

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

**AGREEMENT TO PROVIDE ADMINISTRATIVE SERVICES
FOR A SELF-INSURED DENTAL PROGRAM**

This Agreement is made and entered into this 28th day of January 2015 by and between CITY OF WICHITA, hereinafter referred to as "Employer," and DELTA DENTAL OF KANSAS, INC., hereinafter referred to as "DDKS" and collectively hereinafter referred to as "the Parties". The initial term of this Agreement shall be from January 1, 2015 to 11:59 PM central time on December 31, 2015, inclusive, and shall renew automatically for subsequent one-year terms, subject to the provisions of Section IX. This Agreement is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communication regarding the self-insured dental program.

WHEREAS, Employer offers comprehensive dental benefits under a self-funded program to its Eligible Employees and their Eligible Dependents as those terms are defined herein; and

WHEREAS, Employer desires to utilize the services of DDKS to investigate, administer, process, and adjust the claims of its Enrollees for dental benefits; and

WHEREAS, DDKS has agreed to provide these services and perform the duties of investigation, administering, processing and adjusting such claims in accordance to the writings of this agreement.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

SECTION I – DECLARATIONS

1.1 CONTRACT NUMBER: 60100

1.2 REQUIRED ENROLLMENT AND EMPLOYER PAYMENT CONTRIBUTION:

The required enrollment percentage and Employer contribution is to be determined by the Employer.

1.3 WAITING PERIOD FOR NEW EMPLOYEES:

The waiting period for new Eligible Employees is to be determined by the Employer.

1.4 RATES:

Administrative fees and designated costs are found in Section VIII-ADMINISTRATIVE FEES AND CONDITIONS.

1.5 SELECTED NETWORK:

The Dental Network for this Agreement is Delta Dental PPO as the Exclusive Network.

1.6 SELECTED BENEFITS, MAXIMUMS, DEDUCTIBLES AND CO-INSURANCE PERCENTAGE PAID BY PLAN:

A Covered Service is deemed to be benefited 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 through payment, the Plan will pay the lesser of i) the percentage of the fee actually charged or Maximum Plan Allowance (MPA) for a Covered Service; or ii) the amount which is otherwise payable in accordance with the terms of the Plan.

See the "Summary of Dental Plan Benefits" on the following page for more information regarding Covered Services.

Summary of Dental Plan Benefits

Group #60100

Maximum Benefit(s) Per Person

Regular Services:

The Maximum Benefit for all Covered Services for each Enrollee in any one Contract Year is One Thousand Dollars (\$1000.00).

- * Benefits will increase from the Base Level to the Incentive Level if the member receives an exam and/or cleaning at least once (1) time in twelve (12) months. Benefits will increase to the Incentive Level ninety (90) days after a cleaning and/or exam. Benefits for new members will begin at the Incentive Level. After twelve (12) months, benefit levels will be determined by the date of the last Diagnostic or Preventive treatment.

Deductible Limitations

Coverage for Diagnostic and Preventive Services is not subject to the Deductible. However, the Deductible shall apply during each Contract Year to all other Covered Services which are provided to each Enrollee. After Enrollees have, in any Contract Year, each paid either the individual Deductible of Fifty Dollars \$50.00, or have cumulatively paid charges for Covered Services in the amount of One Hundred Fifty Dollars \$150.00, the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Contract Year.

