DELTA DENTAL

ENROLLMENT AGREEMENT

EXHIBIT "A"

Delta Dental of Missouri ("DDMO") and City of Joplin ("Company" or "Group") agree as follows.

1. Benefits - Commencing with the Effective Date, DDMO will furnish benefits for dental care to eligible and enrolled employees of Company and, if applicable, their eligible and enrolled dependents in accordance with the Group Membership Certificate, the applicable Schedule of Benefits, and the Summary Plan Description issued by DDMO for Group from time to time (all of which are made a part of this Agreement), provided that applicable dues have been paid. Copies of the Group Membership Certificate, the Schedule of Benefits, and Summary Plan Description in effect on the Effective Date are attached to this Agreement.

2. **Group Members, Dues and Member Communications –**
   (a) Company, as sponsor for the group health plan, will give each eligible employee an opportunity to enroll and become a DDMO member, and will remit to DDMO the applicable dues. The Company may enter into agreements related to business divestitures that allow employees affected by a divestiture to remain enrolled in Company benefit plans after termination of employment by the Company. In such an event, the Company will continue to remit to DDMO applicable dues for affected individuals for the period of time specified in such an agreement, and such individuals will be encompassed in the term "employees" as used herein.
   (b) On behalf of its enrolled employees and their dependents, Company will receive certain documents and notices from DDMO (e.g., individual certificate of coverage, privacy notices), and agrees to provide such documents and notices to the enrolled employees and their dependents in accordance with applicable law and the direction of DDMO. Company will indemnify, defend and hold harmless DDMO from and against any losses, penalties, damages or injuries (including reasonable attorneys' fees) that DDMO sustains as a result of Company's failure to comply with this Section 2(b).

3. **Enrollment Conditions –**
   (a) Company certifies that, as of the Effective Date, it has 500 eligible employees.
   (b) Company agrees that at least 93 % of its eligible employees as of the Effective Date and 0 % of such employees' eligible dependents must be enrolled under this Agreement as DDMO members.
   (c) If the number of DDMO members participating under this Agreement is ever less than that required in Section 3(b) above, DDMO may terminate this Agreement by giving written notice of termination to Company or change the dues by giving at least 31 days' written notice to Company, which shall be effective as of the date specified by DDMO in the notice.
   (d) DDMO enrollment regulations in force from time to time shall apply to this Agreement and to Company's memberships hereunder. Such regulations may be waived by DDMO signing an attachment to this Agreement. Unless so waived, these regulations are incorporated herein by this reference.

4. **Termination –** Either party may terminate this Agreement on an anniversary of the Renewal Date or after the Initial Term in accordance with Section 9. Termination of this Agreement for any reason terminates the DDMO membership hereunder of the enrolled employees of Company (and their enrolled dependents). Termination of a business unit or portion of a business unit of the Company due to a business divestiture does not constitute termination of this Agreement, except as otherwise set forth therein.

5. **Data on Members -** Company will furnish DDMO with all data necessary to the determination of dues, payment of benefits, or administration of any provisions of this Agreement, the Group Membership Certificate, the applicable Schedule of Benefits, and the Summary Plan Description. Such data includes names, age and sex, dates of eligibility and termination, and any other relevant information DDMO requests.

6. **Inadvertent Error** - Inadvertent or clerical error by either Company or DDMO shall not prejudice any person's coverage. However, if any such error is discovered to have resulted in reduction or non-payment of dues which should otherwise have been payable, Company shall remit such dues. Conversely, if such error is found to have resulted in an overpayment, DDMO shall refund such overpayment.

7. **Dues** - All dues and service charges shall be due and payable in advance. The initial charges must be paid on or before January 1, 2021. Dues and service charges may be paid within a grace period of 31 days from the due date of each payment after the initial payment.

   DDMO may change the dues by giving 31 days' written notice to Company. Such change shall only be effective on the Renewal Date of this Agreement or any anniversary of the Renewal Date, unless the change is the result of a change in the number of members as provided in Section 3(c) above, or a change in benefits required by state or federal law or any change in the interpretation of state or federal law.

8. **Effective Date and Renewal Date** - For the purpose of carrying out the provisions of this Agreement, the effective date January 1, 2021 ("Effective Date") and the renewal date is January 1, 2023 ("Renewal Date").

9. **Term** - This Agreement shall continue in force for a period of 24 months beginning with the Effective Date (the "Initial Term"). After the Initial Term, it will automatically renew for successive terms of one year each commencing on the Renewal Date and each anniversary of the Renewal Date unless not later than 31 days prior to the end of the then-current term either party notifies the other party that this Agreement will not renew, in which event this Agreement will expire on the last day of the then-current term. This Agreement replaces any prior agreement between Company and DDMO.

