AMENDMENT NO. 4
CONTRACT FOR DENTAL SERVICES AND COVERAGE BETWEEN
FLORIDA HEALTHY KIDS CORPORATION AND
LIBERTY DENTAL PLAN OF FLORIDA, INC.

This Amendment No. 4, entered into between the Florida Healthy Kids Corporation ("FHKC") and Liberty Dental Plan of Florida, Inc. ("Insurer") amends the Contract No.: 2021-300-02 for Dental Services and Coverage between FHKC and Insurer ("Contract").

WHEREAS, the Contract allows for amendments by mutual written consent of the Parties; and

WHEREAS, the Parties desire to amend the Contract as provided in this Amendment, to be effective July 1, 2025.

NOW, THEREFORE, in consideration of the mutual promises and agreements herein contained, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. Section 1.6 Definitions, is hereby modified by deleting the definition of "Region" in its entirety and replacing it as follows:

   Region: any of the geographical areas designated by FHKC and encompassing specified Florida counties pursuant to Section 409.966, Florida Statutes.

2. Section 2.3, Service Area and Premiums, is hereby revised by inserting the following language after the table therein:

   Effective July 1, 2025, the premium paid to Insurer shall be as follows:

Region	PMPM Premium Rate
A	$17.78
B	$16.15
C	$18.44
D	$18.33
E	$17.70
F	$20.95
G	$20.34
H	$20.89
I	$18.27

3. Section 2.8.1 Annual Premium Rate Adjustment Requests, is hereby deleted and replaced in its entirety as follows:

Section 2.8.1 Annual Premium Rate Adjustment Requests

Insurer shall provide an annual premium rate adjustment request for the upcoming Contract Year to FHKC by December 1 of each year unless otherwise required by FHKC, there are no additional Renewal years available under the Contract, or this provision is otherwise waived by FHKC. In the annual premium rate adjustment request, Insurer may request to reduce premium rates, make no change to premium rates, increase premium rates or any combination thereof for the Regions in Insurer's Service Area.

Failure to comply with the requirements of section 2.8 may result in the denial of a premium rate adjustment request without recourse at FHKC's sole discretion.

A. Service Area

The premium rate adjustment request shall be inclusive of Insurer's Service Area. Insurer shall provide a premium rate adjustment for each Region in Insurer's Service Area in the premium rate adjustment request.

B. Timeframe

Unless otherwise required by FHKC, the premium rate adjustment request applies to an entire Contract year and to all of Insurer's Enrollees in a Region. Premium rates shall not:

a. Include planned mid-plan year premium rate changes;

b. Require different premium rates based on when an Enrollee enrolls with Insurer;

c. Require different premium rates based on an Enrollee's age;

d. Require different premium rates based on an Enrollee's sex; or

e. Be discriminatory in any way.

C. Offshoring

Insurer shall not consider any claims paid to a network Provider, out-of-network Provider, Subcontractor, or financial institution located outside the United States in the development of actuarially sound rates.

D. Actuarial Soundness

Insurer shall provide an actuarial memorandum supporting the premium rate adjustment request. The actuarial memorandum shall include the information and level of detail required by FHKC.

The proposed premium rates shall:

a. Be consistent with actuarially sound principles as required by 42 CFR 457.1203;

b. Not be excessive nor inadequate in accordance with the applicable requirements of Chapter 409, Florida Statutes;

c. Be designed to reasonably achieve a medical loss ratio (MLR) standard for the Contract year that is at least equal to the greater of eighty-five percent (85%) or the target MLR implicit in Insurer's best and final offer in response to the ITN and provide for reasonable administrative costs in accordance with 42 CFR 457.1203, Section 624.91, Florida Statutes, and section 9.5 Medical Loss Ratio of this Contract; and

d. Represent an amount adequate to allow Insurer to efficiently deliver Covered Services to Enrollees in a manner compliant with contractual services in accordance with 42 CFR 457.1201(c).

E. Rights and Responsibilities

FHKC may choose to provide Insurer with available trend information that FHKC may utilize when reviewing the premium rate adjustment request.

FHKC may initiate and enter into premium rate adjustment negotiations following Insurer's rate adjustment request submission. FHKC maintains the right to deny a rate adjustment request, require Insurer decrease rates or require Insurer hold rates flat based on the data provided by Insurer, FHKC's analysis, and other relevant factors as determined by FHKC.

Insurer shall respond to FHKC's requests for additional or clarifying information during the premium rate adjustment review process.

F. Premium Rate Adjustment Approval

Any changes to the premium rates must be approved by FHKC's Board of Directors. Premium rate adjustments are also subject to the maximum average rate adjustment recommended by the Social Services Estimating Conference and approval by the Florida Legislature and Governor.

4. The last paragraph of section 11.1 Audit Rights, is hereby deleted and replaced in its entirety as follows:

Insurer shall be MARS-E compliant. Insurer shall ensure an annual information security compliance audit is performed on the application hosting center. Insurer shall provide a copy of the most recent audit report to FHKC by December 31. Insurer shall annually submit information security compliance documentation as agreed upon, in writing,

between Insurer and FHKC. Acceptable documentation is SOC 2 Type II or HITRUST certification.