% paid by DDKS		Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)		
PPO Network Base Level	PPO Network Incentive Level	
100%	100%	<p>I. DIAGNOSTIC: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:</p> <ul style="list-style-type: none"> * <u>Oral evaluations</u> – once (1) each six (6) months. * <u>Bitewing x-rays</u> – bitewings once (1) each six (6) months for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. <u>Full mouth or panoramic x-rays</u> – once (1) each five (5) years.
100%	100%	<p>II. PREVENTIVE: Provides for the following:</p> <ul style="list-style-type: none"> * <u>Prophylaxis (Cleanings)</u> – once (1) each six (6) months. * <u>Topical Fluoride</u> – once (1) each six (6) months for dependent children under age nineteen (19). <u>Space Maintainers</u> for dependent children under age fourteen (14) and only for premature loss of primary molars. <u>Sealants</u> – once (1) per tooth 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)		
60%	80%	III. ANCILLARY: Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
60%	80%	IV. ORAL SURGERY: Provides for extractions and other oral surgery including pre and post-operative care.
60%	80%	V. REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations; composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).
60%	80%	VI. ENDODONTICS: Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
60%	80%	<p>VII. PERIODONTICS:</p> <p>a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.</p>
60%	80%	b. Surgical periodontal procedures.

Summary of Dental Plan Benefits (Continued) Group #60100

Payment of Claims

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

Eligible Children Ages

Children are eligible for coverage to age 26.

% paid by DDKS	Examples of Covered Services
MAJOR (Subject to Deductible)	
PPO	PPO
Network	Network
Base	Incentive
Level	Level
40%	50%
	<p>VIII. SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.</p> <p>IX. PROSTHODONTICS:</p> <p>a. Includes bridges, partial and complete dentures.</p> <p>b. Repairs and adjustments of bridges and dentures.</p>
40%	
40%	
ORTHODONTICS (Subject to Deductible)	
None	None
	<p>X. ORTHODONTICS: Orthodontic appliances and treatment.</p>

*** NOTE: In order to receive benefits under this program, subscribers must use a participating Delta Dental Preferred Provider Option (PPO) dentist.**

1.7 ADDITIONAL PLAN INFORMATION:

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

NOTE: SEE ADDITIONAL EXCLUSIONS AND LIMITATIONS IN SECTION II.

SECTION II - EXCLUSIONS AND LIMITATIONS

2.1 Unless Sections 1.6 and/or 1.7 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, services, or appliances 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, premedication's and relative analgesia, including nitrous oxide; hospital, healthcare facility or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; preventive control programs.
- f. Charges for failure to keep a scheduled visit; and charges for completion of forms.
- g. Appliances or restorations for altering vertical dimension; restoring occlusion; replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; splinting or equilibration.
- h. 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 (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.
- i. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.
- j. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of this Agreement.
- k. Crowns and endodontic treatment in conjunction with an over denture.
- l. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7.
- m. Replacement of lost or stolen dentures or charges for duplicate dentures.
- n. 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 1.6 and/or Section 1.7.
- o. 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.
- p. Any benefit, procedure or service, 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.
- q. Dental benefits and services which are not completed.
- r. Treatment rendered outside of the United States or Canada.
- s. 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.

- t. Benefits or services for control of harmful habits.
- u. Procedures for dental implants and associated services, unless these are specified as Covered Services in Section 1.6 and/or Section 1.7.
- v. Diagnosis or treatment of temporomandibular joint dysfunction, unless these are specified as Covered Services in Section 1.6 and/or Section 1.7.

2.2 Dental Benefits and Services are Limited as Follows, unless Section 1.6 or Section 1.7 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 1.6 and/or Section 1.7.
- 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. Inlays will automatically receive benefits equal to the corresponding surface of a filling.
- i. Individual crowns are not a Covered Service unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. If a Covered Service, the following limitations apply:
 - (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 2.2 (l) will apply.
 - (6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.

- j. Prosthodontics are not a Covered Service unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. If a Covered Service, the following limitations apply unless Section 1.6 and/or Section 1.7 state different limitations:
 - (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.
- k. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7.
- l. Periodontic procedures are not Covered Services 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 non-surgical 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. For surgical periodontal procedures, when covered, payment is limited to only once (1) in any thirty-six (36) month period.
- m. Treatment to correct congenital or developmental malformations.
- 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 one (1) hour, per episode.
- o. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7.

2.3 Certain dental benefits and services may be 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 “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.
- 3.4 “Child” or “Children” 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 1.6.

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.

