Welcome to Delta Dental of Kansas, Inc.

Delta Dental of Kansas, Inc. is a member of Delta Dental Plans Association, the leading and largest underwriter of group dental coverage in the United States. Together with your employer, we have designed a dental benefit plan to help protect the oral health of you and your covered dependents. Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to the overall well-being of every person.

You are free to go to any dentist of your choosing; however, there may be a difference in payment if the dentist is not a participating dentist with Delta Dental. If you receive services from a non-participating dentist, your out-of-pocket expenses may increase. It is to your advantage to choose a Delta Dental PPO or Delta Dental Premier dentist. Since over 75% of the dentists throughout the United States do contract with Delta Dental, the chances are excellent your dentist is already a member.

If you have any questions about whether your dentist participates as a Delta Dental PPO or Delta Dental Premier dentist, ask your dentist when making an appointment or contact the Customer Service staff at Delta Dental of Kansas, Inc. by calling (316) 264-4511 or toll free (800) 234-3375. You may also access our network, nationwide, through our website at www.deltadentalks.com.

From our website, you can

- Check your eligibility and plan information
- Print yourself an ID card
- Check claim status
- Locate a participating Delta Dental PPO or Delta Dental Premier dentist
- Learn about oral health and wellness
- Use our flexible spending account estimator

It is our pleasure to be of service to you.

Summary of Dental Plan Benefits

IMA Financial Group, Inc.
Account Benefit Plan ID# 50914-02

% paid by DDKS				Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible or Maximum)				
PPO Network	Premier Network	Non Network		
100%	100%	100%	I.	**DIAGNOSTIC:** Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral exams – two (2) times each Plan Year. Bitewing x-rays – two (2) times each Plan Year for Dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. Full mouth or panoramic x-rays – once (1) each five (5) years.
100%	100%	100%	II.	**PREVENTIVE:** Provides for the following: *Prophylaxis (Cleanings) – (all types including periodontal maintenance), two (2) times per Calendar Year. Topical Fluoride – two (2) times each Plan Year for Dependent Children under age nineteen (19). Space Maintainers – for Dependent Children under age fourteen (14) and only for premature loss of primary molars. Sealants – once (1) each tooth per lifetime for Dependent Children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
BASIC (Subject to Deductible)				
80%	80%	80%	III.	**ANCILLARY:** Provides for one (1) emergency exam per Plan Year by the Dentist for the relief of pain.
80%	80%	80%	IV.	**ORAL SURGERY:** Provides for extractions and other oral surgery including pre and post-operative care.
80%	80%	80%	V.	**REGULAR RESTORATIVE DENTISTRY:** Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless-steel crowns for Dependents under age twelve (12).
80%	80%	80%	VI.	**ENDODONTICS:** Includes procedures for root canal treatments and root canal fillings. When covered, payment for the initial root canal therapy is limited to one (1) per lifetime, per tooth; payment for the retreatment of a root canal is limited to once (1) per twenty-four (24) months, per tooth.
			VII.	**PERIODONTICS:**
80%	80%	80%		a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal cleaning, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.
80%	80%	80%		b. Surgical periodontal procedures.

% paid by DDKS				Examples of Covered Services
MAJOR (Subject to Deductible)				
50%	50%	50%	VIII.	SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
			IX.	PROSTHODONTICS:
50%	50%	50%		a. Includes bridges, partial and complete dentures.
50%	50%	50%		b. Repairs and adjustments of bridges and dentures.
50%	50%	50%		c. Implants
ORTHODONTICS (Subject to Deductible)				
50%	50%	50%	X.	ORTHODONTICS: Includes orthodontic appliances and treatment, interceptive and corrective, for adults and Dependent Children under age twenty-six (26). Subject to limitations in "Exclusions and Limitations" Section.

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

This is a Summary of Benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Agreement which is binding on all of the parties and supersedes all other written or oral communications.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS
FOR ADDITIONAL INFORMATION

Selected Network
The Dental Network for this Plan is Delta Dental PPO Plus Premier (Delta Dental PPO and Delta Dental Premier).

Maximum Benefit(s) Per Person
Regular Services:
The Maximum Benefit for all Covered Services, excluding Diagnostic and Preventive Services, including Implant Services, for each Enrollee in any one Plan Year is Two Thousand Dollars ($2,000.00).