5. The last paragraph of section 12.6 Monitoring, is hereby deleted and replaced in its entirety as follows:

   Insurer shall provide a quarterly report that includes cost and utilization information for key metrics identified by FHKC, including potentially preventable events. Unless otherwise required by FHKC, Insurer and FHKC shall conduct quarterly meetings via conference calls to discuss the key metrics and performance guarantees. Insurer shall make staff with the appropriate knowledge and expertise available during these meetings and shall be prepared to discuss the report in detail as well as discuss any other relevant topics such as barriers to care, emerging trends and anticipated legislative actions.

6. Section 18.4 Enrollment Files, is hereby deleted and replaced in its entirety as follows:

   FHKC shall provide Insurer all enrollment information necessary for Insurer to provide the services under this Contract. The enrollment information shall identify Enrollees who have been identified as American Indian or Alaskan Native, the Enrollees who are Title XXI eligible, and the Enrollees who are enrolled in the Full-pay Plan.

   FHKC shall provide enrollment information as follows:

   a. FHKC shall provide Insurer a monthly full enrollment file on the 15th of the month prior to the Coverage Month and no later than seven (7) Business Days prior to the start of the Coverage Month. This file will contain enrollments and disenrollments as well as demographic changes.

   b. FHKC shall provide Insurer a supplemental enrollment file on the fifth day of the Coverage Month. Coverage for Enrollees identified on the supplemental enrollment file is effective retroactive to the first day of the Coverage Month. At FHKC's option, FHKC may replace the supplemental enrollment file with a daily change enrollment file. Daily change enrollment files provided prior to the monthly full enrollment file referenced in item a above will contain retroactive changes in coverage for current and past months and demographic changes. Daily change enrollment files provided after the monthly full enrollment file referenced in item a above will contain retroactive changes in coverage for current and past months, new enrollments and reinstatements for the upcoming Coverage Month, and demographic changes.

   c. FHKC may provide manual enrollment updates for reinstatements or terminations at any time. Coverage for Enrollees identified on manual enrollment updates is effective on the first of the identified Coverage Month.

d. FHKC shall notify Insurer in advance of any planned deviations from the enrollment file timeframes listed herein. Insurer shall accept these planned deviations as well as any unplanned deviations regardless of whether FHKC provided prior notification.

Insurer shall maintain an information system capable of electronically receiving and updating enrollment data as provided by FHKC. Insurer shall accept enrollment data in the format required by FHKC. Insurer shall accurately and timely process enrollment changes in accordance with this section and C: Performance Guarantees.

The enrollment file format is subject to change and shall not require a Contract amendment.

7. Section 19: Enrollee Rights, is hereby modified by deleting the last paragraph in its entirety and replacing it as follows:

   In accordance with 42 CFR 457.1220, which incorporates 42 CFR 438.100, and 42 CFR 457.1207, which incorporates 42 CFR 438.10(g)(2)(ix), Enrollees have the right to:

   a. Receive information in accordance with 42 CFR 438.10;
   b. Be treated with respect and consideration for his or her dignity and privacy;
   c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
   d. Participate in decisions regarding his or her health care, including the right to refuse treatment;
   e. Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
   f. Request and receive a copy of his or her medical records and request that such medical records be amended or corrected; and
   g. Receive health care services in accordance with 42 CFR 438.206- 438.210.
   h. Choose between a Covered Service or setting and an available in lieu of service or setting. Enrollees retain the right to receive the Covered Service or setting on the same terms as would apply if an in lieu of service or setting were not an option.

8. Section 22.5 Value-add Services, is hereby modified by deleting it in its entirety and replacing it as follows:

   22.5 Value-add Benefits and In Lieu of Services or Settings

   A. Value-add Benefits

Insurer may offer value-add benefits at no cost to FHKC or the Enrollees. Insurer shall offer any value-add benefits proposed during the ITN and listed in Attachment A: Benefit Schedule.

Insurer shall submit any proposed value-add benefits, including a description of the eligible population and any limitations, to FHKC for approval.

Insurer must request and receive FHKC approval to discontinue any value-add benefits. Value-add benefits shall be offered for at least one (1) complete Contract Year and shall not be discontinued during a Contract Year. Any value-add benefits proposed during the ITN and included in this Contract are considered material to the competitive ITN process. As such, Insurer shall not discontinue these value-add benefits without replacing the value-add benefit with an equivalent value-add benefit, subject to FHKC approval. An equivalent value-add benefit must be relevant to the Florida Healthy Kids population and must be expected to fulfill similar needs for Enrollees regarding the number of Enrollees potentially impacted and the level of care. Requests for changes to value-add benefits shall be submitted to FHKC for consideration annually on July 1. Insurer shall provide Enrollees with notice of any value-add benefit changes at least ninety (90) Calendar Days in advance of such changes.

