DELTA DENTAL OF KANSAS, INC.
A NON-PROFIT SERVICE CORPORATION

SUBSCRIPTION AGREEMENT TO PROVIDE DENTAL BENEFITS

SECTION I - DECLARATIONS

This Subscription Agreement to Provide Dental Benefits ("Agreement") is made and entered into the lst day of December 2014 by and between CITY OF OVERLAND PARK, KANSAS, hereinafter referred to as "Employer", and DELTA DENTAL OF KANSAS, INC., hereinafter referred to as "DDKS". The initial term of this Agreement shall be from January 1, 2015 through December 31, 2015, inclusive, and shall renew for two subsequent one-year terms, subject to the provisions of Section VII. This Agreement is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communication regarding the Plan.

1.1 CONTRACT NUMBER & APPENDIX A: 52840-000-00001-00000

1.2 REQUIRED ENROLLMENT:

No less than sixty-five percent (65%) of all Eligible Employees must be Subscribers at all times, with a minimum group size of no fewer than two (2) Enrolled Employees. If the enrollment falls below the required percentage of Eligible Employees, or if the minimum group size is not maintained, DDKS may terminate this Agreement upon thirty (30) days'notice to the Employer.

1.3 EMPLOYER PREMIUM CONTRIBUTION:

Employer's monthly contribution to the total premium paid for coverage hereunder must at least equal fifty percent (50%) of the total of the individual premiums of all Subscribers.

1.4 WAITING PERIOD FOR NEW EMPLOYEES:

Each employee who first meets the qualifications of Section 4.2 at a time after the first day of the initial term of this Contract (without regard to whether such employee may have previously been an Eligible Employee pursuant to Section 4.2) shall not be eligible for benefits hereunder until 1st of the month following employment and when the qualification of Section 4.2 would have otherwise been met. Each employee who meets the qualifications under Section 4.2 as of the first day of the initial term of this Contract shall be eligible for benefits immediately upon the Effective Date of this Contract.

1.5 MONTHLY PREMIUM RATES:

Employee:	$32.76
Employee + 1:	$69.98
Family:	$105.30

NOTE: 3 year agreement; 4% rate cap for 2016 & 2017.

1.6 SELECTED NETWORK:

The Dental Network for this Agreement is Delta Dental PASSIVE PPO.

1.7 SELECTED BENEFITS, MAXIMUMS, DEDUCTIBLES AND CO-INSURANCE PERCENTAGE PAID BY DDKS:

A Covered Service is deemed to be benefited by DDKS if it is reimbursable, in whole or in part, under the terms of this Plan or would otherwise be reimbursable, in whole or in part, except for the application of a deductible, co-insurance payment, waiting period, frequency limitation, annual or lifetime benefit maximum, or other limitation contained in the Plan. For a Covered Service benefited by DDKS through payment, DDKS will pay the lesser of i) the percentage of the fee actually charged for a Covered Service which is indicated in the Summary of Dental Plan Benefits below, or ii) in the amount which is otherwise paid in accordance with other provisions of the Plan.

Summary of Dental Plan Benefits

Group #52840-000-00001-00000

Maximum Benefit Per Person

The Maximum Benefit for all Covered Services, including Implant Services, for each Enrollee in any one Calendar Year is One Thousand Five Hundred Dollars ($1500.00).

The Maximum Benefit for Orthodontic Services for each Enrollee is Two Thousand Dollars ($2000.00) during such person's lifetime.

Payment for Orthodontic Services shall not be included in determining the Maximum Benefit for each Calendar Year.

The Maximum payment for covered Temporomandibular Joint Dysfunction (TMJ) procedures for each Enrollee is One Thousand Dollars ($1000.00) during such person's lifetime.

Payment for Temporomandibular Joint Dysfunction (TMJ) shall not be included in determining the Maximum Benefit for each Calendar year.

% paid by DDKS			Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)			
PPO Network	**Premier Network**	**Non Network**	
100%	**100%**	**100%**	**I. DIAGNOSTIC:** Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral evaluations – once each six (6) months. Diagnostic x-rays – bitewings once each six (6) months for dependents under age eighteen (18) and once each twelve (12) months for adults age eighteen (18) and over. Full mouth x-rays or panoramic x-rays – once each five (5) years.
100%	**100%**	**100%**	**II. PREVENTIVE:** Provides for the following: Prophylaxis (Cleanings) - once each six (6) months. Topical Fluoride – once each six (6) months for dependent children under age nineteen (19). Space Maintainers for dependent children under age fourteen (14) and only for premature loss of primary molars. Sealants – once (1) per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
BASIC (Subject to Deductible)			
80%	**80%**	**80%**	**III. ANCILLARY:** Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
80%	**80%**	**80%**	**IV. ORAL SURGERY:** Provides for extractions and other oral surgery including pre and post-operative care.
80%	**80%**	**80%**	**V. REGULAR RESTORATIVE DENTISTRY:** Provides amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).
80%	**80%**	**80%**	**VI. ENDODONTICS:** Includes procedures for root canal treatments and root canal fillings.
			VII. PERIODONTICS:
80%	**80%**	**80%**	a. Includes procedures for the treatment of diseases of the tissues supporting the teeth.
80%	**80%**	**80%**	b. Surgical periodontal procedures.
80%	**80%**	**80%**	c. Periodontal Cleanings - four (4) cleanings per Calendar year, less the number of regular prophylaxis.

Summary of Dental Plan Benefits
(Continued)
Group #52840-000-00001-00000

Deductible Limitations
Coverage for oral evaluations, x-rays, prophylaxis, fluoride treatments, space maintainers and sealants is not subject to the Deductible. However, the Deductible shall apply during each Calendar Year to all other Covered Services which are provided to each Enrollee. After Subscriber and his/her Eligible Dependents who are Enrollees have, in any Calendar Year, each paid either the individual Deductible of Twenty Five Dollars ($25.00), or have cumulatively paid charges for Covered Services in the amount of Seventy Five Dollars ($75.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Calendar Year.

Payment of Claims
Before paying claims, DDKS may require reasonable evidence of the payment of Deductibles.

Eligible Dependent Ages
Dependents are eligible for coverage to the end of the Calendar year in which they turn the age of twenty-six (26).

% paid by DDKS				Examples of Covered Services
MAJOR (Subject to Deductible)				
PPO Network	**Premier Network**	**Non Network**		
50%	**50%**	**50%**	**VIII.**	**SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	**50%**	**50%**	**IX.**	**PROSTHODONTICS:** Includes bridges, partial and complete dentures, including repairs and adjustments, and implants.
50%	**50%**	**50%**	**XI.**	**TMJ:** Includes coverage for procedures outlined in Section 1.7.
ORTHODONTICS (Subject to Deductible)				
50%	**50%**	**50%**	**XII.**	**ORTHODONTICS:** Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age nineteen (19). Orthodontic Services are subject to certain additional limitations as well.