Orthodontic Services:
The Maximum Benefit for Orthodontics Services for each Enrollee is Two Thousand Dollars ($2,000.00) during such Enrollee's lifetime. Payment for Orthodontic Services shall not be included in determining the Maximum Benefit for each Plan Year.

Deductible Limitations
Coverage for Diagnostic and Preventive Services as identified in the "Summary of Dental Plan Benefits" and Right Start 4 Kids℠ ("RS4K") coverage are not subject to the Deductible. However, the Deductible shall apply during each Plan Year to all other Covered Services which are provided to each Enrollee, not covered under RS4K. After Enrollees have, in any Plan Year, each paid either the individual Deductible of Fifty Dollars ($50.00) or have cumulatively paid charges for Covered Services in the amount of One Hundred Fifty Dollars ($150.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Plan Year.

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

*Healthy Benefits, Healthy Smile, Healthy You – Patients who are pregnant, diabetic, have a suppressed immune system, have kidney failure, are undergoing dialysis, or have a history of periodontal treatment are eligible for up to (2) two additional periodontal cleanings per Calendar Year. To be eligible for the added benefit you must complete a Self-Report form found within the Subscriber Connection at www.deltadentalks.com or by contacting Delta Dental of Kansas' Customer Service at 1-800-234-3375.

Right Start 4 Kids℠ (RS4K)
Children age eighteen (18) and under receive coverage at one hundred percent (100%) for all Covered Services. Not subject to Deductible, but Plan's annual maximum, frequencies, and limitations apply. Excludes Orthodontic Services. Must see a Participating Dentist or the Plan's underlying contract applies including waiting periods, Deductibles, and coinsurance levels.

Special Health Care Needs Benefit
Members of any age with qualifying special health care needs are eligible for additional oral exams prior to treatment, unlimited cleanings per benefit year and anesthesia and/or nitrous oxide treatment as needed. Code D9997 must be submitted to process expanded benefits.

Eligible Children Ages
A covered Employee's children from birth to the limiting age of twenty-six (26) years. When a child reaches the limiting age, coverage will end on the last day of the child's birth month. Children ages eighteen (18) and under are eligible for RS4K coverage.

DESCRIPTION OF DENTAL CARE COVERAGE

This Description of Dental Care Coverage is issued to the Subscriber by Delta Dental of Kansas, Inc., hereinafter referred to as "DDKS", a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental coverage program and constitutes your summary of the Agreement and contains the provisions of your dental coverage. The Agreement between your Employer and DDKS is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communications regarding the Plan. Only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth are benefits under the Agreement and then only if identified as a covered dental benefit in the "Summary of Dental Plan Benefits" section. Certain restrictions may be applicable to your coverage. It is important to review the "Exclusions and Limitations" section of this document for these conditions.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this booklet, appropriate modifications will be made in the benefits provided under the Agreement.

HOW TO USE YOUR PLAN

Make an appointment with your Dentist. Tell the Dentist that you are covered by Delta Dental of Kansas, Inc.

If the planned treatment involves prosthodontic or orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics or oral surgery, except for simple extraction of a single tooth, the Dentist should submit a treatment plan to DDKS to determine how much of the bill will be paid by DDKS and what your share of the cost will be. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of DDKS's consultant, the treatment is not necessary or a lesser procedure could have restored the tooth to contour and function. Even if the Dentist does predetermine benefits, however, it does not obligate DDKS if you as an employee or dependent are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist or a new treatment plan should be obtained and resubmitted to DDKS.

PAYMENTS FOR COVERED SERVICES

Following treatment, the Dentist should forward the attending Dentist's statement to DDKS. If the Dentist is a Participating Dentist, DDKS will make direct payment to the Dentist for each Covered Service. If the Dentist is not a Participating Dentist, DDKS will pay the Employee on each Covered Service. The amount of payment will be calculated using the percentage amount indicated in the "Summary of Dental Plan Benefits" section in this booklet. If more than one percentage column is shown in the Summary of Dental Plan Benefits, the percentage used will be the one that corresponds to the network status of the Dentist at the time the Covered Services are rendered. DDKS will pay for each Covered Service, subject to the Coordination of Benefits (COB) stipulations in the "Coordination of this Contract's Benefits with other Benefits" section of this booklet, based on the lesser of i) the fee submitted by the Dentist for the Covered Service, or ii) the Maximum Plan Allowance (MPA). For more

information on MPA, see the definition of MPA in the "Definitions" section of this booklet.

