Exhibit D

DELTA DENTAL PLAN

(A Not-for-Profit Corporation Incorporated in California and a Member of the Delta Dental Plans Association)

Home Office: 100 First Street, San Francisco, California 94105
(Herein referred to as "Delta")
415-972-8300

Group Number 2460

IN CONSIDERATION of the application made by GOOGLE, referred to in this Contract as "the Contractholder," and IN CONSIDERATION of payments by the Contractholder as stated in Article 3, Delta agrees to provide the Benefits in Article 4 for a period of 22 months, beginning at 12:01 a.m., Standard Time, on the effective date, September 1, 2003, and continuing from year to year thereafter, unless this Contract is terminated in accordance with Article 9.

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

Appendix A	Orthodontic Benefit Rider
Appendix B	Dental Procedure Numbers
Appendix C	Global Eligibility Maintenance (GEM)
Appendix D	HIPAA Business Associate Agreement

This Contract contains the following Articles:

Article 1	Definitions
Article 2	Eligibility
Article 3	Payments
Article 4	Benefits Provided; Limitations and Exclusions
Article 5	Deductibles & Maximum Amount
Article 6	Coordination of Benefits
Article 7	Conditions Under Which Delta Will Provide Benefits
Article 8	Other Delta Obligations
Article 9	Termination and Renewal
Article 10	Optional Continuation of Coverage
Article 11	General Provisions

ARTICLE 1 - DEFINITIONS

These terms, when used in this Contract, mean the following:

1.1 **Attending Dentist's Statement** - a form completed by a Dentist to request Delta's payment for dental services or predetermination for proposed dental treatment.

1.2 **Benefits** - those dental services that are available under the terms of this Contract as set out in Article 4.

1.3 **Contract** - this agreement between Delta and the Contractholder including the attached appendices. This Contract is the entire Contract between the parties.

1.4 **Contract Term** - the period beginning on September 1, 2003, and ending on June 30, 2005, and each subsequent yearly period during which this Contract remains in effect.

1.5 **DeltaPreferred Option Dentist** - a Delta Dentist who meets the criteria for and has specially agreed with Delta to participate in this DeltaPreferred Option Plan, or a Delta Dentist who specializes in oral surgery, endodontia and periodontia.

1.6 **DeltaPreferred Option Dentist's Fee** - the DeltaPreferred Option Dentist's Usual, Customary, and Reasonable fee, the fee which they have contractually agreed with Delta to accept for treating Enrollees under this plan, or the Fee Actually Charged, whichever is less, for a Single Procedure.

1.7 **DeltaPreferred Option Dentist's Prevailing Fee** - the fee for a Single Procedure that satisfies the majority of DeltaPreferred Option Dentists, as determined by Delta based upon confidential fee listing accepted by Delta from DeltaPreferred Option Dentists.

1.8 **Delta Dentist** - a Dentist who has signed an agreement with Delta or a Participating Plan, agreeing to provide services under the terms and conditions established by Delta or the Participating Plan.

1.9 **Dentist** - a duly licensed Dentist legally entitled to practice dentistry when and where services are provided.

1.10 **Dependent** - a Primary Enrollee's Dependent who is eligible for Benefits under Article 2 of this Contract.

1.11 **Eligibility Date** - the date an Enrollee's eligibility for Benefits becomes effective under the terms of this Contract

1.12 **Enrollee** - a Primary Enrollee or a Dependent who is eligible and enrolls for Benefits under Article 2 of this Contract, or a person ceasing to meet such conditions who chooses Continued Coverage as set out in Article 10, and for whom Delta receives the appropriate monthly payment as set out in Article 3.

1.13 **Fee Actually Charged** - the fee for a particular dental service or procedure which a Dentist submits to Delta on an Attending Dentist's Statement, less any portion of such fee which is discounted, waived or rebated, or which the Dentist does not use good faith efforts to collect.

1.14 **Participating Plan** - Delta and any other member of the Delta Dental Plans Association with which Delta contracts to assist it in administering the Benefits of this Contract.

1.15 **Patient Copayment** - the portion of the Dentist's fees or allowances charged for Benefits that is the Enrollee's responsibility.