1.8 ADDITIONAL PLAN INFORMATION:

a. This Plan is the primary plan for dental procedures that are covered under the enrollee's health plan.

b. Orthodontic services are a Covered Services as shown in Section 1.6, subject to the following conditions:

(1) the Employer maintained a group dental program which was in effect immediately preceding the Effective Date, and

(2) such program provided substantially the same coverage for Orthodontic Services as this Plan provides.

c. **Temporomandibular Joint Dysfunction (TMJ)** – coverage should be predetermined and is limited to:

(1) Those intra-oral services which would normally be provided by a Dentist in the relief of oral symptoms associated with malfunctions of the TMJ, but shall not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.

(2) The following procedures which are specified as intra-oral:
– Closed reduction of dislocation
– Occlusal Orthotic Device
– Occlusal adjustment (limited)
– Occlusal adjustment (complete)

The above services require prior authorization by DDKS.

(3) Benefits for fixed appliances and restorations are excluded. Diagnostic procedures not otherwise benefitted under the Plan are excluded.

(4) The repair and/or replacement of any appliances furnished in whole or in part under TMJ coverage is not covered under the Plan.

(5) All services for TMJ will be limited to the maximum amount stated above. No further benefits will be provided until five (5) years have passed from the last service in the prior course of treatment. If benefits from the initial course of treatment were less than the amount stated above, the unused amount does not carry forward to a subsequent course of treatment.

NOTE: SEE ADDITIONAL EXCLUSIONS AND LIMITATIONS IN SECTION II.

SECTION II - EXCLUSIONS AND LIMITATIONS

2.1 Unless Sections 1.7 and/or 1.8 Specifically Provide For Coverage, The Following Dental Benefits And Services Are Excluded:

a. Coverage for any patient who has been, but no longer is, an Enrollee.

b. Benefits or services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.

c. Benefits or services which are determined by DDKS to be for Cosmetic purposes.

d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the person became an Enrollee.

e. Prescription drugs, premedications and relative analgesia, including nitrous oxide; hospital, healthcare facility or medical emergency room charges**;** laboratory charges; anesthesia for restorative dentistry; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.

f. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for cosmetic purposes; for splinting or equilibration.

g. Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

h. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.

i. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of this Agreement.

j. Crowns and endodontic treatment in conjunction with an overdenture.

k. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in Section 1.7 and/or Section 1.8.

l. Replacement of lost or stolen dentures or charges for duplicate dentures.

m. Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in Section 1.7 and/or Section 1.8.

n. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.

o. Any benefit, procedure or service, a motivating purpose for which is to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

p. Dental benefits and services which are not completed.

q. Treatment rendered outside of the United States or Canada unless the following documentation is provided to process the claim(s)):

1. A copy of proof of licensing for the provider must be attached to the claim form with a receipt of services from the rendering office.

2. The Enrollee must also submit a completed form with all of the following:
    a. Complete name and address, translated into English, of the Enrollee and service provider(s)
    b. Local license identification (if any) of the service provider(s)
    c. Services rendered with U.S. dollar conversion and proof of receipt
    d. Any supporting documentation for processing claims, such as tooth charts and x-rays.

If any of the above steps are omitted, the claim will be denied.

r. Benefits or services for control of harmful habits.

s. Treatment to correct congenital or developmental malformations.

t. Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in Section 1.7. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.

u. Individual crowns unless specifically included as a Covered Service in Section 1.7 and/or Section 1.8.

2.2 Dental Benefits and Services are Limited as Follows, unless Section 1.7 or Section 1.8 specifies other limitations. Typically, when dental benefits and services are limited under the Plan, any amounts not benefited by DDKS due to the limitation are the responsibility of the Enrollee, up to the amount of the Maximum Plan Allowance (MPA).

a. If a more expensive Covered Service is provided than DDKS determines to be the least costly professionally accepted treatment, DDKS will pay the applicable benefit for the Covered Service which is needed to achieve reasonable functionality.

b. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are benefited by DDKS under the Plan and then only if specifically included as a Covered Service in Section 1.7 and/or Section 1.8.

c. Bitewings taken with twelve (12) months of a full mouth series of x-rays will be disallowed.

d. A panoramic film in conjunction with a full mouth services of x-rays is not a separate benefit.

e. A seven (7) vertical bitewing series is limited to once (1) every two (2) years.

f. Restoration of surfaces on teeth are limited to only once (1) or twice (2) within a twenty-four (24) month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within twenty-four (24) months after a crown is seated are subject to frequency limitations.

g. Recementation of space maintainers are limited to once (1) per arch or quadrant per lifetime.

h. Claims not submitted to DDKS within six (6) months of the date that the Covered Service was provided will not qualify as a Covered Service unless it was not reasonably possible to submit the claim within such time and provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

i. Inlays will automatically receive benefits equal to the corresponding surface of a filling.

j. Individual crowns are not a Covered Service unless specifically included as a Covered Service in Section 1.7. If a Covered Service:

(1) Individual crowns on the same tooth are limited to only once (1) in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the Enrollee whether or not the Agreement was then effective. If a crown is placed on a tooth which has had a restoration in the previous twenty-four (24) month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

(2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not benefited by DDKS for any person under twelve (12) years of age due to age limitation.

(3) Recementation of a crown is limited to only once (1) in a lifetime.

(4) Repairs per crown are limited to two (2) in a twelve (12) month period.

(5) Stainless steel crowns are limited to once (1) in a twenty-four (24) month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection will apply.

(6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.

k. Prosthodontics are not a Covered Service unless specifically included as a Covered Service in Section 1.7. If a Covered Service, the following limitations apply:

(1) Not more than one (1) full upper and one (1) full lower denture shall be constructed under the Agreement in any five (5) year period for any Enrollee. Said time period is to be measured from the date the denture was last supplied to the Enrollee whether or not the Agreement was then effective.

(2) A removable prosthetic or fixed prosthetic device, including bridges or implants, or full upper or full lower dentures, may not be provided under the Agreement for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the last date of service the removable prosthetic or fixed prosthetic device, including bridges or implants, or full upper or full lower dentures was last supplied to the Enrollee whether or not the Agreement was then effective.

(3) Denture reline and rebase is limited to only once (1) in any thirty-six (36) month period for Enrollee.

(4) Denture adjustments are limited to only two (2) times in any twelve (12) month period for an Enrollee.

(5) Crowns when used for abutment purposes are benefited at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.

(6) Recementation of a bridge is limited to only once (1) in a lifetime.

(7) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial toward the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.

(8) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.

(9) Tissue conditioning is limited to no more than two (2) per arch each thirty-six (36) months.