You will receive notice of the Plan's payment and the amount, if any, that you owe the Dentist. The amount you owe should be paid in accordance with the Dentist's usual billing procedure.

NO PRE-EXAMINATION

There are no pre-examination requirements for employees and dependents to be eligible for dental benefits.

EMERGENCY TREATMENT

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

INQUIRIES/APPEALS

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

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

Enrollees have the right to appeal a claim determination if the requested dental benefits were not paid in full. In order to appeal a benefit determination, Enrollees or their authorized representative must write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769 within one hundred eighty (180) days of the date of the Explanation of Benefits for the claim. Written appeals should be submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.

2. Subscriber's name and birth date. If the Enrollee is not the Subscriber, the Enrollee's name and birth date must also be included.

3. Dentist name and, if known, license number.

4. Claim number.

5. Date(s) of service.

6. An explanation of the complaint or question, including the basis for appeal.

7. Any additional information that the Enrollee believes supports his/her position.

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

Normally, Enrollees will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of DDKS' receipt. However, if the matter is referred to a review committee, or other unusual circumstances arise, the Enrollee will be advised. Generally, a written answer or decision will be sent to the Enrollee within thirty (30) days thereafter, however, DDKS must provide a written answer or decision within sixty (60) days receipt of the appeal.

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

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

REEVALUATION AND REVIEW

If the Employer or Enrollee does not agree with the determination of benefits and has additional information to supply, reevaluation may be requested by resubmitting a copy of the claim form, x-rays and clinical comments to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas 67278-9769. The review of a claim form and x-rays may not be sufficient to appropriately resolve a matter in all cases. Accordingly, in some cases DDKS may rely on its regional dental consultants to examine patients clinically. When appropriate, examinations may also be conducted at the request of the Enrollee, a treating Dentist, or for other reasons determined by DDKS.

DDKS LIABILITY

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

RIGHT TO INFORMATION

As a condition precedent to the approval of claims hereunder, DDKS, shall be entitled to receive from any attending or examining Dentist, or from hospitals or clinics in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, and/or treatment rendered to, an Enrollee. DDKS, at its own expense, shall have the right to cause any Enrollee to be examined when and so often as DDKS reasonably

deems necessary during the pendency of a claim under the Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under the Agreement constitutes the Enrollee's (and the related Subscriber's, if applicable) automatic and irrevocable consent to the release to DDKS of any and all of the information and records before described, and a full waiver by that Enrollee that any such information and records that otherwise is privileged. Further, by providing Covered Services to an Enrollee, a Dentist or other service provider consents to, upon request, provide such information and records to DDKS as DDKS requests.

MISREPRESENTATIONS

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

LEGAL ACTIONS

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

GOVERNING STATUTES

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

GOVERNING LAW

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

DEFINITIONS

For the purpose of this Description of Dental Care Coverage, the following definitions shall apply:

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

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

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

4. A Covered Employee’s children from birth to the limiting age of twenty-six (26) years. When the child reaches the limiting age, coverage will end on the last day of the child's birthday month.

   The term "Children" shall include natural child, stepchild, adopted child, or a child placed with the Employee for adoption, or Foster Child.

   The term "Children" shall also include children of the Domestic Partner, Civil Union partner. If a covered Employee is the “Legal Guardian” of a child or children, these children may be enrolled in this Plan as covered Dependents.

   The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.
   Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

   The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

   A covered Dependent Child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

   The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

7. “Cosmetic” means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory. The determination of whether services are “Cosmetic” shall be made by DDKS in its discretion. Cosmetic services are not Covered Services under the Plan unless a Cosmetic service is specified as a Covered Service in the “Summary of Dental Plan Benefits” section.

8. “Covered Services” means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of the Plan.

