ADMINISTRATIVE SERVICES AGREEMENT

This Agreement, made and entered into effective January 1, 2019, by and between **City of Broken Arrow**, hereinafter referred to as Plan Sponsor and/or Plan Administrator, and **Delta Dental Plan of Oklahoma**, hereinafter referred to as DDPOK and/or Claims Administrator, is as hereafter provided.

WHEREAS the Plan Administrator has established a self-insured Dental Benefit Plan to provide for certain classes of Employees (and their Eligible Dependents, if applicable), as identified in Appendix A attached to and forming a part of this Agreement by reference herein, under which DDPOK will provide Benefits to which they are entitled; and

WHEREAS DDPOK is willing to provide Benefits for that purpose under the terms and conditions set forth herein and in Appendix A attached to and forming a part of this Agreement;

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and conditions herein contained, City of Broken Arrow and Delta Dental Plan of Oklahoma agree to the terms and conditions hereinafter set forth.

Section 1. Definitions

1. **ACTIVELY AT WORK**: The active expenditure of time and energy in the services assigned by the Employer. An Employee shall be deemed to be Actively at Work on each day of a regular paid vacation, an Employer holiday, or on a regular nonworking day, if such Employee is not disabled and was Actively at Work on the work day preceding his or her Effective Date.

2. **BENEFICIARY**: A person who receives, or is entitled to receive, the Benefits of an insurance plan.

3. **BENEFIT PERIOD**: The specified period of time during which charges for Covered Services must be incurred to be eligible for payment under the Plan. For purposes of this Plan, benefit period shall mean the twelve (12) month period commencing January 1 and continuing through and including December 31 each year thereafter.

4. **BENEFITS**: The payment, reimbursement, or indemnification of any kind for those Dental Services which are made available to Covered Persons under the terms of the Plan and which are listed as part of this Plan Document.

5. **CALENDAR YEAR**: The period of twelve (12) months commencing on the first day of January and continuing through the last day of December.

6. **CONTINUATION COVERAGE**: Coverage under the Plan for a Covered Person with respect to whom a Qualifying Event has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Plan to Covered Persons with respect to whom a Qualifying Event has not occurred.

7. **COPAYMENT**: The amount the Covered Person is required to pay in addition to the Plan's payment.

8. **COVERED PERSON**: The Eligible Person and each of his or her Eligible Dependents who are covered under the Plan.

9. **COVERED SERVICES**: Those Dental Services which are made available to Covered Persons under the terms of the Plan, which are listed as part of Appendix A attached and forming a part of this Plan Agreement by reference herein, and determined by the Claims Administrator and/or Plan Administrator to be covered.

10. **DEDUCTIBLE**: The specified dollar amount a Subscriber or Dependent is required to pay each Benefit Year before the Plan will pay specific Benefits, as defined in the appendix(ices) attached and forming a part of this Plan Agreement by reference herein.

11. **DELTA DENTAL**: Delta Dental Plan of Oklahoma, also referred to as DDPOK, or any Delta Dental Plan which is a member of the Delta Dental Plans Association.

12 **DENTAL SERVICES**: Care and procedures rendered by Dentists for diagnosis or treatment of dental disease or injury.

13. **DENTIST**: A person duly licensed to practice dentistry in the State of Oklahoma; or a person duly licensed to practice dentistry in the state in which the Dental Services are rendered.

    a. **NONPARTICIPATING DENTIST**: A Dentist who has not signed a Participating Dentist Agreement.

    b. **PARTICIPATING DENTIST**: A Dentist who has filed and executed a Participating Dentist Agreement with Delta Dental, and who abides by such uniform rules and regulations as are prescribed, from time to time, by Delta Dental. A list of Delta Dental Participating Dentists is provided upon request, without charge, as a separate document.

        1. **Delta Dental Premier Participating Dentist** – a Participating Dentist in the Delta Dental Premier network.

        2. **Delta Dental PPO Participating Dentist** – a Participating Dentist in the Delta Dental PPO network.

14. **DEPENDENT**: A Covered Person other than the Employee, as specified in the Schedule of Eligibility in Section 1 of Appendix A attached and forming a part of this Plan Agreement by reference herein.

15. **EFFECTIVE DATE**: The date on which coverage for an Eligible Person or Eligible Dependent begins under the Plan, as set forth in the Schedule of Eligibility in Section 1 of Appendix A attached and forming a part of this Plan Agreement by reference herein.

16. **ELIGIBLE PERSON**: A person entitled to apply for coverage, as specified in the Schedule of Eligibility in Section 1 of Appendix A attached and forming a part of this Plan Agreement by reference herein.

17. **EMPLOYEE**: An Eligible Person as specified in the Schedule of Eligibility in Section 1 of Appendix A attached and forming a part of this Plan Agreement by reference herein.

18. **EMPLOYER**: City of Broken Arrow.

19. **FAMILY COVERAGE**: Coverage for the Employee and one or more of the Employee's Eligible Dependents.

20. **GROUP**: Group consists of all Covered Persons eligible to receive Dental Services hereunder.

21. **INCURRED**: An expense is incurred on the date a Covered Person receives the service or supply for which the charge is made.

22. **MAXIMUM ALLOWABLE AMOUNT**: The charge DDPOK will use as the basis for Benefit determination for Covered Services Incurred by a Covered Person under this Plan. The Claims Administrator will use the following criteria to establish the Maximum Allowable Amount:

    a. **Delta Dental Premier Participating Dentists** - the lesser of the Dentist's submitted fee or the amount determined to be the maximum allowable amount for Delta Dental Premier Participating Dentists in the geographic area where the Covered Services were rendered.

    b. **Delta Dental PPO Participating Dentists** - the lesser of the Dentist's submitted fee or the amount the Delta Dental PPO Participating Dentist has agreed to accept as payment for Covered Services in the geographic area where the Covered Services were rendered.

    c. **Nonparticipating Dentists** - the Nonparticipating Dentist's submitted fee up to the amount the Claims Administrator determines to be the Prevailing Fee in the geographic area where the Covered Services were rendered.

23. **MEDICAL CHILD SUPPORT ORDER (MCSO)**: Any judgment, decree, or order issued by a court of jurisdiction made pursuant to a state domestic relations law or which enforces a law relating to medical child support under Medicaid. Documentation of such order may be supplied to a group health plan by a custodial parent, State Department of Health Services, or the district attorney in whose jurisdiction the child resides.

24. **PLAN**: This Plan of Benefits for dental care and services provided by and through the Employer.

25. **PLAN ANNIVERSARY DATE**: January 1 each year

26. **PLAN MAXIMUM BENEFIT PAYMENT**: The maximum dollar amount the Plan will pay in any Benefit Period (or lifetime, if applicable) for Covered Dental Services.

27. **PREDETERMINATION OF BENEFITS**: The procedure whereby DDPOK notifies the Dentist or Eligible Person of estimated Benefits and financial obligations of the Plan and of the Covered Person with regard to the Dentist's recommended treatment plan, prior to the rendition of service to the patient.

28. **PREVAILING FEE**: An amount established by the Delta Dental Plan in the state in which the Dental Services are rendered.

29. **PROCESSING POLICIES**: Policies approved by Delta's Board of Directors, as amended from time to time, to be used in processing treatment plans for payment.

30. **PROOF OF LOSS**: A completed claim form which provides sufficient information to allow DDPOK to determine liability for Covered Services, including the Dentist's itemized statement of services rendered and related charges, and dental records.

31. **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**: A medical child support order that:

    a. Either creates or recognizes the right of an alternate recipient (a Covered Person's child who is recognized under the order as having a right to be enrolled under the Plan) or assigns to the alternate recipient the right to receive Benefits for which a Covered Person or other Beneficiary is entitled under the group dental health plan; and

    b. Includes the name and last known address of the Covered Person and the name and address of each alternate recipient, a reasonable description of the type of coverage to be provided by the group dental health plan or the manner in which such coverage is to be determined, the period for which coverage must be provided, and each plan to which the order applies.

32. **QUALIFYING EVENT**: Any one of the following events that, but for the Continuation Coverage provisions of the Plan, would result in the loss of a person's coverage under the Plan:

    a. The death of a covered Employee;

    b. The termination (other than by reason of a covered Employee's gross misconduct), or reduction in hours, of the covered Employee's employment;

    c. The divorce or legal separation of the covered Employee from the Employee's spouse;

    d. The covered Employee becoming entitled to Benefits under Medicare;

    e. A dependent child ceasing to be eligible.

33. **SINGLE DENTAL PROCEDURE**: A dental procedure listed in the Uniform Procedure Code and Nomenclature of the American Dental Association.