(10) Dental implant procedures and associated services will be a Covered Service, subject to the frequency in subsection k.(2) above, and the following limitations:

a. Coverage should be predetermined and is limited to those Enrollees age sixteen (16) and over. Enrollees do not need to be totally edentulous, meaning without natural teeth in the arch for which the dental implants are being contemplated.

b. The Dentist should submit to DDKS a written report of recommended treatment setting forth the type and number of implants to be used, radiographs to support the dental necessity of the implant procedures as required by DDKS, and the proposed fees for the entire procedure.

c. As determined by DDKS, the Covered Services may include, but are not limited to, consultations and surgical placement of implant devices (including the associated device and/or prosthesis) provided in conjunction with the dental implant procedures.

d. Payments are limited to the lesser of: i) the amount of the annual maximum as stated above, or ii) the amount determined by DDKS to be allowable for dentures that are conventionally constructed using standard procedures, and which are of the same magnitude, i.e. complete upper, complete lower or complete upper and lower, as appropriate.

l. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period.

m. Periodontic procedures are not Covered Service unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. When covered, payment is limited to only once (1) in any twenty-four (24) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is limited to once (1) in any six (6) month period; and crown lengthening which carries no frequency limitation.

n. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services and is limited to a maximum of ninety (90) minutes, per episode.

o. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in Section 1.7 and/or Section 1.8. If a Covered Service:

(1) Plan benefits will cease on the date of termination if the treatment plan is terminated for any reason, or the Enrollee is no longer eligible for benefits before completion of the case. Treatment may be terminated by the Dentist, by written notification to DDKS and to the Enrollee, for lack of Enrollee interest and cooperation.

(2) Related services, such as but not limited to, x-rays, extractions, and study models, shall be payable at the orthodontic co-insurance percentage as specified in Section 1.7 and/or Section 1.8.

(3) The repair or replacement of an orthodontic appliance is not a Covered Service.

(4) Maximum Benefit for Orthodontic Services:

(a) Anything contained in the Agreement or any appendix to the contrary notwithstanding, the maximum benefit for Orthodontic Services payable in any one (1) Calendar Year, as applicable, or any portion thereof, shall be the amount indicated in Section 1.7.

(b) If Orthodontic Services are a Covered Service, payment for Orthodontic Services shall be limited to the Maximum Benefit per Enrollee which is specified in Section 1.7. Payment for Orthodontic Services shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of the treatment.

(c) If a Deductible applies, DDKS shall not be obligated to pay for, or otherwise discharge, in whole or in part, any fee, up to the Deductible.

(d) The Maximum Benefit for Orthodontic Services will be reduced by all amounts previously paid as orthodontics benefits by DDKS or by any other dental plan or arrangement.

(e) Rebonding, recementing and/or repair of fixed retainers must be included in the Orthodontics case fee. A separate fee submitted by the Orthodontics provider is not allowed. In cases of excessive or continuous repairs/recements/rebonds, individual consideration may be given to allow the service as a Covered Service.

2.3 Certain Dental Benefits and Services Provided Are Disallowed under the Plan. When dental benefits or services are disallowed, the fees associated with those items are neither benefited by DDKS nor collectable from the Enrollee by a Participating Dentist. Disallowed services will be so indicated on the applicable Enrollee's Explanation of Benefits.

SECTION III – DEFINITIONS

For the purpose of this Agreement, the following definitions shall apply:

3.1 "Agreement" means this agreement between DDKS and Employer, including the Group Application, the attached appendices, endorsements and riders, if any. This Agreement constitutes the entire agreement between the parties.

3.2 "Benefit Booklet" means the written summary of certain features of the Plan.

3.3 "Child" means, in addition to the Subscriber's own or lawfully adopted unmarried child or children, any unmarried step-child of the Subscriber residing with the Subscriber in a regular parent-child relationship so long as said child is not eligible to enroll in an "eligible employer-sponsored health plan" as defined by federal law. The term "Child" also includes any unmarried person placed with the Subscriber for adoption if such child was placed in the Subscriber's home by a child placement agency as defined by Kansas law, and any unmarried child of the Subscriber who is recognized as an alternate recipient under a qualified medical child support order. A child is eligible for coverage under the Plan if the child meets the age requirements as set forth in Section 1.7.

In addition, a Child includes an unmarried disabled Child who is: i) incapable of earning his or her own living because of mental or physical disability, and ii) principally dependent upon the Subscriber for support at the time the Child would otherwise cease to be eligible for coverage by the Plan because of age. A disabled Child shall continue to be an Eligible Dependent for the duration of the disability, provided: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to DDKS within thirty-one (31) days after Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by DDKS.

3.4 "Continuation Coverage" means the coverage provided under this Agreement pursuant to Section 4980B of the Internal Revenue Code of 1986, as amended ("Code"). All of the requirements, definitions and specifications of said Section 4980B of the Code which are necessary in order for this Agreement to satisfy Section 4980B of the Code, are being hereby adopted and incorporated by reference.

3.5 "Contract Year" means the period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof.

3.6 "Calendar Year" means the twelve (12) month period commencing on the first day of January and terminating at 11:59 P.M. on the last day of December.

3.7 "Cosmetic" means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory. The determination of whether services are "Cosmetic" shall be made by DDKS in its discretion. Cosmetic services are not Covered Services under the Plan.

3.8 "Covered Services" means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of this Agreement.

3.9 "DDKS" means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Association member company which has agreed to provide to Enrollees the benefits described in this Agreement, or both, as applicable.

3.10 **"**Deductible" means the amount specified in the Summary of Dental Benefits in Section 1.7 which must be paid with respect to Covered Services provided to an Enrollee before the Plan provides benefits.

3.11 "Dental Network" means one of the following networks as identified in Section 1.6:

a.1. **"Delta Dental PPO":** The Delta Dental PPO network is a subset of DDKS Participating Dentists who agree contractually to participate in the Delta Dental PPO network as part of a discounted fee-for-service plan. Delta Dental PPO providers sign a supplemental agreement and are paid according to a Maximum Plan Allowance for PPO Dentists as defined below. Delta Dental PPO Dentists are paid at the in-network co-insurance percentages in Section 1.6 and/or Section 1.7, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in Section 1.6 and/or Section 1.7.

2. If Delta Dental PPO is a Passive Network, then co-insurance levels for Delta Dental PPO and Delta Dental Premier are the same and Enrollees can use any Participating Dentist, as shown in Section 1.6 and/or Section 1.7.

3.12 "Dentist" means any duly licensed dentist entitled to practice dentistry at the time and in the place the dental services are performed.

3.13 "Effective Date" means the first day of the initial term of this Agreement.

3.14 "Eligible Dependent" means the spouse or "Qualifying Child" of the Participant. As more specifically set forth in Code Section 152 (as modified by Code Section 105(b)), which is hereby incorporated by reference, to be a "Qualifying Child", an individual must met all of the following 4 requirements:

- The individual must be the Participant's biological child, stepchild, adopted child or a child placed for adoption.
- The individual must have the same principal residence as the Participant for at least 6 months of the calendar year in question.
- The individual must be under the age of 26 on the last day of the calendar year in questions or permanently and totally disabled.
- The individual must provide less than one-half of the individuals' own support during the calendar year in questions.