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

10. “Deductible” means the amount specified in the “Summary of Dental Plan Benefits” section which must be paid with respect to Covered Services provided to an Enrollee before the Plan provides benefits.

11. “Dental Network” means one of the following networks as identified in the “Summary of Dental Plan Benefits” section:

    a.1. “Delta Dental Premier”: The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that DDKS offers. All Delta Dental Premier providers are considered Participating Dentists and are paid according to DDKS’ Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-Participating Dentists are not considered Delta Dental Premier Providers, and are paid according to DDKS’ Non-Participating Dentist Maximum Plan Allowance.

    2. If Delta Dental Premier is the Exclusive Network, then Enrollees must exclusively use Dentists in the Delta Dental Premier network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who does not participate in the Delta Dental Premier network, the Enrollee is responsible for all treatment costs incurred.

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

    2. If Delta Dental PPO is the Exclusive Network, then Enrollees in the plan must exclusively use Dentists in the Delta Dental PPO network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all treatment costs incurred.

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

13. “Effective Date” means the first day of the initial term of the Agreement.

14. “Eligible Dependent” means i) the spouse, as defined in the “Definitions” section, number 26, and ii) a Child as defined in the “Definitions” section, number 4.

15. “Eligible Employee” means any person who meets the conditions of eligibility outlined in “Eligibility of Employees and Their Dependents” section, and any person who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

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

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

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

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

20. “Maximum Plan Allowance” means the lesser of the following:

    a. In the case of a Participating Delta Dental Premier Dentist:

        i) the fee submitted by the Participating Dentist for the Covered Service, or

        ii) the Delta Participating Dentist Maximum Plan Allowance for the Covered Service.

    b. In the case of a Delta Dental PPO Dentist:

        i) the fee submitted by the Delta Dental PPO Dentist for the Covered Service, or

        ii) the Delta Dental PPO Dentist Maximum Plan Allowance for the Covered Service.

    c. In the case of a Non-Participating Dentist:

        i) the fee submitted by the Dentist for the Covered Service,

        ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or

        iii) if this Plan utilizes an Exclusive Network, no benefits are provided.

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

22. “Participating Dentist” means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentist agree to render services in accordance with the terms and conditions established by DDKS and have satisfied DDKS that they are in compliance with such terms and conditions.

23. “Plan” means the dental benefits arrangement which is offered and administered pursuant to the terms of the Agreement.

24. “Policyholder” means an individual who is i) a resident of the State of Kansas; ii) over the age of 18; iii) legally competent to enter into the Agreement; and iv) has provided the information for enrollment and agreed to the terms of this Agreement.

25. “Right Start 4 Kids℠” or “RS4K” means 100% coverage under each Plan for children ages eighteen (18) and under for all services covered under the plan, with no Deductible, if seen by a network (Delta Dental PPO or Delta Dental Premier) provider. If a child covered under RS4K is seen by an out-of-network provider, the underlying contract applies including waiting periods, Deductibles, and coinsurance levels. Orthodontic services are not eligible for coverage under RS4K. Exclusions and Limitations, as listed below, also applies to RS4K coverage.

26. “Special Health Care Needs Benefit” means Members of any age with qualifying special health care needs are eligible for additional oral exams prior to treatment, unlimited cleanings per benefit year and anesthesia and/or nitrous oxide treatment as needed. Qualifying special health care needs may include any physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment or limiting condition that requires medical management, health care intervention and/or use of specialized services or programs. The condition may be congenital, developmental or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in major life activity. Code D9997 must be submitted to process expanded benefits.

27. “Spouse” means a person recognized as a covered Eligible Employee’s spouse as determined under applicable laws of the state or other jurisdiction (including a foreign county) where the marriage was formalized, whether of the same sex or opposite sex as the covered Eligible Employee, including, without limitation, a spouse in a common-law marriage. The term “spouse” will also include:

a) **Same-sex domestic partner.** A covered Eligible Employee’s same-sex domestic partner, as long as the following conditions are met:

i) Both the covered Eligible Employee and the same-sex domestic partner are at least age eighteen (18);

ii) Neither the covered Eligible Employee nor the same-sex domestic partner are the spouse, domestic partner, or civil union partner of any other person;

iii) The covered Eligible Employee and same-sex domestic partner are not related to each other to any degree of closeness that would prohibit marriage under applicable state law;

iv) The covered Eligible Employee and same-sex domestic partner are in an exclusive, committed relationship that is intended to be permanent;

v) The covered Eligible Employee and same-sex domestic partner have mutually agreed to be responsible for each other's common welfare; and

vi) The covered Eligible Employee and same-sex domestic partner reside together and intend to do so permanently.