- 3.5 “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.
- 3.6 “Contract Year” means the period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof.
- 3.7 “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 unless a Cosmetic service is specified as a Covered Service in Section 1.6 and/or Section 1.7.
- 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 the Plan.
- 3.9 “DDKS” means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Plans 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 1.6 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 1.5:
 - a.1. “**Delta Dental Premier**”: The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that DDKS offers. All Delta Dental Premier providers are considered Participating Dentists and are paid according to DDKS’ Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-Participating Dentists are not considered Delta Dental Premier Providers, and are paid according to DDKS’ Non-Participating Dentist Maximum Plan Allowance.

2. If Delta Dental Premier is the Exclusive Network, then Enrollees must exclusively use Dentists in the Delta Dental Premier network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who does not participate in the Delta Dental Premier network, the Enrollee is responsible for all treatment costs incurred.
- b.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 the Exclusive Network, then Enrollees in the plan must exclusively use Dentists in the Delta Dental PPO network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all treatment costs incurred.
- 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 i) the spouse, as determined under applicable state law at the time and location that the marriage was entered into, ii) a Child of an Eligible Employee who satisfies the requirements of Section 3.3, and iii) any such spouse or Child who timely elects Continuation Coverage and for whom the appropriate payment is timely received by DDKS.
 - 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 payment 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 payment is timely received by DDKS. An Enrollee shall be deemed to have enrolled when such Enrollee’s name, enrollment information and the required payment is 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 payment.
 - 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** “Spouse” means the Subscriber’s spouse as determined under the laws of Kansas.
- 3.25** “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 payment 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 an employee who is:
 - (1) Actively employed to work for Employer a regularly scheduled minimum thirty (30) hour week;
 - (2) On paid sick leave from such active employment;
 - (3) On any other approved leave of absence from such active employment; or
- b. Be a former employee of Employer who is entitled to retirement benefits from Employer and meets all other requirements for coverage as determined by Employer.
- c. Be a member in good standing of an organization, association or union which is the Employer, as determined under the rules of such organization, association or union.
- d. Be a self-employed person who is actively engaged in a trade or business with at least one (1) other self-employed person or employee, all as determined by DDKS.

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 required payment 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:

- a. 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.
- b. 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 person under whom the dependent is obtaining coverage 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.
- c. 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 person under whom the dependent is obtaining coverage 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 payments for coverage are timely made, 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 month in which the Subscriber ceases to qualify as a Subscriber or at such other date as designated by the Employer.
- 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 payments for coverage are timely made, 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 month in which the Subscriber upon whom such person is dependent ceases to qualify as 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 provide each Subscriber with a Benefits Booklet.
- c. To permit and to encourage the professional relationship between a Dentist and Enrollee to be maintained without interference.
- d. To encourage Enrollees to notify their Dentist at the time of their first appointment that they are covered by this Agreement.
- e. To permit DDKS, its auditors or other authorized representatives, on reasonable advance written notice, to inspect the records of the Employer in order to verify the accuracy of all information provided by Employer to DDKS.
- f. To provide DDKS with such other information as it shall request in connection with this Agreement.
- g. 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, or Subscriber who receives service from a Non-Participating Dentist, 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 the Maximum Plan Allowance (MPA), any amount in excess of the highest of the Maximum Plan Allowance (MPA) 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 Contract 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 matter that is inconsistent with the generally accepted applicable standards of dentistry.

6.3 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.

6.4 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.

6.5 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 Enrollee'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.

6.6 INQUIRIES/APPEALS:

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.

If a claim for benefits is denied in whole or in part, written notification called an “Explanation of Benefits” will be provided within thirty (30) days after a claim is received, unless special circumstances require an extension of time for processing. If additional time is necessary, DDKS will notify the Enrollee and/or the treating dentist of the reason for the additional time, including a description of additional information that is necessary to process the claim if information is missing. If additional information is necessary, the Enrollee will have forty-five (45) days to provide the additional information or else the claim will be decided based upon the information then available to DDKS.