A Dependent also includes a child for whom legal guardianship has been awarded to the Participant or the Participant's spouse, provided that such child meets (i) the definition of a "Qualifying Relative", as more specifically set forth in Code Section 152 (as modified by the Code Section 105 (b)), which is hereby incorporated by reference; and (ii) the age requirement outlined below. Specifically, a child for whom legal guardianship has been awarded to the Participant or the Participant's spouse must meet all the following 4 requirements:

- The individual must not be the Qualifying Child of the Participant or any other person.
- The individual must be any one of the following: the Participant's biological child, stepchild, adopted child, or foster child, or the descendent of such a child; the Participant's sibling or step-sibling; the Participant's parent, or an ancestor of the Participant's parent; the Participant's step-parent; the child of the Participant's sibling; the sibling of the Participant's parent; the Participant's son-in-law, daughter-in-law, father-in-law, mother-in-law brother-in-law or sister-in-law; someone who has the same principal residence as the Participant but is not the Participant's spouse.

- The individual must be under the age of 26 on the last day of the calendar year in question or permanently and totally disabled.

- The individual must receive over one-half of his or her support from the Participant during the calendar year in questions.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, so long as the child meets the definitions of a "Qualifying Child". We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

As more specifically set forth in Code Section 152 (e)(2), it is possible for the child of a noncustodial parent to meet the "Qualifying Child" definition if the custodial parent signs a written declaration indicating that such custodial parent will not claim the child as a dependent in a particular taxable year. A copy of such written declaration along with a copy of the Participating's Federal Form 1040 must be filed with Human Resources.

3.15 "Eligible Employee" means any person who meets the conditions of eligibility outlined in Section IV of this Agreement, and any person who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

3.16 "Employer" means the person(s) and/or entity(ies) named above which has hereby contracted with DDKS to provide the Plan described in this Agreement, and such members of the Employer's controlled or affiliated group which are specifically listed in the Group Application.

3.17 "Enrollee" means a person, whether an Eligible Employee or Eligible Dependent, who is i) eligible to be covered by the Plan, ii) validly enrolled in the Plan, and iii) for whom the appropriate premium is timely received by DDKS. An Enrollee shall be deemed to have enrolled when such Enrollee's name, enrollment information and the required premium are furnished to DDKS by Employer. However, in the case of an Enrollee in Continuation Coverage, such person shall be deemed to have enrolled when DDKS is timely furnished by the Enrollee with the applicable enrollment form and premium.

3.18 "Group Application" means the formal, written request for coverage by the Employer to DDKS. The Group Application includes all data and related information which is required to be provided to DDKS from time to time.

3.19 "Maximum Benefit" means the maximum benefit provided for Covered Services (and Orthodontic Services if specifically included as a Covered Service) which is set forth in the Summary of Dental Plan Benefits.

3.20 "Maximum Plan Allowance" means the lesser of the following:

a. In the case of a Participating Delta Dental Premier Dentist:
   i) the fee submitted by the Participating Dentist for the Covered Service, or
   ii) the Delta Participating Dentist Maximum Plan Allowance for the Covered Service.

b. In the case of a Delta Dental PPO Dentist:
   i) the fee submitted by the Delta Dental PPO Dentist for the Covered Service, or
   ii) the Delta Dental PPO Dentist Maximum Plan Allowance for the Covered Service.

c. In the case of a Non-Participating Dentist:
   i) the fee submitted by the Dentist for the Covered Service,
   ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or
   iii) if this Plan utilizes an Exclusive Network, no benefits are provided.

3.21 "Orthodontic Services" means appliances and treatments, interceptive and corrective, whose purpose is to correct abnormally aligned or positioned teeth. X-rays, extractions and other dental services provided as part of the treatment of abnormally aligned or positioned teeth are considered "Orthodontic Services."

3.22 "Participating Dentist" means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentist agree to render services in accordance with

the terms and conditions established by DDKS and have satisfied DDKS that they are in compliance with such terms and conditions.

3.23 "Plan" means the dental benefits arrangement which is offered and administered pursuant to the terms of this Agreement.

3.24 "Subscriber" means an Eligible Employee who has enrolled in the Plan during annual open enrollment or other enrollment period established by the Employer following the employee's hire date or the occurrence of a qualifying event, as described in Section 4.2(c), and timely payment of the required premium has been made.

SECTION IV. ELIGIBILITY

4.1 ELIGIBLE EMPLOYEE:

To qualify as an Eligible Employee, an individual must meet the Waiting Period in Section 1.3 and one (1) of the following requirements:

a. Be a full-time employee of the City or:

1. a Covered Person who retires while Covered under the Plan;

2. a part-time Class A employee of the City;

3. a contract employee with health coverage as a term of their contract; or

4. a current or former eligible Governing Body member; or

5. any other person that may be designated as eligible by the City of Overland Park, Kansas.

b. Be a member in good standing of an organization, association or union which has contracted with Plan to provide dental coverage for its members, under the rules of organization, association or union.

c. Be an employee under the requirements of Section 4.1.a or a member which meets the requirements of Section 4.1.b.

4.2 COMMENCEMENT OF COVERAGE FOR EMPLOYEE:

a. With respect to a person who is an Eligible Employee on the Effective Date, coverage hereunder shall begin upon such person becoming a Subscriber.

b. With respect to a person who is not an Eligible Employee on the Effective Date, then coverage hereunder shall begin the first day of the month following the later of i) such person becoming a Subscriber, or ii) the effective date associated with the Employer designated enrollment period.

c. With respect to a person who is an Eligible Employee who experiences a "qualifying event," such Eligible Employee may make a new election within thirty-one (31) days of the qualifying event that corresponds to the gain or loss of eligibility and/or coverage under the Plan, or a plan of the Spouse's or Dependent's employer, that was caused by the occurrence of such qualifying event. Changes in coverage will become effective on the first day of the month coincident with or following the later of: i) the month in which the Eligible Employee becomes a Subscriber, ii) the effective date specified in the election, or iii) the submission of any required enrollment information and the payment of any required premium to DDKS. For purposes of this Section IV, a "qualifying event" is any of the events described below:

(1) Legal Marital Status. A change in an Eligible Employee's legal marital status such as marriage or divorce.

(2) Number of Dependents. A change in the Eligible Employee's number of Dependents, including the birth and/or adoption of a child.

(3) Gaining or Losing Coverage Eligibility Under Another Employer's Plan. A change in coverage or eligibility status in which an Eligible Employee or Eligible Dependent gains or loses eligibility for coverage under a plan that is available to the Eligible Dependent. In such event an Eligible Employee may elect to cease or become covered under the Dependent's employer's plan.