1.16 **Prevailing Fee** – an allowance determined by Delta and/or a Participating Plan for services provided by a dentist who is not a Delta Dentist.

1.17 **Primary Enrollee** - an individual, who by their employment with the Contractholder, is eligible for Benefits under Article 2 of this Contract.

1.18 **Procedure Numbers** - the Procedure Numbers shown on Appendix B.

1.19 **Single Procedure** – a dental procedure to which a separate Procedure Number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT). Many CDT codes are listed in Appendix B of this Contract.

1.20 For a Dentist who has signed a Delta Dentist Agreement with Delta Dental of California, his or her "Usual, Customary and Reasonable Fee" for any Single Procedure is the fee that the Dentist has filed with Delta and which Delta has accepted. For these Dentists, the words "Usual, Customary and Reasonable" means the following:

Usual - the amount which a Dentist regularly charges and receives for a given service. If the Dentist charges more than one fee for a given service, the "usual" fee for that service is the lowest fee which the Dentist regularly charges or offers to patients.

Customary - the fee is within the range of usual fees charged and received for a particular service by Dentists of similar training in the same geographic area that Delta determines is statistically relevant.

Reasonable - a fee schedule is reasonable if it is "usual" and "customary." Additionally, a specific fee to a specific patient is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

ARTICLE 2 - ELIGIBILITY

2.1 All present and future regular employees may enroll and are eligible to receive Benefits on their date of hire.

2.2 Coverage for Enrollees will begin on the effective date.

2.3 The dental and medical coverage is combined. If the employee and/or Dependents are not enrolled under both plans, they are not eligible for either plan.

2.4 Dependents are the Primary Enrollee's legal spouse or domestic partner and unmarried dependent children from birth to age 19, or to age 25 if enrolled as full-time students in an accredited school, college or university. Children include stepchildren, adopted children, children of a domestic partner, children placed for adoption and foster children, provided they depend upon the Primary Enrollee for support and maintenance. 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. A domestic partnership shall exist between two people (regardless of their gender) and each of them shall be the domestic partner of the other if they both complete, sign and file with the employee's Human Resources department an Affidavit of Domestic Partnership. A domestic partner is subject to the same terms and conditions as any other Dependent enrolled in this plan.

2.5 An unmarried child, 19 years old or older, may continue to be a Dependent even though not enrolled as a full-time student if they are incapable of self-support because of physical or mental incapacity, if that handicap or incapacity began before they reached age 19, and if they are chiefly dependent upon the Primary Enrollee for support and maintenance. Proof of such handicap or incapacity and dependency must be submitted within 31 days after request for such proof from either the Contractholder or Delta. Neither Delta nor the Contractholder will request such proof more frequently than annually after the child in question has reached age 21.

2.6 Dependents in military service are not eligible.

2.7 Every enrolled employee and Dependent meeting the preceding conditions of eligibility is an Enrollee. However, Delta will not provide Benefits for any employee or his or her Dependents unless (1) the employee is included on the list of Primary Enrollees submitted as required by this Article (or any revision or correction of such a list), and (2) the appropriate payments are made as required by Article 3 of this Contract, for the months in which Delta provides covered dental services.

2.8 All employees of the Contractholder meeting the eligibility requirements of this Article are "Primary Enrollees" under this plan unless the Contractholder offers one or more alternate plans of dental coverage. In that event, Primary Enrollees will continue to be eligible under this plan unless they file a choice card with the Contractholder electing an alternate plan during an open enrollment period agreed upon between Delta and the Contractholder.

2.9 The Contractholder will compile and furnish Delta with an initial report of all Primary Enrollees, showing their federally assigned Social Security numbers, their dates of hire and location codes. The initial report shall be provided to Delta or prior to the Effective Date of this Contract. The Contractholder also agrees to report all person electing continued coverage under Article 10, showing their federally assigned social security numbers and date of election.

2.10 The Contractholder may continue to submit subsequent eligibility reports monthly or may report only additions or deletions to the initial report. If the report is not updated by the Contractholder or has not arrived or been processed for the current month, Delta will extend the last report received to process claims. The extension of the eligibility report does not waive the requirement that the Contract holder provide an updated report to Delta each month indicating additions or deletions from any previous report. The Contractholder shall pay, as set forth in Article 3, all Premiums applicable for Primary Enrollees reported in the updated report.