Enrollees have the right to appeal a claim determination if the requested dental benefits were not paid in full. In order to appeal a benefit determination, Enrollees or their authorized representative must write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769 within one hundred eighty (180) days of the date of the Explanation of Benefits for the claim. Written appeals should be 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, if known, license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question, including the basis for appeal.
7. Any additional information that the Enrollee believes supports his/her position.

A full and fair evaluation of the appeal will be made by DDKS and, in some cases the Enrollee may be examined clinically. If necessary, additional information or documents may be requested. 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, however, DDKS must provide a written answer or decision within sixty (60) days receipt of the appeal.

If DDKS denies any part of the claim on appeal, DDKS will provide the Enrollee written notice of the basis for the denial and additional information. The Enrollee may request, free of charge, a copy of any applicable rules, exclusions, or limitations relied upon in the benefit determination. In addition, DDKS will provide the Enrollee with a copy of the documents relevant to the benefit determination free of charge upon request.

If the dental plan at issue is governed by the Employee Retirement Income Security Act, an Enrollee may have the right to bring a civil action under Section 502(a). In addition, an Enrollee may be entitled to additional levels of review and/or other voluntary alternative dispute resolution options, such as mediation under his/her group dental plan.

6.7 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.

6.8 NOTICE OF CLAIM:

Written notice of claim must be given to DDKS within six (6) months after the occurrence or commencement of any claim/loss covered by the Agreement, or as soon thereafter as in 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. 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.

6.9 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.

6.10 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.

6.11 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. 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 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.

6.13 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.

6.14 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.

6.15 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.

6.16 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.

6.17 ASSIGNMENT:

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

6.18 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

6.19 BENEFITS BOOKLET:

The Benefits Booklet shall summarize certain features of the Plan's coverage, including the eligibility rules, benefits and, methods of securing claims payments.

SECTION VII - ADMINISTRATIVE TERMS

- 7.1 DDKS shall investigate, determine and process claims arising under the Agreement and shall arrange for prompt payment of the benefits provided by the Agreement. Said payments shall be made by DDKS with funds on behalf of, and provided by, the Employer in accordance with the terms of this Agreement.
- 7.2 DDKS shall determine the amount of benefits, if any, to which a Subscriber shall be entitled in any claims for benefits accruing under the Agreement during the term of this agreement; provided, that under no circumstances shall DDKS be liable to Subscribers of the Employer for benefits payable under the Agreement. In the event of a dispute between DDKS and a Subscriber of the Employer as to the payment of any claims, or as to the amount due the Subscriber covered by said Agreement, said disagreement shall be finally determined by the Employer, and DDKS shall accept such determination. DDKS shall notify the Employer of such disputes hereunder. If any suit shall be brought with respect to any claim for benefits under the Agreement, DDKS agrees to cooperate with the Employer in its defense of said suit. Any judgment resulting from said suit requiring the payments of benefits or damages under the Agreement shall be paid by the Employer. The Employer agrees to reimburse DDKS for expenses incurred in connection with the defense of such suits. DDKS shall have the right to settle, with the Employer's consent, any such claim or suit when in its judgment it appears expedient to do so. Any such settlement shall be paid solely from the Employer's funds. Any such payment by DDKS shall be binding as between the parties hereto and DDKS shall have no liability to the Employer for or as a result of payment made by DDKS hereunder.
- 7.3 In addition to the above-mentioned claim services, DDKS shall provide the Employer with certain actuarial and statistical services in connection with this Agreement, including periodic reports on claim services rendered hereunder.
- 7.4 The Employer shall furnish DDKS all information that it may from time to time request for the purpose of carrying out the terms of this Agreement.
- 7.5 Any disagreement between the parties with respect to the interpretation or application of this Agreement or the obligations of the parties hereunder shall be determined by arbitration. Such arbitration shall be conducted, upon the request of either the Employer or DDKS, before three arbitrators (unless Employer and DDKS mutually agree to one arbitrator) chosen as follows: Each party shall choose an arbitrator and such arbitrators shall choose a third, which three arbitrators shall make a decision, and their decision shall be binding upon the parties hereto. None of said arbitrators shall be related to either party or have any interest, directly or indirectly, personally or otherwise, in the questions decided. The expense of arbitration proceedings conducted hereunder shall be borne equally by the parties. All arbitration proceedings hereunder shall be conducted in Wichita, Kansas, unless otherwise agreed.
- 7.6 It is the intent of the parties that this Agreement is one for the sale of services and shall not be construed as a contract of indemnity.
- 7.7 It is the intention of the parties hereto that funds utilized in accordance with this Agreement are not payments and shall in no case be construed to be payments. In the event that state payment taxes become due and payable hereunder, the Employer agrees to reimburse DDKS for the payment of paid taxes and any penalties or interest due in the event of late payment of paid taxes upon demand. It is agreed that this paragraph and the Employer's obligations expressed herein shall survive the termination of this Agreement.
- 7.8 Any taxes or fees imposed by federal or state authorities on the Plan shall be the sole responsibility of Employer. If mutually agreed upon by the Parties in writing and if permitted by law and/or any regulations promulgated thereunder, DDKS will pay such applicable tax or fee and shall be reimbursed by Employer consistent with the terms for payment of the Administrative Fee. Absent said agreement, Employer shall be responsible for payment of any taxes or fees due.
- 7.9 It is agreed by the parties hereto that DDKS is not the plan administrator as that term is defined by ERISA, 29 U.S.C. § 1002, *et. seq.*