4.3 NO COVERAGE AS BOTH EMPLOYEE AND DEPENDENT:

No person may be insured both as an Eligible Employee and as an Eligible Dependent, and no person will be considered as an Eligible Dependent of more than one (1) Employee. Eligible Dependents do not include another Employee of the Employer who is insured under any employer-sponsored program providing dental expense coverage. A Child who may be otherwise eligible as a dependent under more than one (1) dental plan sponsored by the Employer, shall be covered under the plan of the employee as determined by Section 6.1 of this Agreement.

4.4 COMMENCEMENT OF COVERAGE FOR DEPENDENT:

d. With respect to a person who is an Eligible Dependent on the Effective Date, coverage hereunder shall begin for such Eligible Dependent upon the later of i) the first day that the coverage commences for the Subscriber, or ii) the date such person satisfies the requirements to become an Enrollee.

e. With respect to a person who is an Eligible Dependent who is not an Enrollee on the Effective Date, then coverage hereunder shall begin upon the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee, or iii) upon the effective date associated with such open enrollment period.

f. With respect to a person who becomes an Eligible Dependent and therefore qualifies for coverage as a result of a qualifying event, then coverage hereunder shall begin upon the first day of the month coincident with or following the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee.

4.5 TERMINATION OF BENEFITS:

a. If, at any time, a Subscriber fails to satisfy all of the requirements of this Agreement, coverage under this Agreement shall terminate for such Subscriber, and each dependent of such Subscriber, in the following manner:

1) If the Subscriber qualifies for, timely elects and timely pays for Continuation Coverage, then the Subscriber shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter coverage shall terminate;

2) If the Subscriber fails to qualify for, timely elect or timely pay for Continuation Coverage, then coverage shall terminate at the end of the premium period in which the Subscriber first ceases to satisfy such requirements.

b. If, at any time, an Enrollee who is not the Subscriber ceases to qualify as an Eligible Dependent, coverage under this Agreement shall terminate:

1) If the Enrollee qualifies for, timely elects, and timely pays for Continuation Coverage, then the Enrollee shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter the coverage shall terminate;

2) If the Enrollee fails to qualify for, timely elect, or timely pay for Continuation Coverage, then coverage shall terminate at the end of premium period in which the Subscriber upon whom such person is dependent ceases to constitute a Subscriber, or at the time such dependent ceases to qualify as an Eligible Dependent, whichever occurs first.

c. At termination of coverage under this Agreement, operative procedures which are then in progress and i) which are completed within thirty (30) days of the termination of coverage, and ii) submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges. Operative procedures are considered in progress only if all procedures for commencement of lab work have been completed.

SECTION V - AGREEMENTS

5.1 EMPLOYER AGREES:

Throughout the term of this Agreement, Employer agrees as follows:

a. At the time of the execution of this Agreement, to furnish DDKS with accurate initial enrollment information regarding all Enrollees, including those on Continuation Coverage, together with the Social Security number or other identification number of all such Enrollees. Employer also agrees to furnish DDKS with an accurate list of all Subscribers. Thereafter, Employer agrees to furnish monthly to DDKS an accurate accounting of all changes to such initial list of Subscribers and Enrollees.

b. To timely remit to DDKS all applicable premiums as follows:

Initial premium — on or before the tenth (10) day of the month in which the Effective Date occurs.

Subsequent premiums — on or before the tenth (10) day of each month subsequent to the Effective Date.

Continuation Coverage premiums — on or before the first (1) day of each month commencing with the Effective Date.

Upon discovery of any Employer clerical errors or delays regarding changes in enrollment data, premium amounts and enrollment data may be adjusted by DDKS for all affected months since the Effective Date. However, DDKS shall not be required to refund any amount which is based upon more than two (2) months of retroactive information, and in no event shall such refund exceed the amount of premium attributable to more than ten percent (10%) of the total number of Employer's last reported Enrollees.

c. To provide each Subscriber with a Benefits Booklet.

d. To permit and encourage the professional relationship between a Dentist and Enrollee to be maintained.

e. To encourage Enrollees to notify their Dentist at the time of their first appointment that they are covered by this Agreement.

f. To permit DDKS, its auditors or other authorized representatives, on reasonable advance written notice, to inspect the payroll records of the Employer in order to verify the accuracy of all information provided by Employer to DDKS.

g. To provide DDKS with such other information as it shall request in connection with this Agreement.

h. At the time of the execution of this Agreement, and at all times while this Agreement is in effect, Employer represents and warrants that its Employees and Enrollees constitute a "group" for purpose of state insurance laws. Employer agrees that DDKS has discretion to determine if such requirements are met and will produce information requested by DDKS to substantiate compliance with this requirement. Employer acknowledges no benefits will be provided under this Agreement if such persons do not constitute a "group."

5.2 DDKS AGREES:

Throughout the term of this Agreement, DDKS agrees as follows:

a. Prior to making payment for Covered Services, to require the Dentist or Subscriber, as the case may be, to timely submit a claim which satisfies the claims procedures of DDKS.

b. To make no payment for any Covered Service rendered to a person who is not an Enrollee at the time such service is rendered, except as herein provided under the "Termination of Benefits" Section of this Agreement.

c. To make payment to a Participating Dentist, Non-Participating Dentist, or Subscriber, as the case may be, for each Covered Service based upon the applicable terms of this Agreement.

SECTION VI - GENERAL PROVISIONS

6.1 NON-DUPLICATION OF BENEFITS:

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has dental care coverage under more than one plan. The term "plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed one hundred percent (100%) of the total allowable expense.

B. DEFINITIONS.

(1) A "plan" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(a) The term "plan" includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of two hundred dollars ($200) per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident type coverage; and Medicare or other governmental benefits, as permitted by law.

(b) The term "plan" does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of two hundred dollars ($200) or less per day; medical benefits under group or individual automobile contracts; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.

(2) The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

(3) "Allowable expense" means a dental care service or expense, including deductibles and co-payments, or co-insurance that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An

expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(a) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

(b) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second opinions, precertification requirements, and preferred provider arrangements.

(4) "Claim determination period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

(5) "Closed panel plan" is a plan that provides dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES.

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

(1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

(2) A plan that does not contain a coordination of benefits, maintenance of benefits, or non-duplication of benefits provision that is consistent with this Section 6.1 is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

(4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(a) The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(b) The order of benefits when a child is covered by more than one (1) plan is:

1. The primary plan is the plan of the parent whose birthday is earlier in the year if:

a. The parents are married;

b. The parents are not separated (whether or not they ever have been married); or

c. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

a. The plan of the custodial parent;

b. The plan of the spouse of the custodial parent;

c. The plan of the noncustodial parent; and then

d. The plan of the spouse of the noncustodial parent.

(c) The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a 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. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under Section 6.1 C.(4)(a) hereof.

(d) If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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.

(e) The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

(f) If a health plan includes coverage for dental procedures under the major medical provisions of the plan, that plan may be primary if stated in Section 1.7.