10. **Status** – DDMO may provide enrollment and disenrollment information to the "Plan Sponsor" (within the meaning of 45 CFR 164.103) or a "Business Associate" (within the meaning of 45 CFR 160.103) of the Plan. The Company certifies that it is the "Plan Sponsor" for the group health plan which includes the dental benefits provided hereunder ("Plan"). The Company agrees that it will have and maintain a fully-executed Business Associate Agreement with any "producer" or "agent of record" designated by the Company for the Plan ("Broker") that provides services for or on behalf of the Plan, and will promptly notify DDMO, in writing, of such designated person and any changes thereto. The Company will provide a copy of such fully- executed Business Associate Agreement to DDMO, upon its request. The Company authorizes to DDMO to disclose to the Broker information and data concerning the Plan's dental benefits and claims, participation in the Plan, enrollment in or disenrollment from the Plan and other information relating to the Plan.

11. **Acceptance By Company** - The Company shall, and is hereby deemed to, accept and be bound by this Agreement by payment of the Company's dues or by the signature of an authorized Company officer below.

City of Joplin	Delta Dental of Missouri
Company	
Authorized Officer	Authorized Officer
	President and CEO
Title	Title
Date of Signing	Date of Signing

DELTA DENTAL

GROUP DATA FORM – FULLY INSURED

☑ Dental ☐ Vision ☐ Both

☑ New Group ☐ Change ☐ New Add

Legal Name of Group (Group Sponsor) City of Joplin Phone #: (417)624-0820

Address: 602 S. Main St. City: Joplin State: MO Zip: 64801

Tax ID #: _____ Plan's Fiscal Year End: 12/31 Plan # (3 digit, assigned by plan sponsor): _____ SIC Code: 9121

	Name & Title	Address, if different	Phone #	E-mail Address
Plan Administrator				
Billing Contact				
Trustee				
Agent of Legal Service				

Effective Date: January 1, 2021

Eligibility provision, choose one:

☐ Coverage begins on the 1st of the month following _____ days of employment. Coverage ends on the last day of the month.

☐ Coverage begins on the date of employment. Coverage ends on the day employment terminates.

☐ Coverage begins on the day following _____ days of employment. Coverage ends on the day employment terminates.

☐ Other (explain): _____

Dependent children, choose one:

☐ Dependent children covered from birth to the end of the month in which they turn age 26.

☐ Other _____

Coverage Available for Domestic Partners: ☐ Yes ☐ No

Applicable employees working _____ hours per week are eligible for coverage.

Dental (if applicable):

Company agrees to contribute _____% of the employee dues and _____% of the dependent dues.

Company agrees that at least _____% of eligible employees and _____% of eligible dependents must be enrolled.

Prior coverage: ☐ Yes ☐ No If yes, name of carrier: _____

If applicable, Company currently has _____ eligible participants (_____%) **literate in the same non-English language**.

What language(s) _____.

Vision (if applicable):

Company agrees to contribute _____% of the employee dues and _____% of the dependent dues.

Prior coverage: ☐ Yes ☐ No If yes, name of carrier: _____

Invoice Type, choose one: ☐ Preferred option - Electronic retrieval – On-Line Access ☐ Paper invoice mailed

Does the invoice need to be separated by division, class, or location? ☐ Yes ☐ No If yes, please **submit** division listing with your enrollment.

AGENT/AGENCY INFORMATION

Legal Agency Name: Segal **Tax ID:** _____

Business Address: 101 N. Wacker Dr. Suite 500

City: Chicago **State:** IL **Zip:** 60606

Agent Name: John Hardy **Agent License #:** _____

Agent Phone: (312)984-8651 **Agent Email:** jhardy@segalco.com

Agent/Agency Commission: Dental 0 **%** **Vision** _____ **%**

TPA Name: _____ **TPA Admin Fee %:** _____ **TPA Tax ID:** _____

GA Name: _____ **GA Admin Fee %:** _____ **GA Tax ID:** _____

If applicable, attach the following documents:

Rates and benefit plan(s) agreed upon.

A copy of your current schedule of benefits/SPD outlining prior coverage, coinsurance, deductibles, maximums, and benefit period.

A check for the initial monthly dues must accompany this application. (If after the 10th of the month of coverage, two month's premium is required.)

Standard delivery for contracting documents to Plan Sponsor for distribution will be electronic.

GROUP SPONSOR: I VERIFY THAT THE PRECEDING INFORMATION IS CORRECT.

_____ _____

Signature and Title Date

The contract becomes valid and effective only after Delta Dental has accepted and returned a fully executed contract to the group sponsor. Any misrepresentation of submitted data may cause the contract to be declared null and void by Delta Dental.