b) **Same-sex civil union partner or registered domestic partner**. A covered Eligible Employee's same-sex partner in a civil union or registered domestic partnership established under the laws of a state that recognizes such civil union or registered domestic partnership.

c) **Opposite-sex civil union partner or domestic partner.** If and to the extent required by law (taking into account preemption of certain state laws by ERISA), a covered Eligible Employee's opposite-sex partner in a civil union or domestic partnership established under the laws of a state that recognizes such civil union or domestic partnership.

In all cases, the Plan Administrator may require documentation proving a marriage, domestic partnership, registered domestic partnership, or civil union, including, without limitation, a marriage certificate, affidavit of common-law marriage, affidavit of domestic partnership, civil union certificate, or certificate of registered domestic partnership. In addition, in the case of a common-law marriage or domestic partnership, the Plan Administrator may request evidence of common residence, including, without limitation a joint deed or mortgage, joint lease agreement, or copies of drivers' licenses, tax returns or bank statements showing common address.

Note. The definition of "spouse" for purposes of health plan eligibility may not allow for tax-free benefits for a "spouse" who is not considered a valid spouse of the covered Eligible Employee under federal tax law. For federal tax purposes, the term "spouse" does not include an individual who is a domestic partner or partner in a civil union (whether or not formally recognized under state law), unless the relationship qualifies as a lawful marriage under the laws of the state or other jurisdiction. For questions about the tax treatment of spousal coverage, please contact the Employer.

28. "Subscriber" means an Eligible Employee who has enrolled in the Plan during annual open enrollment or other enrollment period established by the Employer following the employee's hire date or the occurrence of a qualifying event, as described in the "Eligibility of Employees and Their Dependents" section, number 2.c., and timely payment of the required premium has been made.

EXCLUSIONS AND LIMITATIONS

1. **Unless the "Summary of Dental Benefits" Section Specifically Provides For Coverage, The Following Dental Benefits And Services Are Excluded:**

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

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

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

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

e. Prescription drugs, premedication's and relative analgesia, including nitrous oxide; hospital, healthcare facility or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; preventive control programs.

f. Charges for failure to keep a scheduled visit.

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

h. Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

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

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

k. Crowns and endodontic treatment in conjunction with an over denture.

l. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

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

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

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

p. Dental benefits and services which are not completed.

q. Treatment rendered outside of the United States or Canada.

r. Diagnosis or treatment of temporomandibular joint dysfunction unless these are specified as Covered Services in the "Summary of Dental Plan Benefits" section.

s. Benefits or services for control of harmful habits unless these are specified as Covered Services in the "Summary of Dental Plan Benefits" section.

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

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

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

   c. Bitewings taken within six (6) months of a full mouth series of x-rays are not billable to the patient.

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

   e. Restoration of surfaces on teeth are limited to only once (1) or twice (2) within a twenty-four (24) month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within twenty-four (24) months after a crown is seated are subject to frequency limitations, with the exception of the first and second upper molars due to the anatomy of the teeth (transverse ridge).

   f. Re-cementation of space maintainers are limited to once (1) per quadrant per lifetime.

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

   h. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service:

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

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

      (3) Re-cementation of a crown is limited to only once (1) in a lifetime.

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

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

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

i. Prosthodontics are not a Covered Service unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service, the following limitations apply unless the "Summary of Dental Plan Benefits" section states different limitations:

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

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

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

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

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

(6) Re-cementation of a bridge is limited to only once (1) in a lifetime.

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

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

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

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

(a) Coverage should be predetermined and is limited to those Enrollees, age nineteen (19) and over. They do not need to be totally edentulous, meaning there may still be natural teeth in the arch for which the dental implants are being contemplated.