Insurer shall include all value-add benefits in Insurer's Enrollee handbook.

B. In Lieu of Services and Settings

If Insurer chooses to provide in lieu of services and settings, as defined by section 42 CFR 438.2, Insurer must meet the requirements of 42 CFR 438.16, as required by 42 CFR 457.1201(c). FHKC approval is required prior to Insurer offering any in lieu of service or setting.

9. Section 23.2 Appeals, is hereby revised by deleting the first paragraph and replacing it as follows:

Enrollees may file an Appeal orally or in writing within sixty (60) Calendar Days of the date of notification of an Adverse Benefit Determination. Insurer shall acknowledge receipt of the Appeal in writing within five (5) Business Days. Appeals are limited to a single level. Enrollees wishing to further appeal Insurer's decision to uphold an Appealed decision may proceed to the independent external review process.

10. Section 24.10 Physician Incentive Plans, is hereby modified by adding the following paragraphs after the first paragraph:

Insurer's incentive payment contracts with Providers must:

- Have a defined performance period that can be tied to MLR reporting periods;

- Be signed and dated by all appropriate parties before commencement of the performance period;
- Include clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that the Provider must meet to receive the incentive payment; and
- Specify a dollar amount or a percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the contract, including a date of payment.

Insurer must maintain documentation to support the incentive payments in a manner that is consistent with generally accepted audit standards. Insurer may not rely upon Subcontractors or any third parties to maintain such documentation. Insurer must directly maintain such documentation. Such documentation must be made available to FHKC, or FHKC's authorized representative, upon request, or, if FHKC should choose to establish routine reporting, by the dates required by FHKC. In accordance with 42 CFR 457.1285, which incorporates 42 CFR 438.608(e), attestations are not acceptable supporting documentation.

11. Section 24.12.3 Provider Overpayments, is hereby modified by deleting it in its entirety and replacing as follows:

Insurer must maintain policies and procedures relating to Provider overpayments which shall include a:

i. Mechanism for a Provider to report in writing to Insurer that an overpayment has been received and the reason why the overpayment was received; and

ii. Requirement that Providers return any overpayments to Insurer within sixty (60) Calendar Days after the date on which the overpayment was identified.

Insurer shall provide a report listing all overpayments to Providers identified or recovered, including overpayments made related to Fraud, Waste and Abuse and all other overpayments, within 30 Calendar Days. Such report shall be routinely due on the first of each month, beginning January 1, 2026.

Insurer shall provide an annual report listing all overpayments to Providers identified or recovered, including overpayments made related to Fraud, Waste and Abuse and all other overpayments.

12. Section 26.6.2 Net Promoter Score, is hereby created as follows

Section 26.6.2 Net Promoter Score

As required by FHKC, Insurer shall implement a net promoter score tool to measure customer satisfaction. Insurer shall work with FHKC to establish the net promoter score

baseline, develop action steps to improve customer satisfaction, and reporting requirements.

13. Attachment C: Performance Guarantees, is hereby amended by deleting PG-6: Enrollment Files in its entirety and replaced as follows:

    Insurer shall accurately process one hundred percent (100%) of enrollment files within two (2) Business Days of receipt.

    Reporting Frequency: Monthly

    Financial Consequences: one thousand dollars ($1,000) per Calendar Day

    Calculation Methodology:

    - Enrollment files include monthly full enrollment files and daily change enrollment files.
    - For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the number of Calendar Days beyond two (2) Business Days for which it takes Insurer to process one hundred percent (100%) of enrollment files.
    - Financial consequences apply to each Calendar Day beyond the due date until accurately processed, inclusive of the date processed.

    Related Contract Reference: Section 18: Eligibility and Enrollment

14. Except as expressly amended hereby, the Contract shall remain in full force and effect in accordance with its provisions.

15. This Amendment No. 4 sets forth the entire understanding between the Parties with regard to the subject matter of the Contract and supersedes all other agreements, negotiations, understanding, or representations, verbal or written, between the Parties regarding the Contract.

16. In the event of any conflict between the Contract and this Amendment No. 4, the terms of this Amendment No. 4 shall govern.

17. This Amendment No. 4 may be executed in counterparts, each of which shall constitute an original and all of which together shall constitute the same document.

18. This Amendment No. 4 may be executed in counterparts, each of which shall constitute an original and all of which together shall constitute the same document.

IN WITNESS WHEREOF, the Parties have caused this Amendment No. 4 to be executed by their undersigned officials as duly authorized.

FOR
FLORIDA HEALTHY KIDS CORPORATION:

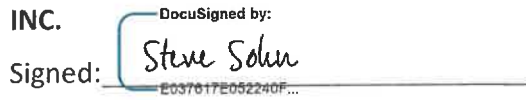
Signed:

Name: Ryan West

Title: Chief Executive Officer

Date: 7/1/2025

FOR
PLAN: LIBERTY DENTAL PLAN OF FLORIDA, INC.

Signed: 

Name: Steve Sohn

Title: Chief Administrative Officer

Date: 6/30/2025