(g) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

D. EFFECT ON THE BENEFITS OF THIS PLAN.

(1) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than one hundred percent (100%) of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(a) Determine its obligation to pay or provide benefits under its contract;

(b) Determine whether a benefit reserve has been recorded for the covered person; and

(c) Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero (0). A new benefit reserve must be created for each new claim determination period.

(2) If a covered person is enrolled in two (2) or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one (1) closed panel plan, COB shall not apply between that plan and other closed panel plans.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts about coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. DDKS may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. DDKS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give DDKS any facts it needs to apply those rules and determine benefits payable.

F. FACILITY OF PAYMENT.

A payment made under another plan may include an amount that should have been paid under this plan. If it does, DDKS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. DDKS will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY.

If the amount of the payments made by DDKS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2 DENTIST CONDUCT:

DDKS may refuse to pay for any Covered Services which are provided in a manner that is inconsistent with the generally accepted applicable standards of dentistry.

6.3 DDKS LIABILITY:

DDKS shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any such person including but not limited to employees, Enrollees, Dentists, dental assistants, dental hygienists, hospitals, or the agents or employees of any of such foregoing persons, whether receiving or providing services. Further, DDKS shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee.

6.4 ENDORSEMENTS:

Nothing contained in any endorsement shall affect any of the conditions, provisions or limitations of the Agreement except to the extent expressly provided in the endorsement. Otherwise, all conditions, provisions and limitations of this Agreement shall apply to any endorsement.

6.5 PUBLICATION OF THIS AGREEMENT:

No material shall be published or distributed by Employer or otherwise, interpreting, relating to or concerning this Agreement unless such material has been approved by DDKS in advance of such publication or distribution.

6.6 RIGHT TO INFORMATION:

As a condition precedent to the approval of claims hereunder, DDKS, shall be entitled to receive from any attending or examining Dentist, or from hospitals or clinics in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, and/or treatment rendered to, an Enrollee. DDKS, at its own expense, shall have the right to cause any Enrollee to be examined when and so often as DDKS reasonably deems necessary during the pendency of a claim under this Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under this Agreement constitutes the Enrollee's (and the related Subscriber's, if applicable) automatic and irrevocable consent to the release to DDKS of any and all of the information and records before described, and a full waiver by that Enrollee that any such information and records that otherwise is privileged. Further, by providing Covered Services to an Enrollee, a Dentist or other service provider consents to, upon request, provide such information and records to DDKS as DDKS requests.

6.7 CONFIDENTIALITY:

DDKS agrees that it has "protected health information" ("Information") as defined in 45 C.F.R. Part 160-164 (the HIPAA Privacy Rule). DDKS agrees that it will:

1) not use or further disclose the Information other than as permitted or required by this Agreement or as required by law;

2) use appropriate safeguards to prevent use or disclosure of Information other than as provided for by this Agreement;

3) report to the Enrollee any use or disclosure of the Information not provided for by this Agreement of which DDKS becomes aware;

4) ensure that any agents, including a subcontractor to whom DDKS provides Information received from or created by the business associate on behalf of the Enrollee, agree to the same restrictions and conditions that apply to the business partner with respect to such Information;

5) make available Information in accordance with 45 C.F.R. 164.520;

6) make available Information for amendment and incorporate any amendments to Information in accordance with 45 C.F.R. 164.526;

7) make available the Information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

8) make its internal practices, books, and records related to the use and disclosure of Information received from, or created or received by, the business associate on behalf of the Enrollee available to the United States Secretary of Health and Human Services for the purpose of determining the compliance with 45 C.F.R. Part 160-164; and,

9) at the termination of this Agreement, if feasible, return or destroy all Information received from or created or received by, the business associate on behalf of the Enrollee, that the business partner still maintains in any form and retain no copies of such Information; or, if such return or destruction is not feasible, extend the protections of the this Agreement to the Information and limit further uses and disclosures to those purposes that make the return or destruction of the Information infeasible.

6.8 MISREPRESENTATIONS:

No statements made by the Employer, or any other person, shall be deemed a warranty or shall be used in defense of a claim or in any other dispute under this Agreement, unless it is contained in a written instrument, a copy of which has been agreed to in writing by Employer and DDKS.

6.9 POLICY CHANGES:

No agent or representative has authority to change this Agreement or waive any of its provisions. No change in this Agreement shall be valid unless approved by an executive officer of DDKS and evidenced by endorsement hereon.

6.10 LEGAL ACTIONS:

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of this Agreement. Further, and in all events, any action of any kind by any person who is subject to this Agreement must be commenced within five (5) years from the date on which the right, claim, demand, or cause of action shall first accrue.

6.11 GOVERNING STATUTES:

Any provision of this Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

6.12 GOVERNING LAW:

Except to the extent preempted by the Employee Retirement Income Security Act of 1974 (ERISA), the laws of the State of Kansas (irrespective of choice of law principles) shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties. Any action brought to enforce, construe, or interpret this Agreement (including but not limited to any mediation or arbitration but only if arbitration is voluntarily agreed to by the parties at the time a dispute arises) shall be commenced and maintained in a location mutually agreeable by the parties to the dispute. Except to the extent preempted by ERISA, the parties irrevocably consent to the exclusive jurisdiction and venue in the court mutually agreed to by the parties for such purpose and agree not to seek transfer or removal of any action commenced in connection with this Agreement.

6.13 SEVERABILITY:

If any part of this Agreement is determined to be invalid, unenforceable, or contrary to law or professional ethics, that part shall be reformed, if possible to conform to applicable law and ethics. If reformation is not possible, that part shall be deleted, and the other parts of the Agreement shall remain fully effective.

6.14 ASSIGNMENT:

Employer may not assign its interest in this Agreement without the prior written consent of DDKS.

6.15 NOTICE:

Any notice required or desired to be given under this Agreement shall be deemed to have been given if delivered personally to hereinafter named designee of Employer or DDKS, or sent by first-class United States Postal mail as provided herein. Any such notice shall be effective upon receipt of said notice unless an alternate date is specified. Employer shall have the right to designate a different address or agent for the receipt of notice by providing written notice of such designation in the manner set forth herein. Notices to the Employer shall be in writing and, shall be sent to the person named in the Group Application at the address stated therein. Notices to DDKS shall be in writing and sent to:

Compliance Officer
Delta Dental of Kansas, Inc.
PO Box 789769
Wichita, KS 67278-9769

6.16 PREDETERMINATION OF BENEFITS:

Treatment plans that involve Covered Services which include prosthodontic services, orthodontic services, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics, and oral surgery except for simple extraction of a single tooth, should be submitted to DDKS for predetermination of benefits. Failure to do so may result in a loss of benefits if, in the professional judgment of DDKS, such treatment is not necessary or a lesser procedure could have restored the tooth or dental arch to a reasonable degree of functionality. A predetermination of benefits does not obligate DDKS to provide any benefits associated therewith if the Enrollee is no longer eligible to receive such benefits at the time the Covered Services are performed. A predetermination of benefits is only effective with respect to Covered Services which commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist. Otherwise a new predetermination of benefits must be sought.

