law.

10. CHANGE IN COST FOR SERVICES OR COVERED EMPLOYEE COPAYMENTS

The PLAN guarantees that the Cost for Services set forth herein shall not be increased during each individual year of the Term. The Reduced Rate charges set forth in the Schedule of Benefits and Copayments are guaranteed during each individual year of the Term, with the exception of gold crown and bridgework (gold will be charged to the Covered Employee at market prices). Upon completion of each individual year of Term, the Plan reserves the right to change the Cost for Services or Covered Employees Copayments. Notice of any change will be given sixty (60) days prior to the Annual Termination Date.

11. CONTINUATION OF SERVICES AFTER TERMINATION OF UNDERLYING EMPLOYMENT

A. Payroll deduction for PLAN coverage for Covered Employees and their Dependents will terminate when Covered Employee ceases to be an Eligible Employee of the GROUP. In order to continue coverage, the Covered Employee shall pay the Cost for Services at the GROUP rate on an annual basis only, thereby maintaining the same coverage previously paid through payroll deductions and under the terms of this Contract. The Covered Employee must forward the annual payment to the PLAN Administrative Office within thirty-one (31) days after ceasing to be an Eligible Employee of the GROUP.

B. The Participating DENTIST shall notify the Covered Employees or Dependent of the termination of this Contract if the Covered Employee or Dependent visits the DENTIST's office when the DENTIST is aware that the Contract has terminated, and under such circumstances, the Participating DENTIST shall inform the Covered Employee or Dependent of the charge for any scheduled dental services before performing any such dental service.

12. CHANGING DENTISTS

Covered Employees may transfer coverage for themselves and Dependents to another Participating DENTIST. Transfers may be made with notification to the PLAN Administrative Office which includes the Covered Employee's Name and Policy Number, new "Personal

Participating DENTIST" selected, the reason for changing and the date of the last appointment with current Participating DENTIST. Transfers will be effective on the first day of the following month.

13. OUT-OF-AREA EMERGENCY CARE

Covered Employees and Dependents, when temporarily more than fifty (50) miles from their "Personal Participating DENTIST," may have emergency care rendered by any licensed DENTIST. Emergency care is defined as "emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness." PLAN pays for emergency out-of-area care up to Fifty Dollars ($50) per person per emergency. Plan will reimburse Covered Employee upon presentation of bona fide documentation of emergency care expenses. Written notice to PLAN of claim is not required before twenty (20) days after the occurrence or commencement of the loss covered by the policy. The PLAN may not invalidate or reduce a claim if it is shown that it was not reasonably possible to give notice within 20 days, and notice was given as soon as was reasonably possible.

14. BROKEN APPOINTMENTS

The Covered Employee and Dependents may cancel or break an appointment without penalty if the dental office is given advance notice of twenty-four (24) hours or more. If sufficient advance notice is not given, the Covered Employee or Dependent is responsible for the payment of a fee as specified in the Schedule of Benefits and Copayments.

15. MAJOR DISASTERS AND OTHER CATASTROPHES

In the event of major disaster or epidemic, Participating DENTISTS shall render dental services as provided in this Certificate insofar as is practical, according to their best judgement, within the limitations of such facilities and personnel as are then available, but the PLAN and the Participating DENTISTS shall have no liability or obligation for the delay or failure to provide or arrange for such services if such delay or failure is the result of such disaster or epidemic, except as may be mandated by the Insurance Commissioner of the Commonwealth of Virginia.

If, during the term of this Contract, none of the Participating DENTISTS or Approved Specialists can render necessary care and treatment to the Covered Employee or Dependents due to circumstances not reasonably within the control of the PLAN, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes or the disability of a significant number of the Participating DENTISTS, the Covered Employee may seek treatment from an independent licensed DENTIST of his own choosing. The PLAN will reimburse the Covered Employee for such services; provided, however, that the PLAN will reimburse the Covered Employee for services which are listed in the Schedule of Benefits and Copayments as "No Charge," only to the extent that such fees are approved by the PLAN, and the PLAN will further reimburse the Covered Employee for those services listed in the Schedule of Benefits and Copayments for which there is a monetary surcharge, to the extent that the Dentist's charges for such services exceed the reduced charge for such services as set forth in the Schedule of Benefits and Copayments. The Covered Employee shall be required to give written proof of loss. The PLAN agrees to be subject to the jurisdiction of the Virginia Insurance Commissioner with respect to any determination of the impossibility of providing services by PLAN DENTISTS.