Section 2. Administrative Fee

The Administrative Fee for the contract period commencing January 1, 2019, shall be Six Dollars and Fifty Cents ($6.50) per enrolled primary subscriber per month. Notification, payment, or modification of such administrative fee shall be as follows in this Section and in Sections 6.A. and 6.E. of this Agreement:

A. DDPOK will bill Plan Administrator the monthly administrative fee by the tenth (10th) day of each month.

B. Plan Administrator will remit payment for the monthly administrative fee to DDPOK within thirty (30) days of receipt of such billing.

C. Any notification or modification of the monthly administrative fee shall be as set forth in Sections 6.A. and 6.E. of this Agreement.

Section 3. Plan Administrator Responsibilities

Plan Administrator agrees:

A. To furnish to DDPOK an accurate statement of the total number and names of all Eligible Persons to the group (and their Dependents, if covered) who are eligible to receive dental Benefits hereunder commencing on January 1, 2019, and monthly thereafter to furnish DDPOK with additions and deletions to such list on forms provided by DDPOK or in a form and format mutually agreeable to Plan Administrator and DDPOK.

B. When reporting Eligible Person and Dependent eligibility in an electronic format (file or on-line), to report such data in the established, agreed format.

C. To retain eligibility/enrollment records for the statutory period of time required by law and in compliance with federal and state laws related to privacy and confidentiality of participant and other information.

D. To reimburse DDPOK each week, through electronic funds transfer system, an amount equal to the eligible claims paid. "Eligible claims paid shall mean the claims payment amounts for claims by Covered Persons for Benefits for which the Plan Administrator is liable under the provisions of this Agreement and excludes the amount of such claims for which the Covered Persons are liable. Under this reimbursement system:

1. Plan Administrator agrees to provide a bank account from which electronic funds transfers can be made and to maintain sufficient funds in the account to cover claims and administrative costs incurred by DDPOK under the provisions of this Agreement.

2. Each Wednesday (or third work day each week), DDPOK will advise the Plan Administrator's designee, by telephone, e-mail, or facsimile, the amount of claims for the weekly claims reimbursement.

3. Each Friday (or fifth work day each week), Plan Administrator will reimburse DDPOK an amount equal to the weekly claims reimbursement amount reported to the Plan Administrator's designee the preceding Wednesday (or third work day of the week). By separate agreement between Plan Administrator and DDPOK, such reimbursement shall occur by Plan Administrator's wire transfer to DDPOK designated account or by DDPOK's draft from Plan Administrator's designated account.

4. DDPOK will provide the monthly invoice and supporting claim listing to Plan Administrator's designee on or before the tenth (10th) day of the following month.

5. In the event Plan Administrator fails to make funds available as specified herein, DDPOK shall have no obligation to pay such claims from its own funds.

E. To remit payment for the monthly administrative fee to DDPOK in compliance with the provisions set forth in Section 2 of this Agreement.

F. To provide all Eligible Persons with a Summary Plan Description, to be provided by DDPOK upon request of the Plan Administrator, in an electronic format unless specifically requested otherwise, as to the existence and terms of this Plan and the right of Eligible Persons and Eligible Dependents to receive care as provided hereunder.

G. To encourage Eligible Persons and Eligible Dependents to notify the Dentist at the time of their first appointment that they are covered hereunder and provide the Dentist with their group identification and member ID numbers.

H. To notify DDPOK, in a form and format mutually agreeable to Plan Administrator and DDPOK, when an Eligible Person or Eligible Dependent elects Continuation Coverage. Such notice shall be given to DDPOK within thirty (30) days of Beneficiary's election.

I. Should Plan Administrator fail to properly notify DDPOK of Eligible Person's or Eligible Dependent's termination of eligibility, as provided in Section 3.A. of this Agreement, the Plan shall be liable for claims payments issued to the Dentist(s) or Eligible Person for services rendered to such person after termination of their eligibility, subject to the provisions of Section 5.F. of this Agreement.

J. To issue any billing, notification, payment, and/or report in compliance with the requirements set forth in this Agreement.

K. To all benefit terms and conditions, Limitations and Exclusions, and other Plan benefit conditions as found herein and in Appendix A. Appendix A defines substantially all of the benefit claims, Limitations, and Exclusions utilized in the ordinary course of business; however, the complete benefit Limitations and Exclusions for this Plan are available to the Plan Administrator, upon request, by contacting Delta Dental Plan of Oklahoma, Customer Service Department, P.O. Box 54709, Oklahoma City, Oklahoma 73154.

L. To treat with the highest degree of confidentiality all information compiled and reported to Plan Administrator by DDPOK and identified therein as confidential, including but not limited to statistical and actuarial information and claims procedure manuals.

Section 4. DDPOK Responsibilities

DDPOK agrees:

A. To provide dental Benefits to Covered Persons in accordance with the Plan design set forth in Appendix A attached to and forming a part of this Agreement and any amendments thereto which are hereafter approved in accordance with Section 5 and Section 6 of this Agreement.

B. To be responsible for all claims administration services related to the delivery of dental Benefits under the provisions of this Agreement.

C. To make available to Plan Administrator such utilization statistics and actuarial information compiled and retained by DDPOK which Plan Administrator and DDPOK agree to be reasonable for reporting purposes.

D. To issue any billing, notification, payment, and/or report in compliance with the requirements set forth in this Agreement.

E. To implement the following performance standards and guarantees and reimburse the Plan Administrator an amount of the administrative charge, as outlined below, should DDPOK's performance for the contract period fall below the level outlined herein:

1. Annual Claims Accuracy Performance Guarantee: DDPOK guarantees financial accuracy (correct dollars paid) of ninety-nine percent (99%) and procedural accuracy (claims entry/data entry) of ninety-seven percent (97%) for claims paid during each twelve (12) consecutive month period, beginning January 1 and continuing through and including December 31 each year so long as the Administrative Services Agreement remains in effect or until modified by agreement of the parties. DDPOK will draw a random sample of claims from total dental claims paid during the twelve (12) consecutive month review period. From this sample of claims, DDPOK will measure financial and procedural accuracy, and report to Plan Administrator annually. Financial accuracy will be determined by dividing the total dollar amount paid in error by the total dollar amount paid for claims included in the annual sample. Procedural accuracy will be determined by dividing the number of errors, or combination of errors, in data entry by the total number of claims in the annual sample. DDPOK will reimburse Plan Administrator One Hundred Dollars ($100) for each percentage point financial accuracy and/or procedural accuracy fall below the percentages guaranteed for each. The maximum reimbursement for failure to satisfy the financial and/or procedural guarantee shall be One Thousand Dollars ($1000) per twelve (12) consecutive month review period. Any penalty DDPOK is required to pay for failure to perform at the guaranteed financial and/or procedural accuracy level will be based on the annual measurement performed following the end of the twelve (12) consecutive month review period.
2. Annual Claims Turnaround Time Guarantee: DDPOK guarantees one hundred percent (100%) of dental claims during each twelve (12) consecutive month period, beginning January 1 and continuing through and including December 31 each year so long as the Administrative Services Agreement remains in effect or until modified by agreement of the parties, will be processed within an average of six (6) working days. For the purpose of this Claim Turnaround Time Guarantee, DDPOK's claim processing time will be as reported on DDPOK's annual Turnaround Time Report for the twelve (12) consecutive month review period. DDPOK's annual Turnaround Time Report will measure the claim processing time beginning with the date a claim is received by DDPOK and date stamped as part of DDPOK's daily incoming mail, and ending with the date the claim is adjudicated. Should DDPOK's annual Turnaround Time Report show that DDPOK paid less than one hundred percent (100%) of dental claims within an average of six (6) working days or less, DDPOK will reimburse Plan Administrator One Hundred Dollars ($100) for each day in excess of an average of six (6) working days required to reach the one hundred (100) percentile. The maximum reimbursement for failure to satisfy the Claim Turnaround Time Guarantee shall be One Thousand Dollars ($1000) for the twelve (12) consecutive month review period.

3. Customer Satisfaction Guarantee: Each year, DDPOK will conduct a random survey of a representative sample of DDPOK Plan-wide participants with regard to overall satisfaction with the service they received from DDPOK. If DDPOK does not receive a satisfactory rating from at least eighty-five percent (85%) of survey respondents, DDPOK will reimburse Plan Administrator

One Hundred Dollars ($100) for each percentage point satisfactory ratings fall below eighty-five percent (85%), to a maximum of One Thousand Dollars ($1000) for the plan year to which such survey applies.