6.17 BENEFITS BOOKLET:

DDKS shall prepare a Benefits Booklet which shall be approved by the Commissioner of Insurance for the State of Kansas. The Benefits Booklet shall summarize certain features of the Plan's coverage, including the eligibility rules, benefits and, methods of securing claims payments.

6.18 EMERGENCY TREATMENT:

Each individual dental office has its own emergency treatment protocol and Enrollees should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours. Hospital or medical service emergency room expenses are not covered benefits under this Agreement.

6.19 INQUIRIES/APPEALS:

Dentists and Enrollees are encouraged to contact DDKS when they have a question concerning a particular claim. Such inquiry should be directed to the DDKS Customer Service Department. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511 or from outside of the Wichita area, 1-800-234-3375.

Enrollees who have inquiries or an appeal regarding the Agreement are encouraged to write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769. Written inquiries are best submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.
2. Subscriber's name and birth date. If the Enrollee is not the Subscriber, the Enrollee's name and birth date must also be included.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question.

When appropriate, an evaluation will be made by DDKS and, in some cases the Enrollee may be examined clinically. If necessary, additional information or documents may be requested for a full and fair review. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, Enrollees will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of DDKS' receipt. However, if the matter is referred to a review committee, or other unusual

circumstances arise, the Enrollee will be advised. Generally, a written answer or decision will be sent to the Enrollee within thirty (30) days thereafter.

6.20 REGIONAL CONSULTANTS:

The review of a claim form and x-rays may not be sufficient to appropriately resolve a matter in all cases. Accordingly, in some cases DDKS may rely on its regional dental consultants to examine patients clinically. When appropriate, examinations may also be conducted at the request of the Enrollee, a treating Dentist, or for other reasons determined by DDKS.

6.21 NOTICE OF CLAIM:

Written notice of claim must be given to DDKS within twenty (20) days after the occurrence or commencement of any claim/loss covered by the Agreement, or as soon thereafter as in reasonably possible. Notice given by or on behalf of the Enrollee or the beneficiary to the Enrollee to DDKS at 1619 N. Waterfront Parkway, Wichita, KS 67206, or to any authorized agent of DDKS, with information sufficient to identify the Enrollee, shall be deemed notice to DDKS.

6.22 CLAIM FORMS:

DDKS, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time frame fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

6.23 PROOFS OF LOSS:

Written proofs of loss/claims must be submitted to DDKS at its office within six (6) months of the date that the Covered Service was provided. But, failure to submit a claim within six (6) months of the date that the Covered Service provided will not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time, provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

6.24 TIME OF PAYMENT OF CLAIMS:

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

6.25 MISCELLANEOUS:

a. Waiver of Breach. The waiver of any breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach.

b. Captions. The paragraph headings are for convenience only, and shall be disregarded in interpreting this Agreement.

c. Authorized to Enter into Agreement. Both Employer and DDKS represent and warrant they are authorized to enter into this Agreement.

d. No Presumptions Based on Drafter. No provisions of this Agreement shall be interpreted for or against any party hereto on the basis that such party was the draftsman of such provision, and no presumption or burden of proof shall arise disfavoring any party by virtue of the authorship of any of the provisions of this Agreement.

SECTION VII - TERM AND TERMINATION

7.1 This Agreement shall remain in full force and effect for the term specified in Section I, but the Agreement may be terminated by DDKS if:

a. The Employer engages in fraudulent conduct, breaches any representation or warranty, or otherwise materially breaches its responsibilities, under this Agreement; or

b. If Employer fails to timely pay premiums as due, DDKS has the right to terminate this Agreement following a thirty (30) day grace period. If DDKS subsequently accepts any late premiums, the payments shall reinstate this Agreement, but such reinstatement shall provide coverage under the Plan only with respect to Covered Services which are first provided more than ten (10) days after the date of such reinstatement.

If Employer defaults in the making of premium payments during the applicable grace period, termination of the Agreement shall become effective on the date of the expiration of the period for which the last monthly premium was paid. In no event will DDKS be required by this Agreement to provide any benefits for any period for which the Policyholder has not made the premium payments in advance of the incurrence of the benefits.

c. The Employer permits "voluntary enrollment" of Enrollees, or otherwise fails to satisfy the requirements of Section 1.2, except as specified in the Declarations Section; or

d. The Employer refuses to allow DDKS (by its auditors or other authorized representatives) to inspect Employer's records in order to verify the accuracy of the Eligible Employee and/or enrollment information, or Employer otherwise defaults, by an act of either omission or commission, in the performance by it of any duties or obligations hereunder.

7.2 At least sixty (60) days prior to the expiration of the initial term of this Agreement, DDKS will send Employer or Employer's designated agent written notification of renewal, setting forth adjustments to Contract terms including premium rates. If Employer wishes to alter the terms of the Agreement or does not wish to renew the Agreement, it should provide DDKS with written notification of the same. Should the parties agree to additional terms to include premium rates, the Parties shall enter into a contract renewal indicating the agreed upon terms and other amendments. If Employer makes payment to DDKS under the adjusted premium rates, or otherwise takes action which indicates continued performance under the Agreement after the expiration date of the term of this Agreement, the Agreement will be automatically renewed for a subsequent one year term upon the same terms and conditions as are herein set forth, modified by those adjustments set forth in the written notification of renewal if allowed by the Marketplace. If, after the expiration of the initial term of the Agreement, Employer makes payment to DDKS which is not consistent with the adjusted premium rates set forth in the written notification of renewal, then DDKS may at it sole option either consider this Agreement to have been renewed under the adjustment terms set forth in the written notification and bill Employer for the remainder of the premium rate due, or consider this Agreement to have not been renewed and return the premium to Employer.

7.3 This Agreement may be terminated by either party by delivering to the other party a written notice of intention to terminate so long as such notice is delivered at ninety (90) days prior to such termination, except that if Employer defaults in the making of premium payments, termination of the Agreement shall become effective on the date of the expiration of the period for which the last monthly premium rate was paid.

7.4 The premium rate for this Agreement is determined by using the actuarial assumption that the Agreement will remain in full force and effect for a minimum period equal to the initial term hereof. If, during the initial term, the Agreement is terminated for any one (1) or more of the preceding reasons, the Employer shall nevertheless owe DDKS, in addition to whatever premium or premiums have already been paid and in addition to any accrued but unpaid premiums, a minimum termination premium that shall be calculated as follows:

Total of premiums paid plus premiums accrued but unpaid, if any, by Employer for the months prior to termination. / Number of months for which such premiums were paid or accrued and owed.	x	Number of months remaining in the initial term after termination.	=	Amounts of minimum termination premium.