DELTA DENTAL
THIRD PARTY DISCLOSURE ACKNOWLEDGEMENT

City of Joplin ("Plan Sponsor") and Delta Dental of Missouri ("Delta Dental") entered into a contract ("Enrollment Agreement") under which Delta Dental provides either prepaid dental benefits or administrative services in connection with Plan Sponsor's employee welfare benefit plan ("Plan"). Plan Sponsor has retained Segal ("Vendor") for purposes of providing certain services ("Services") in connection with its Plan.

In connection with such Services, Plan Sponsor requests that Delta Dental disclose to Vendor certain information concerning Delta Dental, its business, networks or operations, the Plan's dental benefits, participation in the Plan, enrollment in or disenrollment from the Plan and other matters that Delta Dental deems to be confidential or proprietary to Delta Dental, the Plan, Plan Sponsor or individuals. Plan Sponsor acknowledges that the requested disclosure and use do not violate the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as from time to time amended and all regulations promulgated thereunder, and this request for disclosure is being made by a person authorized under HIPAA and the Plan to make such request.

Plan Sponsor also acknowledges that a fully-executed Business Associate Agreement is in place with Vendor for the Plan and will provide a copy of such fully-executed agreement to Delta Dental, upon its request.

Plan Sponsor further acknowledges that Delta Dental will be informed in writing, via certified mail, of any termination or change in the scope of Services provided by Vendor at least 30 days prior to the effective date of such termination or change. Written notice should be sent to the following address:

Karl Mudra
CIO, Security Officer
Delta Dental of Missouri
12399 Gravois Rd
St. Louis, MO 63127

Plan Sponsor

By:_____
Authorized Signature

Print Name:_____

Print Title:_____

Date:_____

DELTA DENTAL® DeltaVision®

REQUEST FOR ACCESS TO ONLINE EMPLOYER PORTAL

GROUP NAME: City of Joplin

ACCESS FOR ■ **DENTAL** [■ Full Update Access ☐ View Only] ☐ **VISION** [☐ Full Update Access ☐ View Only]

Group Number _____ Group Number _____

Sublocations: ■ All ☐ Other (list below) Sublocations: ☐ All ☐ Other (list below)

_____ _____

_____ _____

(If only specific sublocations are needed, please list them individually in the "Other" section above.)

KEY USER INFORMATION

NOTE: Separate accounts will be created for the Dental and Vision Employer Portals. Only Authorized Key User, listed below, will have the ability to grant employees of Group, including temporary employees and contracted staff, herein referred to as "Workforce," access to the Employer Portal(s) for the benefit plans specified above. Authorized Key User and other Workforce members granted access will collectively be referred to as "Authorized Individuals." It will be the responsibility of Authorized Key User to manage user access for Group including any additions, terminations or modifications. If access is needed for a broker, consultant, TPA or other third party please contact your group accounts representative.

AUTHORIZED KEY USER'S NAME: _____

AUTHORIZED KEY USER'S WORK EMAIL ADDRESS: _____
(Username and password will be emailed to this address)

AUTHORIZED KEY USER'S WORK PHONE NUMBER: _____

Delta Dental of Missouri ("DDMO") permits Authorized Individuals to open Employer Portal user accounts to submit enrollment data on Group's behalf and to access certain other Group benefit plan data. Group, acting through its undersigned authorized representative, (a) certifies that the Authorized Individuals are authorized to submit data to DDMO on Group's behalf for the benefit plans specified above; (b) accepts and agrees to comply with DDMO's Terms and Conditions of Use, available for review online at https://www.deltadentalmo.com/; and (c) agrees to the following conditions: (1) DDMO may rely on all electronically submitted data to the same extent as if submitted by non-electronic means; (2) Group shall ensure that Authorized Individuals safeguard account information to access the Employer Portal(s), including username and password, do not share or disclose user name or password to any party and shall immediately notify DDMO in writing if the confidentiality or security of such account information is compromised; (3) Authorized Key User shall ensure that all Authorized Individuals are members of Group's Workforce and shall immediately terminate access for any Authorized Individual who leaves Group's Workforce or otherwise no longer requires access; (4) Authorized Key User will not grant access to anyone not a part of Group's Workforce and will instead require that any third party performing services on Group's behalf requiring access to the Employer Portal request access directly through DDMO; (5) Group shall ensure its Authorized Individuals safeguard and hold in confidence all information accessed via the Employer Portal(s), and only access, use or disclose any information as permitted by law, including HIPAA; (6) Group shall be solely responsible for any liability arising from the use of the Employer Portal(s) and shall indemnify, hold harmless and defend DDMO against any claim arising from any Authorized Individual's use of the Employer Portal(s) or Group's or any Authorized Individual's failure to safeguard the confidentiality and security of account information or any information available via the Employer Portal, including, but not limited to, any errors, omissions or violations of any laws; Upon termination of the applicable agreement between DDMO and Group, any and all access to the Employer Portal shall be immediately terminated. **The individual signing this form represents and warrants that they have the authority to permit the requested access and bind Group to (i) DDMO's Terms and Conditions of Use and (ii) the terms and conditions set forth above.**