4. Management Satisfaction Guarantee: Should DDPOK's performance in any administrative area not be perceived as satisfactory by Plan Administrator's benefit managers, Plan Administrator will notify DDPOK. DDPOK will, within ten (10) working days of receipt of such notice, submit to Plan Administrator a plan and schedule for improvement of DDPOK's performance.

5. Phone Call Abandonment Guarantee: DDPOK guarantees one hundred percent (100%) of phone calls to DDPOK will be answered by a customer service representative within an average of forty-five (45) seconds. For the purpose of this Phone Call Abandonment Guarantee, DDPOK's phone abandonment will be as reported on DDPOK's annual Phone Call Abandonment Report reflecting plan-wide results. Should DDPOK's annual Phone Call Abandonment Report show that DDPOK's average hold time exceeded forty-five (45) seconds, DDPOK will reimburse the Plan Administrator the sum of One Thousand Dollars ($1000) for the twelve (12) consecutive month review period.

F. To endeavor to enlist Dentists to become Participating Dentists in sufficient number to ensure adequate choice of Dentist.

G. To provide professional review of the adequacy and appropriateness of services rendered by Dentists.

H. To encourage each Dentist to schedule and render all dental treatment provided in this Plan in accordance with applicable standards of the dental profession in his or her community.

I. To encourage Participating Dentists to complete and submit for Predetermination of Benefits a standardized Attending Dentist Statement (claim form) prior to rendition of service, except for emergency services or brief routine services, indicating the Eligible Person's or Eligible Dependent's dental needs and treatment necessary in the professional judgment of the Dentist and to notify the Eligible Person or Eligible Dependent of all actions taken by Delta with respect to such Attending Dentist Statement.

J. To issue a notice of Predetermination regarding the Attending Dentist Statement when satisfied that the patient is eligible hereunder. Such Predetermination by DDPOK shall be for a maximum period of three hundred sixty-five (365) days from the date of Predetermination by DDPOK (one hundred eighty [180] days for periodontal procedures), but no longer than the period of this Agreement as stated in Section 6.

K. To make no payments from the moneys received from the Plan Administrator for any services rendered to a patient who is not eligible at the time of rendition of the service, subject to the provisions of Section 3.I. and Section 5.F.

L. To issue an Explanation of Benefits regarding services rendered an eligible person and make payment of that portion of the fee for which the Plan is liable in accordance with this Agreement. Such payment, together with the Eligible Person's or Eligible Dependent's portion of the fee required, shall discharge the claim of a Participating Dentist.

M. When Dental Services are performed or provided by a properly licensed dentist, to provide Benefits to eligible Subscribers and eligible Dependents for the Dental Services listed in Appendix A attached to and forming a part of this Agreement by reference herein, subject to the terms and conditions set forth in such Appendix A.

N. Upon request, to make available to Plan Administrator, as a separate document, the Processing Policy(ies) utilized in the adjudication of a claim.

O. To make available to Plan Administrator, Covered Persons, and Beneficiaries a list of Delta Dental Network Participating Dentists in the state of Oklahoma.

P. To treat personal information collected under this Agreement with the highest degree of confidentiality, except as is necessary for the proper administration of the Plan, and in accordance with federal and state law.

Section 5. General Provisions

A. The provisions of this Agreement shall apply to the specified coverage and terms and conditions set forth in Appendix A attached to and forming a part of this Agreement.

B. Neither the Plan Administrator nor DDPOK hereby undertakes to provide a Dentist to the Eligible Person or Eligible Dependent. Nothing contained in this Agreement shall be construed as obligating the Plan Administrator or DDPOK to render Dental Services.

C. Participating Dentists are independent contractors and neither the Plan Administrator nor DDPOK shall be liable for any act or omission of any Participating Dentist, his or her employees or agents, or any person furnishing dental or other professional services.

D. By performing or receiving services under this Agreement, all dentists and all patients are bound by its terms.

E. Clerical errors or delays in keeping or relating data relative to coverage shall not invalidate coverage which otherwise would be validly in force, nor continue coverage which would otherwise be validly terminated. Upon discovery of such errors or delays, an equitable adjustment of charges shall be made.

F. Should Plan Administrator fail to properly notify DDPOK of termination of a Covered Person's eligibility under the Plan, as provided in Section 3.A. of this Agreement, DDPOK shall request refund(s) of claims payments made for services rendered after such person's termination of eligibility only if DDPOK receives Plan Administrator's notification of such eligibility termination within thirty (30) days of such termination. Any such request for refund will be made to the person or entity to which payment was issued. Request(s) for refunds will not be made by DDPOK if notice of eligibility termination is received from Plan Administrator more than thirty (30) days after such Covered Person's termination of eligibility under the Plan.

G. The Plan Administrator assumes the legal role as the program fiduciary. For purposes of this Agreement, DDPOK shall have the right to determine the amount of Benefits, if any, payable from

the Plan Administrator's funds on behalf of a Covered Person. Such determination shall be based on provisions of this Agreement, including Appendix A attached to and forming a part of this Agreement. Notwithstanding any claims decision by DDPOK, Plan Administrator shall have the absolute right to review any and all claims decisions (including both payment and denial of claims) and overrule any and all such decisions, on a case-by-case basis, in Plan Administrator's sole discretion in its role as fiduciary.

H. Claim and Appeal Processing and Procedures.

1. Emergency Care.

This Plan does not require any preauthorization for any Dental Services (including emergency care); however, said services are subject to the plan's specific Limitations, non-covered charges, deductibles, and co-payment amounts, as well as any charges over the plan maximum as defined in Appendix A.

2. Request for Predetermination of Benefits.

If the cost estimate of a dental procedure is more than Three Hundred Dollars ($300) and the treatment is not emergency care, the dentist can determine the treatment needed and submit a treatment plan to DDPOK for Predetermination of Benefits. This procedure will enable a Subscriber, dependent, or Beneficiary and the Dentist to know in advance of treatment what services are covered, how much of the cost will be paid by this Plan, and how much of the cost will be the responsibility of the Covered Person or Beneficiary.

Note: The Predetermination of Benefits is only an estimate and not a guarantee of payment. The patient must be eligible for Benefits at the time services are actually rendered, and the procedure must be a Covered Service on the date of service.

3. Filing a Claim.

Whether the Covered Person is treated by a Dentist who is a Delta Dental Participating Dentist, or is not a Delta Dental Participating Dentist, the filing forms and procedures shall be the same, as defined in the Claim and Appeal Procedure.

Once treatment is completed, the Covered Person or designated personnel in a dental office must complete the information portion of the claim form with the Subscriber's full name; Subscriber's social security number or, if applicable, unique identification number; the name and date of birth of the person receiving dental care; and the group name and number.

All claims must be submitted to Delta Dental Plan of Oklahoma at the assigned address.

The Plan is not obligated to pay any claim submitted later than twelve (12) months following the date of service.

Participants and Beneficiaries can obtain from DDPOK, without charge, the necessary claim filing forms.

4. Explanation of Benefits.

Once DDPOK has received the claim form, and all necessary information, a copy of an Explanation of Benefits will be sent to the Subscriber by DDPOK within a reasonable time, but no later than thirty (30) days after receipt of a claim. DDPOK may extend this time period one time up to fifteen (15) days, prior to the expiration of the thirty (30) day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Subscriber will be given forty-five (45) days from receipt of the notice within which to provide the necessary information.

Note: If the "Patient Pays" amount on an Explanation of Benefits (EOB) is zero dollars ($0.00), the EOB will not be mailed to the Subscriber unless DDPOK is requesting additional information to finalize the claim. An authorized person may obtain a copy of any applicable EOBs from DDPOK's online system.

5. Benefits, Limitations and Exclusions.

Under the Delta Dental participating agreements with Participating Dentists, benefit claims are reimbursed based on the lesser of the Dentist's submitted fee for his or her services or the maximum allowable amount for Participating Dentists. Participating Dentists accept the amount that Delta Dental determines to be the maximum allowable amount as payment in full. Covered Persons or Beneficiaries are responsible only for any non-covered charges, deductible and co-payment amounts, and any charges over the Plan Benefit Maximum. The Plan shall be the governing policy of all claims and appeals, which shall be administered in accordance with Appendix A.

Each Covered Person or Beneficiary, agrees to all benefit terms and conditions, Limitations and Exclusions, and other Plan benefit conditions as found herein and in Appendix A. Appendix A defines substantially all of the benefit claims, Limitations and Exclusions utilized in the ordinary course of business. In order to be apprised of the current, complete benefit Limitations and Exclusions for this Plan, please contact Delta Dental Plan of Oklahoma, Customer Service Department, P.O. Box 54709, Oklahoma City, Oklahoma 73154.