SIGNATURES

In witness whereof, the parties have caused this Agreement to be signed by their authorized representatives.

EMPLOYER
NAME_____

By: _____
(Authorized Signature)

By: _____
(Authorized Printed Name)

_____
(Title)

Date: _____

DELTA DENTAL OF KANSAS, INC.

By: _____
(Authorized Signature)

President & CEO
(Title)

Date: September 18, 2014

APPENDIX A

City of Overland Park
Enhanced Performance Guarantees
2015 Dental Request for Proposal

ITEM/TASK	Performance Standard	Monetary Penalty for Non-Compliance
Claim Savings	We guarantee a minimum 7% claims savings over the course of each policy year. These savings result from cost management features contained in our contracts with participating dentists.	Monetary credit given to the group equal to the difference between 7% and the lesser amount actually saved.
Claim Procedural Accuracy	We guarantee that, over the course of each policy year, 98% of all claims will be processed accurately.	The administrative fee charged for the group's last month of service of such policy year.
ID Card Turnaround	We guarantee that ID Cards will be mailed within 7 business days from receipt of clean eligibility data.	$1,000
Eligibility Turnaround	We guarantee that submitted files will be processed within 5 business days of clean receipt	$1,000
Eligibility Accuracy	We guarantee that eligibility files will have no more than a 5% error rate.	$1,000
Service Call Resolution	We guarantee that any telephone inquiry which cannot be answered immediately will receive a follow-up call before the close of the following business day.	The group will be reimbursed $50 per occurrence.
Plan Document / Booklet Delivery	We guarantee that all plan documents and booklets will be sent within 10 calendar days of receipt of clean eligibility.	$1,000
Balance Billing	We guarantee no balance billing to patients by participating dentists. Patients who receive treatment for covered services from a participating dentist will not be inappropriately billed	The group will be reimbursed $50 per occurrence.
Smooth Implementation	We guarantee a smooth conversion/implementation for all groups, as defined by the group. The criteria for the group's successful enrollment is mutually determined by the group and Delta Dental.	The administrative fee charged for the group's second month of service.

Category	Measure	Target	Definition	Dollar Amount at Risk
Claim Quality				
Financial payment	Accuracy of paid benefit dollars	>99.25%	Calculated as the total audited "paid" dollars minus the absolute value of over and underpayments, divided by total audited paid dollars.	$1,000/year
Claims Processing (total) accuracy	Incidence of claims processed without any error	>95.0%	Calculated as the total number of audited claims minus the number of claims processed with error, divided by the total number of audited claims. Definition of "error" includes any type of error (coding, procedural, system, Payment, etc.), whether a payment of non-payment error. Each type of error is counted as one full error and no more than one error can be assigned to one claim.	The administrative fee charged for the groups last month of service of such policy year.
Payment incidence accuracy	Incidence of claims processed without payment error	>97.0%	Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims. Error is defined as any error, regardless of cause (e.g., coding, procedural, system) that results in an overpayment or an underpayment. Each type of error is counted as one full error and no more than one error can be assigned to one claim.	The administrative fee charged for the groups last month of service of such policy year.
Claims Timeliness (turnaround time – TAT)				
Turnaround time in 14 calendar or 10 business days	The timeliness of claims processing	90.0%	TAT is measured from the date a claim is received by the administrator (either via paper or electronic data interchange) to the date it is processed for payment, denied, or pended for external information.	The administrative fee charged for the groups last month of service of such policy year.
Turnaround time in 30 calendar days	The timeliness of claims processing	>99.0%	TAT is measured from the date a claim is received by the administrator (either via paper or electronic data interchange) to the date it is processed for payment, denied, or pended for external information.	The administrative fee charged for the groups last month of service of such policy year
Customer Service				
Telephone response time	Timeliness of customer service call answer	90.0% answered in 30 seconds or less	The amount of time that elapses between the time a call is received into a customer service queue to the time the phone is answered by a Customer Service Representative (CSR).	$1,000/year
Call abandonment rate	The percentage of calls that are abandoned before answer	3.0% or less	Percentage of calls that are not answered by administrator (caller hangs up before answer). Calculated as the number of calls that are not answered, divided by number of calls received.	$1,000/year

Category	Measure	Target	Definition	Dollar Amount at Risk
First call resolution rate	Percentage of calls that are handled to conclusion on first call	90.0%	Percentage of calls that are completed on first call. Measured by the number of calls that are completed without need for referral or follow-up actions, divided by total number of calls received.	$1,000/year
Customer Service Quality	% of phone calls handled in a professional manner	100%	Based on audited telephone inquiries – live monitoring or taped calls	$1,000/year
Networks				
Provider Access	Recruit a minimum number of providers in The City's locations (to be determined based on access results)	>75.0% of eligible general dentists	Will be based on total number of contracted dentists in-network divided by total number of eligible general dentists in a given The City location	$1,000/year
Surveys				
The City member satisfaction with claims processing and/or customer service	Percentage of survey respondents who give a positive rating	>90.0%	Measured as the number of positive survey ratings divided by the total number of survey responses.	$1,000/year
Client benefits staff's satisfaction with account management	Overall performance rating by The City's benefits staff on the service provided by administrator	4.0	Designated members of the client's benefits staff will complete report card to evaluate the administrator's account team, or the overall service performance. Scoring can be pass/fail or based on a rating such as: 5 = Outstanding 4 = Commendable 3 = Satisfactory 2 = Needs improvement 1 = Unacceptable Account team is typically scored on: ▪ Technical knowledge ▪ Accessibility ▪ Interpersonal skills ▪ Communication skills ▪ Overall performance Administrator's overall service may be scored on such dimensions as: ▪ Proactiveness in communication of issues and recommendations ▪ Timeliness and accuracy of reports ▪ Responsiveness to day-to-day needs ▪ Adequacy of staffing and training	$1000/year

Category	Measure	Target	Definition	Dollar Amount at Risk
Benefit Staff involvement	Ability of administrator to avoid involving The City's Benefit Staff when administrator supplied members with erroneous information.	0 occurrences	Measured by the number of occurrences the City's Benefit Staff gets involved in a complaint by the member and it is later determined that the administrator provided incorrect or inconsistent information to the City member.	$1,000 per occurrence
One Time Guarantees				
Implementation	The City's satisfaction with administrator's implementation	4.0	Measured by vendor's ability to complete the following functions in an accurate and timely manner according to the detailed work plan: ▪ General materials delivery ▪ Network directories ▪ ID cards ▪ Documents (e.g., SPDs, plan documents) ▪ Banking setup Designated members of the client's benefits staff will complete report card to evaluate the administrator's account team, or the overall service performance. Scoring can be pass/fail or based on a rating such as: 5 = Outstanding 4 = Commendable 3 = Satisfactory 2 = Needs improvement 1 = Unacceptable	$1000/year