16. REMEDIES IN CASE OF DEFAULT

In the event that a Personal Participating DENTIST is unable to provide care and treatment to a Covered Employee or Dependent during the Coverage Period, the Covered Employee shall be obligated to select another Personal Participating DENTIST from the list of Participating DENTISTS, and the Covered Employee shall notify the PLAN of such change.

17. PROFESSIONAL LIABILITY INSURANCE

Participating DENTISTS and Approved Specialists shall at all times carry professional liability insurance with annual coverage of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate, and shall provide proof of such coverage to the PLAN upon demand.

18. REPRESENTATIONS AND NOT WARRANTIES

In the absence of fraud, all statements made by Covered Employees or the GROUP shall be deemed to be representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written instrument signed by the GROUP or the Covered Employee, a copy of which has been furnished to the GROUP or the Covered Employee.

This contract may not be contested, except for nonpayment of premiums or fraud, after it has been in force for two (2) years from its date of issue. A statement, unless the statement was material to the risk and was contained in a written application, made by any person covered under this contract relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two (2) years during the person's lifetime.

19. ENTIRE CONTRACT; CHANGES

A. This Contract, includes the Group Certificate of Coverage For Employees, the Schedule of Benefits and Copayments, the Group Dental Services Contract, any endorsements, amendments, and other attachments, if any, and constitutes the entire contract between the parties. No change in this Contract shall be valid until approved by an executive officer of the PLAN and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Contract or to waive any of its provisions.

B. This Contract shall be construed according to the laws of the Commonwealth of Virginia.

C. Any provision of this Contract which, on its Effective Date, is in conflict with the Laws of the Commonwealth of Virginia is hereby amended to conform to the minimum requirements of such laws.

D. Upon any anniversary of the Effective Date, the Contract shall be automatically revised to conform to minimum statutory requirements of applicable statutes enacted subsequent to the prior anniversary.

20. HOW TO RECEIVE BENEFITS

In order to make an appointment, the Covered Employee must telephone the office of the "Personal Participating DENTIST" selected. The Covered Employee must pay the fees listed on the Schedule of Benefits and Copayments directly to the "Personal Participating DENTIST" who renders treatment.

21. LEGAL ACTION

An action at law or in equity may not be brought to recover on this contract before the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this contact and after the expiration of three (3) years after the written proof of loss is required to be furnished.

22. REGULATORY AUTHORITY

The PLAN is subject to regulation in the Commonwealth of Virginia by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

23. ASSIGNMENT AND DELEGATION

The PLAN may assign this Group Certificate of Coverage for the Covered Employee and/or Dependents and its rights hereunder and delegate its duties hereunder to any entity into which it is merged or which substantially acquires all its assets.

24. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT ("USERRA")

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

If an Eligible Employee leaves his or her job to perform military service, the Eligible Employee has the right to elect to continue his or her Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Eligible Employee's military service, the Eligible Employee has the right to be reinstated in his or her Group coverage when reemployed, without any waiting periods or pre-existing condition exclusions except for service connected illnesses or injuries. If an Eligible Employee has any questions regarding USERRA, the Eligible Employee should contact the Plan Administrator.

IN WITNESS THERETO, the parties have caused this Contract to be executed the day, month, and year first written above.

WITNESS:

_____

GROUP REPRESENTATIVE:

BY: _____

CAREFIRST BLUECHOICE, INC. REPRESENTATIVE

_____

ENCLOSURES: Schedule of Benefits and Copayments
Group Certificate of Coverage for Covered Employees
Benefit Determinations and Appeals