If a Covered Person obtains treatment from a Dentist who has not signed a participating agreement with Delta Dental, any benefit payment will be paid directly to the Subscriber, or to other participant if required by law, and will be based on the Dentist's submitted fee for his or her service or the Prevailing Fee, whichever is less. Each Covered Person is responsible for paying the Dentist and for filing their own claims.

All claims shall be evaluated, reviewed and paid in accordance with this Plan Agreement and Appendix A, subject to Plan Administrator's absolute right to review any and all claims decisions including both payment and denial of claims and overrule any and all such decisions, on a case-by-case basis, in Plan Administrator's sole discretion in its role as fiduciary.

All Deductibles, Maximum Benefit Payments, and covered classes of benefit services as applicable to this Plan Agreement are defined in Appendix A.

6. Appeal of Claim Determination.

   DDPOK, or a designee, shall have the right to resolve any questions concerning Dental Services or treatment which may arise hereunder and any such determination made in good faith shall be binding upon all parties, subject to legal recourse in a court of competent jurisdiction and/or Plan Administrator's right to review any and all claims decisions (including both payment and denial of claims) and overrule any and all such decisions, on a case-by-case basis, in Plan Administrator's sole discretion in its role as fiduciary. In the event of the Plan Administrator overruling the decision of DDPOK, or any other party, in the appeal process, the Plan Administrator will issue a written directive to DDPOK as to adjudication to be made by DDPOK. No action at suit of law or equity shall be commenced upon or under this Agreement until thirty (30) days after notice of claim has been given to DDPOK, nor shall action be brought at all later than three (3) years after such claim has arisen.

I. DDPOK shall have no liability under this Agreement for Benefits required to be paid from the Plan Administrator's funds. The Plan Administrator shall have no liability for Benefits required to be paid from DDPOK funds. It is agreed that the Benefits paid from the funds of the Plan Administrator and DDPOK are, and shall be, mutually exclusive.

J. Any notice required or permitted to be given by the Plan Administrator or DDPOK hereunder shall be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the Plan Administrator or DDPOK at the address listed below; such notice shall be deemed to be given when so personally delivered or three (3) days after having been placed in the United States mail, postage prepaid, return receipt requested. Any party shall have the right to designate a different address or agent for the receipt of notice by providing notice of such designation in the manner set forth herein.

   1. City of Broken Arrow
      Plan Administrator
      220 South First Street
      Broken Arrow, Oklahoma 74012

   2. Delta Dental Plan of Oklahoma, Inc.
      Mr. John E. Gladden
      President and Chief Executive Officer
      16 Northwest 63rd Street
      Oklahoma City, Oklahoma 73116-9115

K. During the term of this Agreement, any taxes or fees enacted and levied on DDPOK by the state or federal government with respect to administrative fees and/or claim payments charged pursuant to this agreement and/or Benefits provided may be passed on to the Plan Administrator, but will remain the liability of DDPOK.

L. A copy of any materials published or distributed by Plan Administrator concerning this Agreement and the Benefits hereunder shall be furnished to DDPOK.

M. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the Plan Administrator and DDPOK other than that of independent contractors.

N. All statements made by the Plan Administrator, DDPOK, or by an individual shall be deemed representations and not warranties. No such statement shall be used in defense to a claim under this Plan unless it is contained in a written application.

O. No agent or employee of DDPOK has the authority to change this Agreement or its provisions. This Plan may, at any time, be amended and changed by written agreement between legally authorized representatives of the Plan Administrator and DDPOK. Any such amendment shall be binding on all Eligible Persons and Eligible Dependents regardless of the date their coverage became effective under the Plan.

P. Neither party to this Agreement may transfer or assign its interest herein without the prior written consent of the other party, and any attempt to transfer or assign this Agreement without prior written consent of the other party shall automatically terminate all rights hereunder.

Q. The individuals who sign the Agreement are authorized to do so on behalf of Plan Administrator and DDPOK, respectively.

R. Any provision in this Agreement that, on its effective date, is in conflict with the statutes of the state of Oklahoma, or with the statutes of the state in which the Eligible Person or Eligible Dependent resides, is hereby amended to the minimum requirement of such statute. Any provision in this Agreement that would be invalidated by such statute(s) shall be deleted and the balance of the Agreement shall remain in full force and effect.

S. This Agreement shall be construed and enforced in accordance with the laws of the state of Oklahoma and any applicable federal laws. The site of this contract is the state of Oklahoma. Each party to this Agreement chooses the state of Oklahoma as its forum for any suit or other action that may be filed to enforce all or any part of this Agreement or for damages arising, directly or indirectly, from it.

T. Failure by the Plan Administrator or DDPOK to insist upon strict compliance with any term of this Agreement, or any applicable statutes, rules, or regulations, shall not constitute a waiver of such term, statute, rule, or regulation by the Plan Administrator or DDPOK.

U. This Agreement, including Appendix A attached to and forming a part hereof, constitutes the entire understanding between the parties hereto and no changes, amendments, or alterations shall be effective unless agreed to in writing by the party to this agreement affected by any such change, amendment, or alteration.

V. This Agreement shall be executed in multiple counterparts, each of which shall be deemed an original.

W. DDPOK shall maintain records of all transactions relating to this Agreement for the duration required by law. Such records shall remain accessible for audit by Plan Administrator's designated auditor. Any such audit by Plan Administrator's designated auditor shall be subject to the following provisions: (i) audits shall be conducted at DDPOK's corporate office, during DDPOK's regular business hours; (ii) audits shall be at Plan Administrator's sole expense; (iii) audits may be made upon not less than sixty (60) days prior notice to DDPOK, and not more often than once during any period of twelve months; (iv) audits shall consist solely of utilization and services generated for the Plan Administrator under the provisions of this Agreement; (v) no audit shall be for periods more than three (3) years prior to the date of such audit; and (vi) audits are subject to DDPOK audit requirements and federal, state, and/or local laws pertaining to participant-specific medical/dental record confidentiality requirements.

X. Should the Plan Sponsor fail to fund the account as described hereinabove, within seven (7) days of notification from DDPOK to the Plan Administrator of the amount necessary to properly fund the payments to cover the expenditures made on behalf of the Plan Sponsor, DDPOK shall be absolved of all liability to provide further administration of the group dental plan and shall be entitled to reimbursement with interest at the rate of ten percent (10%) for each month payment due is withheld. DDPOK shall have no obligation to pay such claims from its own funds.

Y. The Delta Dental Signature, consisting of the Delta Symbol and the Delta Dental Logotype, and the Delta Dental Product/Program Signatures are the exclusive property of Delta Dental. Plan Administrator and/or Plan Sponsor shall not utilize such Signatures in published material of any type without the express written consent of Delta Dental.

Section 6. Term and Termination

A. This Agreement shall remain in full force and effect through December 31, 2019, and shall continue thereafter from year to year, subject to the provisions of Section 6.B., Section 6.C., and/or Section 6.D. of this Agreement; provided, however, that either party hereto may terminate this Agreement by notice served upon the other party at least thirty (30) days prior to the anniversary date hereof. Anniversary date shall mean January 1, 2020, and January 1 of each subsequent year.

In the event DDPOK determines a change in the administrative fee, operating fund deposit, if applicable, benefit design, and/or other terms of this Agreement are necessary effective on the Anniversary Date, advice of such proposed changes must be given to the Plan Administrator, in writing, no less than ninety (90) days preceding the first and any subsequent Anniversary Date of this Agreement

B. This Agreement shall automatically terminate as of the earliest of the following dates:

1. The date on which the Plan Administrator shall not have made funds available for the payment of all Benefits required to be paid from its funds in accordance with this Agreement; or

2. The date on which the Plan Administrator discontinues payment of the monthly administrative fee.

C. If either party otherwise fails to observe or perform any of its obligations under this Agreement and if the failure continues for a period of thirty (30) days after written notice thereof to the defaulting party, then without prejudice to any other rights or remedies the other party may have, this Agreement will terminate as of the expiration date of the notice period.

D. Either party may immediately suspend all or any part of its obligations under this Agreement and/or immediately terminate this Agreement upon written notice if the other party becomes or is declared insolvent or bankrupt or becomes the subject of any proceedings related to its liquidation, insolvency, or for the appointment of a receiver or similar officer for it. Any such suspension of performance will not be a breach of this Agreement and will not affect the suspending party's right to pursue or enforce any rights under this Agreement or otherwise.