2.11 Enrollees are not eligible during a period the Primary Enrollee does not report to work on a regular basis and is not actively employed as determined by the Contractholder. Eligibility resumes on the first day of the month following the return to active employment if amounts due to Delta for Enrollees have been paid. But, eligibility can continue without interruption if the Contractholder continues to report the employee as a Primary Enrollee and the amounts due to Delta are paid on the employee's behalf.

2.12 A Primary Enrollee absent from work due to a leave of absence governed by the "Family and Medical Leave Act of 1993" (P.L. 103-3) will not be subject to Section 2.11.

2.13 A Primary Enrollee absent from work due to a leave of absence governed by the "Uniformed Services Employment and Re-employment Rights Act of 1994" (P.L. 103-353) will not be subject to Section 2.11. Such Primary Enrollee shall have the right to continue coverage for up to 18 months while he or she is on military leave. If the Primary Enrollee elects this continued coverage, he or she must submit the Premiums necessary to the Contractholder.

2.14 A Primary Enrollee's eligibility ends on the last day of the month in which his or her full-time employment ends, unless he or she chooses to continue coverage under Article 10. A Dependent's eligibility ends along with the Primary Enrollee's, or sooner if the Dependent loses his or her dependent status, unless continued coverage is chosen in a timely fashion by or on behalf of the Dependent(s) under Article 10. Eligibility for such continued coverage will continue for the period required by the Option. In any event, eligibility ends immediately when this Contract ends.

7.11 If an Enrollee has any questions about the services received from a Delta Dentist, Delta recommends that he or she first discuss the matter with the Dentist. If he or she continues to have concerns, the Enrollee may call or write Delta. Delta will provide within thirty (30) days written notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial, reference to the specific dental plan provision(s) on which the decision is based, a description of any additional material or information necessary to perfect the claim and an explanation why such information is necessary, a description of plan procedures and time limits for appeal of the decision and a statement of the claimant's right to sue in federal court, a statement that any internal rule, guideline or protocol relied upon in making the decision and an explanation of any scientific or clinical judgment may be obtained upon request. Delta will respond, within three (3) days of receipt, to claims involving severe pain or imminent and serious threat to the patient's health. Any questions of ineligibility should first be handled directly between the Enrollee and the group. If an Enrollee has any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta, or the quality of dental services performed by a Delta Dentist, he or she may call Delta toll-free at 1-800-765-6003, contact Delta on the Internet through e-mail: cms@delta.org or through the web site: www.deltadentalca.org or write Delta at P.O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

If an Enrollee's claim has been denied or modified, the Enrollee may file a request for review (a grievance) with Delta within 180 days after receipt of the denial or modification. If in writing, the correspondence must include the group name and number, the Primary Enrollee's name and social security number, the inquirer's telephone number and any additional information that would support the claim for benefits. The correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, Delta will provide the Enrollee with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Delta's review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of Delta's regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Delta's review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and Delta will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract terms, Delta shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Delta will provide the Enrollee a written acknowledgement within five days of receipt of the request for review. Delta will make a written decision within 30 days of receipt, or inform the Enrollee of the pending status if more information or time is needed to resolve the matter. Delta will respond no later than sixty (60) days from receipt of the request for review. Written notification of adverse determination on review shall state the specific reasons for denial, a reference to the specific plan provision(s) upon which the decision is based, a statement that any internal rule, guideline or protocol relied upon in making the decision and an explanation of any scientific or clinical judgment may be obtained upon request, a statement of the right to sue in federal court, a statement indicating the right to receive upon request reasonable access to or copies of all documents, records or other information relevant to the determination, and the following statement, "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what is available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." Delta will respond, within three days of receipt, to complaints involving severe pain and imminent and serious threat to a patient's health.

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 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, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

7.12 The Benefits that Delta provides are limited to the applicable percentages of the Dentist's fees or allowances specified in Article 4. The Contractholder requires the Enrollee to pay the balance of any such fee or Allowance, known as the "Patient Copayment," as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Delta only provides as Benefits the Dentist's fees or allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.