SECTION VIII - ADMINISTRATIVE FEE AND CONDITIONS

8.1 DDKS shall have no obligation to arrange for payment of benefits under this Agreement if the Employer has not made the requisite funds available to DDKS. If any benefits under said Agreement are paid by DDKS from its funds at any time or for any reason, the Employer shall, within thirty (30) days after the close of each calendar month, reimburse DDKS for said amounts so paid.

8.2 In consideration for the services provided hereunder, the Employer agrees to pay DDKS an Administrative Fee, for the services provided herein, as follows and said Fee shall be calculated and paid monthly.

January 1, 2015 through December 31, 2015	Three Dollars and Thirty Cents (\$3.30) per Subscriber
January 1, 2016 through December 31, 2016	Three Dollars and Thirty Cents (\$3.30) per Subscriber
January 1, 2017 through December 31, 2017	Three Dollars and Thirty Cents (\$3.30) per Subscriber

SECTION IX - TERM AND TERMINATION

This Agreement may be terminated by either party upon giving written notice thereof to the other party at least thirty (30) days prior to the date of termination; provided that, this Agreement shall automatically terminate in the event that:

- (a) Employer's Plan is terminated or discontinued or Employer suffers bankruptcy or insolvency; or
- (b) Employer fails to provide DDKS with sufficient funds with which to carry out its duties hereunder, or
- (c) Employer fails to pay DDKS the service fee when due.

In the event of termination, DDKS will have no liability for the payment of claims, regardless of the date of service, unless an attachment to this Agreement is established between DDKS and Employer governing the payment of claims incurred and received after termination of this Agreement. This attachment shall specify the length of time DDKS will need to continue payment; the revised, if applicable, service fee to provide the administrative functions after the termination of the Agreement; and the conditions of reimbursement for said paid claims and service fees.

SIGNATURE PAGE

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

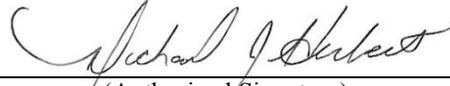
EMPLOYER COMPANY NAME

INSURANCE COMPANY NAME

DELTA DENTAL OF KANSAS, INC.

By: _____

By: _____



(Authorized Signature)

(Authorized Signature)

By: _____

By: _____

Michael J. Herbert

(Authorized Printed Name)

(Authorized Printed Name)

President & CEO

(Title)

(Title)

January 28, 2015

(Date)

(Date)