E. In the event of contract termination:

1. Adjudication and payment of claims incurred after midnight on the termination date shall be the sole responsibility of the Plan Administrator.

2. Adjudication and payment of claims incurred during the existence of this Agreement but received by DDPOK after the date of termination shall also be the responsibility of Plan Administrator. Upon separate agreement between DDPOK and Plan Administrator, which may take the form of a letter, e-mail, or facsimile, DDPOK shall continue adjudication and payment of claims incurred prior to the termination date of this Agreement and submitted to DDPOK within twelve (12) months following the termination date of this Agreement, subject to payment to DDPOK by the Plan Administrator as follows:

   a. Each month during the first three (3) months following termination of this Agreement, Plan Administrator shall reimburse DDPOK each month for claims paid. DDPOK will bill Plan Administrator the monthly claims paid by the tenth (10th) day of each month, and Plan Administrator shall remit payment for said claims paid to DDPOK within ten (10) days of receipt of such billing. No administrative fees shall accrue or be due from Plan Administrator for claims adjudicated by DDPOK during the first three (3) month period following the termination date of this Agreement.

   b. Commencing the first day of the fourth month following termination of this Agreement, Plan Administrator shall reimburse DDPOK each month for claims paid, plus an administrative fee equal to fifteen percent (15%) of paid claims for said month. DDPOK will bill Plan Administrator the monthly claims paid and any applicable administrative fee by the tenth (10th) day of each month, and Plan Administrator shall remit payment for said claims paid and administrative fee to DDPOK within ten (10) days of receipt of such billing.

   c. DDPOK shall have no further obligation or liability to adjudicate or pay claims under this provision should Plan Administrator fail to remit payment as provided herein.

3. In no event will claims be adjudicated or paid by DDPOK if received later than twelve (12) months following the termination date of this Agreement.

F. This Agreement supersedes any prior Agreement between the Plan Administrator and DDPOK and shall continue until termination; provided, however, the obligations of the parties shall survive termination to the extent necessary to effect the intent of the parties as herein expressed. No modification, amendment, or assignment of this Agreement shall be valid unless made in writing and executed by authorized officers of the Plan Administrator and DDPOK.

NOW, IN WITNESS HEREOF, Plan Sponsor and DDPOK have caused this Agreement to be executed, as evidenced by the affixing of their authorized signatures below.

AUTHORIZED SIGNATURES:

DELTA DENTAL PLAN OF OKLAHOMA

By: _____
Lan Miller
Vice President of Sales

October 24, 2018
Date of Signing

Attest: _____
Frank Turbeville
Chief Financial Officer

October 24, 2018
Date of Signing

CITY OF BROKEN ARROW:

I(we) hereby acknowledge receipt of the Administrative Services Agreement effective January 1, 2019, between Plan Sponsor/Plan Administrator and DDPOK, and Plan Sponsor's/Plan Administrator's agreement to the terms and conditions set forth therein.

By: _____

_____
Date of Signing

Attest: _____

_____
Date of Signing

Attachments: Appendix A

APPROVED AS TO FORM:
_____
ASSISTANT CITY ATTORNEY

APPENDIX A

CITY OF BROKEN ARROW
GROUP DENTAL PLAN

EFFECTIVE JANUARY 1, 2019

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SECTION 1 - SCHEDULE OF ELIGIBILITY

A. ELIGIBLE PERSON

1. Eligible Person is defined as a regular, common law Employee, as determined from the City of Broken Arrow's books and records on a basis precluding individual selection, who is regularly scheduled to work at least the minimum number of hours set by City of Broken Arrow at City of Broken Arrow's place of business or such other place or places as required by City of Broken Arrow. The minimum number of hours is currently set at thirty (30) hours per week, or one hundred thirty (130) hours per month.

   Persons not considered an Eligible Person include part-time employees regularly scheduled to work fewer than thirty (30) hours per week, temporary employees, collectively-bargained employees who are members of the International Association of Firefighters (IAFF), leased employees, and/or independent contractors.

2. The date the Employee becomes eligible for Benefits is the first of the month following thirty (30) days of continuous employment.

3. A person may not be simultaneously covered under the Plan as both an Employee and a Dependent of another Employee.

B. ELIGIBLE DEPENDENT

1. Eligible Dependent is defined as:

   a. The spouse to whom the Eligible Person is legally married, as defined by the state in which the Employee was legally married.

   b. The Eligible Person's natural (biological) child.

   c. The Eligible Person's child by legal adoption or placement for adoption, guardianship, or marriage (stepchildren).

   d. A child on whose behalf a Qualified Medical Child Support Order (QMCSO) has been issued.

   The term Eligible Dependent does not include any person who resides outside the United States, is in the armed forces of any country, or is a covered Employee or is already considered a Dependent of another covered Employee.

2. The limiting age for a Dependent child is:

   a. The date on which such child attains the age of twenty-six (26), except as hereafter set forth in Section 1.B.2.b. of this Appendix A.

   b. An Eligible Person's unmarried dependent child who is incapable of self-support because of a physical or mental incapacity that commenced prior to his or her reaching age twenty-six

(26) can continue to be covered under the Plan as a Dependent after reaching age twenty-six (26), provided he or she is chiefly dependent on the Eligible Person for support and a physician's certificate is received by the Plan Administrator within thirty-one (31) days after the date on which said dependent child's coverage would otherwise terminate due to said dependent child attaining the maximum age for dependent children coverage.

c. The Plan Administrator reserves the right to request verification of a Dependent child's age, and/or status as a disabled Dependent child, upon initial enrollment and from time to time thereafter as the Plan may require.

d. A person may not be simultaneously covered as a Dependent of more than one Employee.

C. EFFECTIVE DATE

1. If a person is an Eligible Person on the Plan Effective Date and their application for Employee Only or Family Coverage is received by the Plan Administrator at that time, the Effective Date is the Plan Effective Date.

2. If a person becomes an Eligible Person after the Plan Effective Date and their application for Employee Only or Family Coverage is received by the Plan Administrator within thirty (30) days of eligibility, the Effective Date is the first of the month following the date the person becomes eligible.

3. An Eligible Person can change from Employee Only coverage to Family Coverage if application is received by the Plan Administrator within thirty (30) days after acquiring an Eligible Dependent. The Effective Date for the Eligible Dependent will be the date the Eligible Dependent was acquired.

4. An Eligible Person with Family Coverage can add additional Eligible Dependents if application is received by the Plan Administrator within thirty (30) days after acquiring an Eligible Dependent. The Effective Date for the Eligible Dependent will be the date the Eligible Dependent was acquired.

5. A child under a Qualified Medical Child Support Order (QMCSO) may be added to an Eligible Person's coverage provided the Plan Administrator receives the Medical Child Support Order (MCSO) within thirty (30) days of the date it is issued and such MCSO is determined by the Plan Administrator to be a QMCSO. The Effective Date for such child will be the date ordered by the court.

6. An adopted child may be added to an Eligible Person's coverage provided application to add the child is received by the Plan Administrator within thirty (30) days of the date the child is placed in the Eligible Person's custody. The Effective Date for the child will be the date the Eligible Person assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child.

7. An Employee can change from Family Coverage to Employee Only coverage upon Eligible Dependent(s) acquiring coverage elsewhere. The change will be effective the first of the month next following the date such request is received by the Plan Administrator.

8. An Employee can change from Family Coverage to Employee Only coverage upon Eligible Dependent's loss of eligibility under this Plan. The change will be effective the first of the month next following the month in which Eligible Dependent's loss of eligibility occurs.

9. If an Eligible Person does not apply for Employee Only or Family Coverage within thirty (30) days of being first eligible to do so, or if an Eligible Person with Family Coverage does not apply to add an Eligible Dependent within thirty (30) days after acquiring the Eligible Dependent or, in the case of a QMCSO, within thirty (30) days after the date the order is issued, then the Eligible Person will not be allowed to enroll until the enrollment date for the next Benefit Period. The change will be effective the first day of the next Benefit Period.

D. COVERAGE UNDER A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

1. Upon receipt of a MCSO, the Plan Administrator will promptly notify the covered Employee and each child (alternate recipient) listed in the MCSO that the MCSO has been received and inform them of the procedures for determining if the order is a QMCSO. Such procedures shall be in writing and shall provide for the prompt notification of each alternate recipient specified in the MCSO as eligible to receive Benefits under the Plan of such procedures and shall permit each alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a MCSO.