(b) The Dentist should submit to DDKS a written report of recommended treatment setting forth the type and number of implants to be used, radiographs to support the dental necessity of the implant procedures as required by DDKS, and the proposed fees for the entire procedure. This treatment plan should be received and approved by DDKS before any dental services are performed.

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

j. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

k. Periodontic procedures are not Covered Services unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. When covered, payment is limited to only once (1) in any twenty-four (24) month period for all non-surgical periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is limited to two (2) times per Plan Year period; and crown lengthening which carries no frequency limitation. For surgical periodontal procedures, when covered, payment is limited to only once (1) in any thirty-six (36) month period.

l. Treatment to correct congenital or developmental malformations.

m. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services.

n. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service:

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

(2) Related services, such as but not limited to, x-rays, extractions, and study models, shall be payable at the orthodontic co-insurance percentage as specified in the "Summary of Dental Plan Benefits" section.

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

(4) Maximum Benefit for Orthodontic Services:

(a) Anything contained in the Agreement or any appendix to the contrary notwithstanding, the maximum benefit for Orthodontic Services payable in any one (1) Plan Year, as applicable, or any portion thereof, shall be the amount indicated in the "Summary of Dental Plan Benefits" section.

(b) If the Employer had orthodontic coverage under an immediate previous carrier, no waiting period applies.

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

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

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

3. Certain dental benefits and services may be not billable to the patient under the Plan. When dental benefits or services are not billable to the patient, the fees associated with those items are neither benefited by DDKS nor collectable from the Enrollee by a Participating Dentist. Benefits or services not billable to the patient will be so indicated on the applicable Enrollee's Explanation of Benefits.

ELIGIBILITY OF EMPLOYEES AND THEIR DEPENDENTS

1. Eligible Employee:

To qualify as an Eligible Employee, an individual must meet one (1) of the following requirements:

a. Be an employee who is:

(1) Is a Full-Time Employee of the Employer. An Employee is considered to be Full-Time if he or she is employed an average of at least thirty (30) hours of service per week and is on the regular payroll of the Employer for that work.

(2) Is a Part-Time Employee of the Employer. An Employee is considered to be Part-Time if he or she is employed an average of at least twenty (20) to twenty-nine (29) hours of service per week and is on the regular payroll of the Employer for that work.

(3) On paid sick leave from such active employment;

(4) On any other approved leave of absence from such active employment; or

b. Be a former employee of Employer who is entitled to benefits from Employer and meets all other requirements for coverage as determined by Employer.

c. Be a member in good standing of an organization, association or union which is the Employer, as determined under the rules of such organization, association or union.

d. Any other change which the Plan Administrator determines will allow a change of an election during the Plan Year under the regulations or rulings of the Internal Revenue Service.

2. Commencement of Coverage for Employee:

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

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

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

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

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

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

3. No Coverage as Both Employee and Dependent:

No person may be insured both as an Eligible Employee and as an Eligible Dependent, and no person will be considered as an Eligible Dependent of more than one (1) Employee. Eligible Dependents do not include another Employee of the Employer who is insured under any employer-sponsored program providing dental expense coverage. A Child who may be otherwise eligible as a dependent under more than one (1) dental plan sponsored by the Employer, shall be covered under the plan of the Employee as explained in the "Coordination of this Contract's Benefits with other Benefits" section.

4. Commencement of Coverage for Dependent:

a. With respect to a person who is an Eligible Dependent on the Effective Date, coverage hereunder shall begin for such Eligible Dependent upon the later of i) the first day that

the coverage commences for the Subscriber, or ii) the date such person satisfies the requirements to become an Enrollee.

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

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

5. Termination of Benefits:

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

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

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

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

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

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

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

6. Coordination of this Contract's Benefits with other Benefits:

a. GENERAL.

The Coordination of Benefits (COB) provision applies when a person has health care (or dental) coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

b. DEFINITIONS.

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

(a) The term "plan" includes: group and nongroup insurance contracts; health maintenance organization (HMO) contracts; closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law. A nongroup insurance contract or nongroup coverage issued through a closed panel plan is considered to be a "plan" only if it was issued on or after January 1, 2014.

(b) The term "plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Further, a "plan" does not include nongroup insurance contracts or nongroup coverage through closed panel plans issued on or before December 31, 2013.