Group Administrator: _____ Phone: _____

Group Administrator's Signature: _____ Date: _____

Once completed, please email to your group accounts representative or GAService@deltadentalmo.com

DELTA DENTAL® DeltaVision®

REQUEST FOR ACCESS TO ONLINE EMPLOYER PORTAL
(BROKERS, CONSULTANTS and OTHER THIRD PARTIES)

GROUP NAME: City of Joplin

ACCESS FOR ☑ **DENTAL** [☑ Full Update Access ☐ View Only] ☐ **VISION** [☐ Full Update Access ☐ View Only]

Group Number _____ Group Number _____

Sublocations: ☑ All ☐ Other (list below) Sublocations: ☐ All ☐ Other (list below)

_____ _____

_____ _____

(If only specific sublocations are needed, please list them individually in the "Other" section above.)

BROKER/CONSULTANT INFORMATION

NOTE: Separate accounts will be created for the Dental and Vision Employer Portals. Only Authorized Key User, listed below, will have the ability to grant employees of Company, including temporary employees and contracted staff, herein referred to as "Workforce," access to the Employer Portal(s) for Group's benefit plans specified above. Authorized Key User and other Workforce members granted access will collectively be referred to as "Authorized Individuals." It will be the responsibility of Authorized Key User to manage user access for Company including any additions, terminations or modifications.

COMPANY (AGENCY) NAME: _____

AUTHORIZED KEY USER'S NAME: _____ PHONE: _____

AUTHORIZED KEY USER'S BUSINESS EMAIL ADDRESS: _____
(Username and password will be emailed to this address)

Delta Dental of Missouri ("DDMO") permits Group to allow a third party contracted to perform services on Group's behalf ("Company") to open Employer Portal user accounts for Authorized Individuals, for the purpose of submitting enrollment data to DDMO on Group's behalf and to access certain other Group benefit plan data. Company, acting through its undersigned authorized representative, (a) certifies that, subject to Group's approval, Authorized Individuals are authorized to submit data to DDMO on Group's behalf for the benefit plans specified above; (b) accepts and agrees to comply with DDMO's Terms and Conditions of Use, available for review online at https://www.deltadentalmo.com/; and (c) agrees to the following conditions: (1) DDMO may rely on all electronically submitted data to the same extent as if submitted by non-electronic means; (2) Company shall ensure that Authorized Individuals safeguard account information to access the Employer Portal(s), including username and password, do not share or disclose user name and password to any party and shall immediately notify DDMO in writing if the confidentiality or security of such account information is compromised; (3) Authorized Key User shall ensure that all Authorized Individuals are members of Company's Workforce and shall immediately terminate access for any Authorized Individual who leaves Company's Workforce or otherwise no longer requires access; (4) Company shall ensure its Authorized Individuals safeguard and hold in confidence all information accessed via the Employer Portal(s), and only access, use or disclose any information as permitted by law, including HIPAA; (5) Company shall be solely responsible for any liability arising from the use of the Employer Portal(s) and shall indemnify, hold harmless and defend DDMO against any claim arising from any Authorized Individual's use of the Employer Portal(s) or Company's or any Authorized Individual's failure to safeguard the confidentiality and security of account information or any information available via the Employer Portal, including, but not limited to, any errors, omissions or violations of any laws. Upon termination of the applicable agreement between DDMO and Group, any and all access to the Employer Portal shall be immediately terminated. **The individual signing this form on behalf of the Company represents and warrants that they have the authority to bind Company to (i) DDMO's Terms and Conditions of Use and (ii) the terms and conditions set forth above.**

Company (Agency) Representative: _____ Title: _____

Signature: _____ Date: _____

Group certifies that it is the "Plan Sponsor" for the group health plan which includes dental and/or vision benefits. Group approves Company to access Group's information as set forth above, and agrees that DDMO shall have no liability to Group for any claim arising out of any Authorized Individual's use of the Employer Portal(s). Group acknowledges it has a Business Associate Agreement in place with Company to permit Company to access Group's information that is available on the Employer Portal(s). **The individual signing below on behalf of the Group represents and warrants that they have the authority to permit the requested access and bind the Group to the terms and conditions of this paragraph.**

Group Administrator: _____ Phone: _____

Group Administrator's Signature: _____ Date: _____

Once completed, please email to your group accounts representative or GAService@deltadentalmo.com