2. The Plan Administrator will review the MCSO in accordance with the requirements of ERISA and any regulations issued concerning QMCSOs. If the order appears to be in compliance with those requirements, coverage of the alternate recipient will begin on the date ordered by the court. If the order does not appear to be in compliance, it will be returned to the court with a list of any deficiencies noted by the Plan Administrator. When a new or supplemental MCSO is received by the Plan Administrator correcting these deficiencies, coverage of the alternate recipient will be retroactive to the date ordered by the court.

3. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a QMCSO and notify the covered Employee and each alternate recipient of such determination.

4. A child who is an alternate recipient under a QMCSO shall be considered a Covered Person under the Plan for the purposes of any provision of ERISA, if applicable. Any payment of Benefits made by the Plan for expenses incurred by an alternate recipient shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

5. Subject to the Continuation Coverage provisions of this Plan, coverage for an alternate recipient will terminate on the earliest to occur of the following:

   a. The date the covered Employee's coverage ends;

   b. The date the QMCSO is no longer in effect;

   c. The date the covered Employee obtains other comparable health coverage through another dental plan to cover the alternate recipient;

d. The date City of Broken Arrow eliminates Family Coverage for all of its Employees under all of its Plans.

E. CONTINUATION COVERAGE (COBRA)

1. Eligibility for Continuation Coverage

When a Qualifying Event occurs, eligibility under this Plan shall continue for the Eligible Person and/or his or her Eligible Dependents who were covered on the date of the Qualifying Event, provided the Eligible Person or Eligible Dependent elects Continuation Coverage within sixty (60) days after the later to occur of (1) the date the Qualifying Event would cause him or her to lose coverage, or (2) the date City of Broken Arrow notifies the Eligible Person or Eligible Dependent of his or her Continuation Coverage rights; and provided the required contributions are submitted. Such Continuation Coverage shall not exceed:

a. Eighteen (18) months from the date of a Qualifying Event involving the termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment; or

b. Thirty-six (36) months from the date of a Qualifying Event involving the Employee's death, divorce or legal separation, or entitlement to Medicare Benefits; or the ineligibility of the Employee's Dependent child.

2. COBRA participants are required to pay the entire cost for their coverage, including administration costs if applicable.

3. Disability Extension

Continuation Coverage may be extended from eighteen (18) months to twenty-nine (29) months for persons who are determined by the Social Security Administration to have been disabled on the date of a Qualifying Event involving the Employee's termination of employment or reduction in working hours. The person must give notice of the disability determination to City of Broken Arrow before the end of the initial 18-month Continuation Coverage period, and no later than sixty (60) days after the date of the Social Security Administration's determination. In addition, the person must notify City of Broken Arrow within thirty (30) days after the Social Security Administration makes a determination that he or she is no longer disabled.

4. Notification of Continuation Coverage

a. The Eligible Person or Eligible Dependent must notify the Plan Administrator within 60 days from the date of the Qualifying Event of their eligibility for Continuation Coverage.

b. City of Broken Arrow or its designated agent shall, within forty-four (44) days after receiving notification from the Eligible Person or Eligible Dependent that a Qualifying Event has occurred, notify the Eligible Person and/or Eligible Dependent of his or her right to elect Continuation Coverage.

c. In the event an Eligible Person or Eligible Dependent elects Continuation Coverage after the Qualifying Event, City of Broken Arrow shall permit payment of dues for such Continuation Coverage during the period preceding the election to be made within forty-five (45) days of the date of the election.

5. Maximum Continuation Period for Dependents

In no event will a Dependent be entitled to continue coverage under the Plan under this Continuation Coverage provision for more than thirty-six (36) months from the date of the event that first entitled him or her to Continuation Coverage.

F. TERMINATION OF ELIGIBILITY AND/OR COVERAGE

1. When a covered Employee ceases to be an Eligible Person, coverage for such Employee, and his or her covered Dependents, will terminate at 11:59:59 P.M. (CT) of the last day of the month in which such Employee ceases to be an Eligible Person. When a covered Eligible Dependent ceases to be an Eligible Dependent, coverage for such person will terminate at 11:59:59 P.M. (CT) of the last day of the month in which such person ceases to be an Eligible Dependent.

2. In the case of a person covered under the Continuation Coverage provisions of the Plan, coverage shall cease on the earliest to occur of the following dates:

   a. The date the coverage period ends following expiration of the 18-month, 29-month, or 36-month Continuation Coverage period, whichever is applicable;

   b. The first day of the month that begins more than thirty (30) days after the date of the Social Security Administration's final determination that the person is no longer disabled (when coverage has been extended from eighteen [18] months to twenty-nine [29] months due to disability);

   c. The date on which City of Broken Arrow ceases to provide any group dental plan to any Employee;

   d. The date on which coverage ceases because of a person's failure to make timely payment to City of Broken Arrow of any dues required for the Continuation Coverage;

   e. The date on which the person becomes covered under any other group dental plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to that person;

   f. The date on which the person becomes entitled to Benefits under Medicare;

   g. On the last day of the month for which the last payment has been made if the Plan Administrator fails to make payment to DDPOK;

   h. On the last day of the month in which this Plan is terminated or canceled.

3. Termination of the Plan automatically terminates all Covered Persons' coverage at the same time and date.

SECTION 2 - SCHEDULE OF BENEFITS

Subject to the Exclusions, Limitations, and conditions of the Plan, a Covered Person is entitled to Benefits for Covered Services described in the Covered Dental Services section in the amounts as specified in this Schedule of Benefits.

BENEFIT PERIOD: January 1 – December 31 each year

COVERED SERVICES:

	PERCENTAGE OF ALLOWABLE CHARGE*		
	PPO Network	Premier Network	Out-of-Network
Class I Services—Diagnostic and Preventive	80%	80%	80%
Class II Services—Basic	80%	80%	80%
Class III Services—Major Restorative	80%	80%	80%
Class IV Services—Orthodontic	80%	80%	80%

* Payment of the percentages above is subject to any applicable Deductible and Maximum Benefit Payment limitation.

Note: The Allowable Charge for a Covered Service may be less if treatment is provided by a Nonparticipating Dentist. To prevent unexpected out-of-pocket expenses, Predetermination of Benefits is strongly encouraged, particularly if the cost of treatment is to exceed $250.

DEDUCTIBLE:

	PPO Network	Premier Network	Out-of-Network
Class I Services—Diagnostic and Preventive	N/A	N/A	N/A
Class II Services—Basic	$25	$25	$25
Class III Services—Major Restorative	$25	$25	$25
Class IV Services—Orthodontic	$25	$25	$25

*The $25 deductible applies to each Covered Person each Benefit Year and may be met in Class II, Class III, or Class IV Covered Services, or any combination of Class II, Class III, and Class IV Covered Services.

MAXIMUM BENEFIT PAYMENTS:

Classes I, II, III and IV Services Combined ..... $2,500 Per Covered Person Per Benefit Period

SECTION 3 - COVERED DENTAL SERVICES

Subject to the Exclusions, Limitations, and conditions of the Plan, a Covered Person is entitled to Benefits for the following Covered Services in the amounts specified in the Schedule of Benefits.

A. CLASS I SERVICES

1. **Diagnostic Services**: Dental procedures performed by properly licensed Dentists in evaluating existing conditions to determine the required dental treatment. By way of description, such Covered Services include: Oral evaluations (examinations) and radiographic images (x-rays).

2. **Preventive Services**: Dental procedures performed by properly licensed Dentists to prevent the occurrence of dental disease. By way of description, such Covered Services include: Routine prophylaxis (cleaning), topical application of fluoride, and space maintainers; and limited sealants for eligible dependent children.

B. CLASS II SERVICES

1. **Basic Restorative Services**: Dental procedures performed by properly licensed Dentists in the treatment of carious lesions (decay/cavity). By way of description, such Covered Services include: Amalgam and composite restorations (fillings).

2. **Oral Surgery Services**: Dental procedures performed by properly licensed Dentists for extractions and other oral surgery, including preoperative and postoperative care.

3. **Endodontic Services**: Dental procedures performed by properly licensed Dentists for the treatment of non-vital teeth. By way of description, such Covered Services include: Pulpal therapy and root canal filling.

4. **Periodontic Services**: Dental procedures performed by properly licensed Dentists for the treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance procedures following active treatment.

5. **Adjunctive General Services**: By way of description, such Covered Services include: General anesthesia performed by properly licensed Dentists in the dental office in conjunction with covered oral surgery procedures.

6. **Other Services**: By way of description, such Covered Services include: Re-cement fixed partial denture (bridge), and adjustments to complete denture provided at least six (6) months has elapsed from the installation date of such complete denture.