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

(2) This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care (or dental) benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

(3) The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when the person has health care (or dental) coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

(4) "Allowable expense" means a health care or dental care service or expense, including deductibles, co-insurance and copayments that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(a) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(b) If a person is covered by two (2) or more plan that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(c) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

(6) "Custodial parent" is the parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

c. ORDER OF BENEFIT DETERMINATION RULES.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(1) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(a) Except as provided in paragraph (c)(2), a plan that does not contain a coordination of benefits provision that is consistent with K.A.R. 40-4-34 is always primary unless the provisions of both plans state that the complying plan is primary.

(b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. These types of situations include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(2) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other Plan.

(3) Each plan determines its order of benefits using the first of the following rules that apply:

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

(b) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:

i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

2. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

ii. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

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

2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph C(3)(b)(i) above shall determine the order of benefits.

3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph C(3)(b)(i) above shall determine the order of benefits; or

4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    a. The plan covering the custodial parent;
    b. The plan covering the spouse of the custodial parent;
    c. The plan covering the non-custodial parent; and then
    d. The plan covering the spouse of the non-custodial parent.

iii. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subparagraph (c)(3)(b)(i) and C(3)(b)(ii) above shall determine the order of benefits as if those individuals were the parents of the child.

(c) Active Employee or Retired or Laid-Off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C(3) above can determine the order of benefits.

(d) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. The rule does not apply if the rule labeled C(3) above can determine the order of benefits.

(e) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

d. EFFECT ON THE BENEFITS OF THIS PLAN.

(1) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care or dental coverage.

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

e. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

f. FACILITY OF PAYMENT.

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

g. RIGHT OF RECOVERY.

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

DELTA DENTAL OF KANSAS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:

Privacy Officer
Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769
(316) 264-1099 or (800) 733-5823

Delta Dental of Kansas, Inc. (the "Plan") is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information and we are committed to protecting the privacy and confidentiality of your health and personal information.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

The Plan may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your enrollment in the Plan.

Payment means activities related to the Plan's payment to pay you or your health care provider for covered expenses. Activities associated with payment include, but are not limited to, enrollment activities; collection of contributions from you and your employer; payment for covered expenses, including coordination of benefits; review of payment decisions upon appeal; activities related to pre-authorization of benefits and utilization review; and disclosure of contribution payment history to a consumer reporting agency.

Health Care Operations means activities undertaken to administer your program including, but not limited to, activities necessary to reduce overall health care costs; contacting you or your health care provider about alternative treatments; evaluating practitioner and provider performance; training of non-health care professionals; activities related to obtaining an insurance contract, such as census rating for premiums; conducting or arranging for claims review, legal services, and auditing functions; fraud and abuse detection and compliance-related activities; analysis related to managing and operating the Plan; development or change of payment methods or coverage policies; and educational activities.

Under applicable federal law, there are other uses and disclosures the Plan may make without your specific authorization some are included below:

Disclosures of Protected Health Information to the Plan Sponsor. The Plan will disclose protected information only to the minimal extent it helps your employer administer the program, such as providing billing information, and confirmation of enrollment. The employer must limit its use of that information to obtaining quotes or modifying, amending, or terminating the Plan.

Creation of de-identified health information. The Plan may use your protected health information to create de-identified health information. This means that all data items that

would help identify you, such as name, address, birth date, and hire date are removed or modified. Once information is de-identified it is no longer protected.

Furnishing data to Business Associates. The Plan's Business Associates (e.g., printers, mailing services, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

Uses and disclosures required by law. The Plan will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

Disclosures for public health activities. We may disclose your protected health information for the following public health activities in circumstances that would help prevent or control disease, report child abuse, and domestic violence. Such disclosure will be made only to extent required by law or with your agreement.

Disclosures for health oversight activities. The Plan may disclose your protected health information to a health oversight agency for oversight activities to complete applicable audits, investigations or inspections.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed during any judicial or administrative proceeding as required by appropriate administrative or judicial court proceedings.

Disclosures for law enforcement purposes. We may disclose your protected health information to a law enforcement official as required by law or to comply with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer.