C. **CLASS III SERVICES**

1. **Major Services:** Provides porcelain or cast restorations for the treatment of carious lesions (decay/cavity) when teeth cannot be restored with another filling material. By way of description, such Covered Services include: Single crowns, inlays, onlays, and veneers if not for cosmetic purposes.

2. **Prosthodontic Services:** Dental procedures for construction of fixed partial dentures (bridges), removable partial dentures, complete dentures, and/or repair of an existing prosthodontic device.

3. **Implant Services:** Procedures for implant placement, implant-supported prosthetics, and maintenance and repair of implants and implant-supported prosthetics.

C. **CLASS IV SERVICES**

By way of description, covered services include the necessary treatment and procedures required for the correction of malposed teeth, including limited, interceptive, and/or comprehensive orthodontic treatment; preliminary study including radiographic images, diagnostic casts, treatment plan, and retention appliance; and fixed or cemented appliance for tooth guidance or to control harmful habits.

SECTION 4 - LIMITATIONS AND EXCLUSIONS

A. **LIMITATIONS:** The Benefits to be provided to Eligible Persons and Eligible Dependents under this Plan shall be limited as follows:

1. For purposes of this Plan, any procedure frequency limitation shall be measured in a period of continuous calendar-year months referred to as a consecutive-month period, which begins on the date of service for which the procedure was last paid.

2. Bitewing radiographic images are a benefit once in a twelve (12) consecutive month period.

3. Full-mouth radiographic images, a panoramic radiographic image, or multiple same-day radiographic images are a benefit once in a thirty-six (36) consecutive month period unless necessary for the diagnosis and treatment of a specific disease or injury.

4. Topical application of fluoride solutions is a benefit twice in a twelve (12) consecutive month period.

5. A space maintainer is a benefit, limited to non-orthodontic purposes.

6. Sealants are a benefit for persons less than age fourteen (14), limited to permanent first and second molar teeth free of caries and restorations on the occlusal surfaces. Sealants are a benefit once per tooth in a thirty-six (36) consecutive month period.

7. Anesthesia: General anesthesia/IV sedation is a benefit only when administered by a properly licensed Dentist in a dental office in conjunction with oral surgical procedures (D7000-D7999) when covered. Otherwise, the fee for general anesthesia/IV sedation is denied. The fee for general anesthesia/IV sedation is denied when billed by anyone other than a licensed Dentist.

8. Prosthodontics: A complete denture, a removable partial denture, or a fixed partial denture (bridge) involving replacement of teeth extracted before the patient was covered under this Plan is not a benefit unless such denture also replaces a tooth that is extracted while the patient is covered, and such tooth is an abutment for a fixed or removable denture installed during the preceding five (5) years.

9. Orthodontic Benefits:

   Comprehensive Treatment

   a. Benefits are available to the Employee, the Employee's spouse, and the Employee's eligible dependent children under the age of twenty-six (26).

   b. Benefits for comprehensive orthodontic treatment or services will be allowed only if such eligible person's comprehensive orthodontic treatment commences on or after his or her effective date of orthodontic coverage under the Plan, or if comprehensive orthodontic treatment is active and ongoing on the patient's effective date of orthodontic coverage under the Plan.

c. Benefits for comprehensive orthodontic treatment are limited to periodic payments for services performed, including a lump-sum down-payment equal to up to one-third (1/3) of the total treatment plan or the maximum allowable amount, whichever is less, and monthly installments of the remaining amount, subject to any applicable deductible and the maximum benefit payment.

d. The obligation of the Plan to make periodic payments for covered comprehensive orthodontic services shall cease upon termination of treatment for any reason prior to completion of the case, including but not limited to termination of the treatment plan by the Dentist.

e. The Plan's obligation to make periodic payments for covered comprehensive orthodontic services shall cease on the last day of the month in which patient becomes ineligible for coverage under this Plan; treatment is terminated for any reason before completion of the treatment plan; the treatment plan is completed; the maximum orthodontic benefit has been paid; orthodontic benefits are discontinued under the Plan; or the Plan Agreement is terminated, whichever occurs first.

f. Comprehensive orthodontic treatment must be provided by a licensed dentist.

Limited or Interceptive Treatment

a. Benefits are available to Benefits are available to the Employee, the Employee's spouse, and the Employee's eligible dependent children under the age of twenty-six (26).

b. Benefits for limited or interceptive orthodontic treatment or services will be allowed if an eligible person's limited or interceptive orthodontic treatment commences on or after his or her effective date of orthodontic coverage under the Plan.

c. Benefits are limited to a one-time payment for limited or interceptive orthodontic services performed.

d. The obligation of the Plan to make payment for covered limited or interceptive orthodontic services shall cease upon termination of treatment for any reason prior to completion of the case, including but not limited to termination of the treatment plan by the Dentist.

e. The Plan's obligation to make payment for covered limited or interceptive orthodontic services shall cease on the last day of the month in which patient becomes ineligible for coverage under this Plan; treatment is terminated for any reason before completion of the treatment plan; the treatment plan is completed; the maximum orthodontic benefit has been paid; orthodontic benefits are discontinued under the Plan; or the Plan Agreement is terminated, whichever occurs first.

f. Limited or interceptive orthodontic treatment must be provided by a licensed dentist.

10. To be eligible for Benefits, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not Covered Services. The dental plan is designed to assist Covered Persons in maintaining dental health.

2. Benefits or services available from any federal or state government agency, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.

3. Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.

4. Benefits for services or appliances started prior to the date the patient became eligible under the Plan may be excluded.

5. Benefits for services when a claim is received for payment more than twelve (12) months after the date of service.

6. Charges for any professional services performed by a member of patient's immediate family or a person residing in the patient's household.

7. Charges for treatment by other than a properly licensed Dentist (unless allowed by state law), except radiographic images (x-rays) ordered by a dentist, cleaning and scaling of teeth, and topical application of fluoride may be performed by a properly licensed hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.

8. Charges for completion of forms or submission of supportive documentation required by DDPOK for a Benefit determination.

9. Charges for house or hospital calls; office visits; missed or cancelled appointments; hospitalization or additional fees charged for hospital treatment; management fees;, bleaching of teeth; or telephone, email, or on-line consultations with Dentist.

10. Prescription drugs, pre-medications, and relative analgesia.

11. Experimental procedures.

12. Charges for occlusal guards.

13. Benefits or services for orthodontic treatment, except as specifically provided within this Appendix A.

14. Charges for replacement of lost or missing crowns or appliances, or for replacement of stolen appliances.

15. Benefits or services to correct congenital or developmental malformations, including, but not limited to, congenitally-missing teeth and cleft palate.

16. Services for the purpose of improving appearance when form and function are satisfactory and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).

17. Restorations for altering occlusion (bite), involving vertical dimensions, replacing tooth structure lost by attrition (grinding of teeth), erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting.

18. Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).

19. All other Benefits and services not specified in this Appendix A or by the Plan Administrator.

SECTION 5 - COORDINATION OF BENEFITS (COB)

If an Eligible Person or Eligible Dependent is covered for Dental Services or Benefits by another third party provider's contract, arrangement, or insurance carrier, the Plan's liability for payment will be determined as follows:

A. A plan with no rules for coordination with other Benefits will be deemed to pay its Benefits before a plan that contains such rules.

B. A Plan that covers the person as a Dependent of a person whose birthday comes first in a Calendar Year will be primary to the Plan that covers the person as a Dependent of a person whose birthday comes later in that Calendar Year. If a Plan does not have this provision regarding birthdays, the rule set forth in that Plan will determine the order of Benefits.

C. If the person for whom claim is made is a Dependent child and the parents are separated or divorced:

1. If there is a court decree which would establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the Benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the Benefits of any other Plan which covers the child as a Dependent child.

2. If there is not a court decree which would establish financial responsibility for the medical, dental, or other health care expenses with respect to the child:

   a. If the custodial parent has not remarried, the Benefits of a Plan which covers the child as a Dependent of the custodial parent will be determined before the Benefits of a Plan which covers the child as a Dependent of the noncustodial parent.

   b. If the custodial parent has remarried, the Benefits of a Plan that covers the child as a Dependent of the custodial parent shall be determined before the Benefits of a Plan which covers that child as a Dependent of the stepparent or the noncustodial parent. The Benefits of a Plan which covers that child as a Dependent of the stepparent will be determined before the Benefits of a Plan which covers that child as a Dependent of the noncustodial parent.

D. If A., B., C., and/or D. above do not establish an order of payment, the Plan under which the person has been covered for the longest period of time will be deemed to pay its Benefits first, except that:

1. The Benefits of a Plan that covers the person as a laid-off or retired Employee, or as a Dependent of such person, pays after the contract which covers such person as other than a laid-off or retired Employee, or a Dependent of such person.

2. The Benefits of a plan that covers the person as a laid-off or retired Employee, or as a Dependent of such person, pays after the contract which covers such person as other than a laid-off or retired Employee, or a Dependent of such person.

3. If either plan does not have a provision regarding laid-off or retired Employees and, as a result, each plan determined its Benefits after the other, the paragraph immediately preceding will not apply.

SECTION 6 - GENERAL PROVISIONS

A. COVERED PERSON/DENTIST RELATIONSHIP

1. The choice of a Dentist is solely the Covered Person's.

2. The Plan does not hereby undertake to provide a Dentist to the Eligible Person or Eligible Dependent. Nothing contained in this Plan Agreement shall be construed as obligating the Plan to render Dental Services; its obligation being to make payment for Covered Services received by Covered Persons.

3. The use or nonuse of an adjective such as "Participating" or "Nonparticipating" in modifying the term "Dentist" is not a statement or warranty as to the professional competency or the ability of the Dentist.

4. The Plan has no responsibility for a Dentist's failure or refusal to render services to a Covered Person.

B. BENEFITS TO WHICH COVERED PERSONS ARE ENTITLED

1. The liability of the Plan is limited to the Benefits for Covered Services specified in this Appendix A.

2. No person other than a Covered Person is entitled to receive Benefits under this Plan. Any right to Benefits and coverage is not transferable.

C. AMENDMENT, ALTERATION, OR TERMINATION OF THE PLAN

1. The Plan, or any specific Benefit under the Plan, in whole or in part, may be terminated, suspended, withdrawn, amended, or modified by agreement between Plan Administrator and DDPOK. Any such termination, suspension, withdrawal, amendment, or modification shall be binding on all Covered Persons regardless of the date their coverage became effective. The Plan Administrator does not promise the continuation of any dental Benefits nor does it promise any specific level of Benefits at or during retirement.

2. All statements made by the Plan Administrator, DDPOK, or by an individual shall be deemed representations and not warranties. No such statement shall be used in defense to a claim under this Plan unless it is contained in a written application.

3. No agent or employee of Delta Dental has the authority to change the Plan or its provisions. No change in the Plan shall be valid unless approved by the Plan Administrator and DDPOK.

D. PAYMENT OF BENEFITS

1. DDPOK is authorized by the Plan and the Covered Person to make payments directly to Dentists furnishing services for which Benefits are provided. However, DDPOK reserves the right to make payments directly to the Covered Person.

2. Once Covered Services are rendered by a Dentist, DDPOK will not honor Covered Persons' requests not to pay the claims submitted by the Dentist. DDPOK will have no liability to any person because of its rejection of the request.

3. Anytime an Eligible Person or Dentist files a claim, the Eligible Person will receive a form called an Explanation of Benefits (EOB) from DDPOK within a reasonable time, but no later than thirty (30) days after receipt of a claim. DDPOK may extend this time period one time up to fifteen (15) days, prior to the expiration of the thirty (30) day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Eligible Person will be given forty-five (45) days from receipt of the notice within which to provide the necessary information.

4. DDPOK will make payment of that portion of the fee for which the Plan is liable in accordance with this Appendix A and such uniform policies and procedures as are deemed proper by the Board of Directors of DDPOK and the Plan Administrator. Payment for Covered Services shall be as follows:

    a. If a Delta Dental PPO Participating Dentist provides covered treatment, the Plan will pay its Benefits to the Dentist at the applicable Percentage of the Allowable Charge specified in the Schedule of Benefits in this Appendix A. Such payment of Benefits shall be based on the Dentist's submitted fee for his or her service or the maximum allowable amount for Delta Dental PPO Participating Dentists, whichever is less. Payment of Benefits will be subject to any applicable Covered Person's Co-payment, Deductible, and/or Maximum Benefit Payment. The Plan's payment, together with the Covered Person's portion of the fee required, shall discharge the claim of a Delta Dental PPO Participating Dentist.

    b. If a Delta Dental Premier Participating Dentist provides covered treatment, the Plan will pay its Benefits to the Dentist at the applicable Percentage of the Allowable Charge specified in the Schedule of Benefits in this Appendix A. Such payment of Benefits shall be based on the Dentist's submitted fee for his or her service or the maximum allowable amount for Delta Dental Premier Participating Dentists, whichever is less. Payment of Benefits will be subject to any applicable Covered Person's Co-payment, Deductible, and/or Maximum Benefit Payment. The Plan's payment, together with the Covered Person's portion of the fee required, shall discharge the claim of a Delta Dental Premier Participating Dentist.

    c. If Covered Services are provided by a Dentist who has not signed a participating agreement with Delta Dental, the Plan will pay its Benefits directly to the Eligible Person, or to other participant or Beneficiary as required by law, at the applicable Percentage of the Allowable Charge specified in the Schedule of Benefits in this Appendix A. Such payment of Benefits shall be based on the Dentist's submitted fee for his or her service or the Prevailing Fee, whichever is less. The Eligible Person shall be responsible for paying the Nonparticipating Dentist both the payment received from the Plan and any portion of the Nonparticipating Dentist's fee not discharged by such payment.

5. State courts can rule that Benefits may be paid to someone other than the Eligible Person or the Eligible Person's named Beneficiary, according to a Qualified Domestic Relations Order (QDRO). The QDRO must relate to child support, alimony payment or marital property rights.

   In the event of a Participant receiving a QDRO, the Participant must obtain a copy of the Medical Support Notice form, supplied by either Plan Administrator or DDPOK. This Notice form, with a copy of the QDRO, must be submitted to the Plan Administrator. The Plan Administrator shall take the necessary steps to ensure compliance with said QDRO.

6. DDPOK or its designee shall have the right to resolve any questions concerning Dental Services or treatment which may arise under the Plan and any such determination made in good faith shall be binding upon all parties, unless within one hundred eighty (180) days after receipt of a notice of denial, an Eligible Person or Dentist may make a written request for review of such denial by addressing the request to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154, or Appeals@DeltaDentalOK.org, stating the reason(s) re-evaluation of the denial is being requested. The Eligible Person or Dentist may submit written comments, documents, records, and other information relating to the claim for Benefits. An Eligible Person may request reasonable access to and, at no charge, copies of all documents, records, and other information relevant to his or her claim for Benefits. All requests for review of denials shall be made taking into account all comments, documents, records, and other information submitted by the Eligible Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

   DDPOK shall make a full and fair review of each request for re-evaluation and may require additional documents as it deems necessary or desirable in making such a review. The Eligible Person shall receive a decision on his or her initial request for a review, in writing, within thirty (30) days after DDPOK receives the request.

   If the Eligible Person wishes to have the initial review determination appealed further, the Eligible Person must make a written request for a second review of the denial by addressing the request to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154, or Appeals@DeltaDentalOK.org, stating the reason(s) re-evaluation of the denial is being requested. The Eligible Person shall receive a decision on his or her second request for a review, in writing, within thirty (30) days after DDPOK receives the second request.

E. RELEASE OF INFORMATION

In consideration of waiving physical examination of an Eligible Person or Eligible Dependent and as a condition precedent to the approval of claims hereunder, DDPOK shall be entitled to receive from any attending or examining Dentist, or from any facility in which a Dentist's care is rendered, such information and records relating to attendance to or examination of any Covered Person required in the administration of such claim, provided, however, that DDPOK shall, in every case, preserve the confidentiality of such information except as is necessary for the proper administration

F. POWERS OF PLAN ADMINISTRATOR

1. If any section, word, term, or phrase in the Plan is deemed to be ambiguous, it shall be the responsibility of the Plan Administrator to define same.

2. If any provision in the Plan is, on its effective date, in conflict with the statutes of the state in which the Covered Person resides, it is hereby agreed by the Plan Administrator that the intent is for the provision to be amended to the minimum requirement of such statute.

3. Plan Administrator assumes the legal role as the Plan's fiduciary. For purposes of the Plan, DDPOK shall have the right to determine the amount of Benefits, if any, payable from the Plan's funds on behalf of a Covered Person. Such determination shall be based on provisions of the Plan. Notwithstanding any claims decision by DDPOK, the Plan Administrator shall have the absolute right to review any and all claims decisions (including both payment and denial of claims) and overrule any and all such decisions, on a case-by-case basis, in Plan Administrator's sole discretion as the Plan fiduciary.