Disclosures regarding victims of a crime or to avert a serious threat to health or safety. In response to a law enforcement official's request, the Plan may disclose information about you with your approval or in an emergency situation and you are incapacitated, or if it appears you were the victim of a crime. We may also disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. The Plan may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

Other Uses and Disclosures Requiring Your Authorization. All other uses and disclosures of your health information, including family members or any other individual not already authorized to receive protected health information, will be made by the Plan only with your express written authorization.

Furthermore, while the Plan does not typically use or disclose your protected health information for marketing purposes; sell your protected health information for direct or indirect financial benefit or non-financial benefit (i.e. in-kind item or service); or retain, use or disclose psychotherapy notes, if the Plan does intend to engage in such activity, your authorization will be obtained as required by law prior to engaging in said activity.

If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure.

ADDITIONAL PRIVACY FOR REPRODUCTIVE HEALTH CARE. Federal law prohibits the Plan from using or disclosing your protected health information when it is sought to investigate or impose liability on you, health care providers, or others who seek, obtain, provide, or facilitate lawful reproductive health care, or to identify persons for such activities. This prohibition applies where the Plan, or others acting on the Plan's behalf, have reasonably determined that:

- The reproductive health care is lawful under the law of the state in which it was provided under the circumstances in which it was provided, for example, if a resident of one state traveled to another state to receive reproductive health care, such as an abortion, that is lawful in the state where the health care is provided; or
- The reproductive health care is protected, required, or authorized by Federal law, including the U.S. Constitution, regardless of the state in which such health care is provided, for example, if the use of reproductive health care, such as contraception, is protected by the U.S. Constitution; or
- The reproductive health care was not provided by the Plan, but the Plan presumes it was lawful. However, if the Plan receives a request for your protected health information, and the Plan has actual knowledge that the reproductive health care was not lawful under the circumstances under which it was provided to you, this presumption does not apply, for example, if you tell the Plan you received reproductive health care from an unlicensed person and the Plan knows that the specific reproductive health care must be provided by a licensed health care provider.

When the Plan receives a request for your protected health information potentially related to reproductive health care, the Plan must obtain a valid, signed attestation from the requester that the use or disclosure is not for a prohibited purpose when the request relates to health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosures to coroners and medical examiners. For example, if the Plan receives a lawful subpoena for medical records that includes protected health information related to reproductive health care, the Plan must obtain a valid, signed attestation from the requester that states the request is not for a prohibited purpose.

ADDITIONAL PRIVACY FOR SUBSTANCE USE DISORDER (SUD) TREATMENT. Although the Plan is not a substance use treatment program ("SUD Program"), the Plan may receive information from a SUD Program about your treatment. The Plan may not disclose this information so that it can be used in a civil, criminal, administrative, or legislative proceeding against you unless:

- The Plan has your written consent; or
- A court order accompanied by a subpoena or other legal requirement compelling disclosure issued after the Plan and you were given notice and an opportunity to be heard.

In addition, if the Plan uses this protected health information to raise funds for the Plan's benefit, the Plan must first provide you with a clear and conspicuous opportunity to elect

not to receive any fundraising communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice. You may request that your health information be provided in an electronic form and we can work together to agree on an appropriate electronic format. You may be charged a fee to cover expenses associated with your request. We can refuse access under certain circumstances. If the Plan refuses access, you will be notified in writing and may be entitled to have a neutral person review the refusal.

Right To Amend Incorrect or Incomplete Information. You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request.

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, http://www.deltadentalks.com.

Right to Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

COMPLAINTS

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

The effective date of this Notice is December 18, 2024. The Plan reserve the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.

DISCRIMINATION IS AGAINST THE LAW

Delta Dental of Kansas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental of Kansas does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Kansas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

    If you need these services, contact the Compliance Officer.

If you believe that Delta Dental of Kansas has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Officer
1619 N. Waterfront Pkwy
Wichita, KS 67206
1-800-234-3375
316-264-1099
legal@deltadentalks.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE SERVICES

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-234-3375 (TTY: 1-800-234-3375).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-234-3375 (TTY: 1-800-234-3375).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-234-3375 (TTY: 1-800-234-3375)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-234-3375 (TTY: 1-800-234-3375).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-234-3375 (TTY: 1-800-234-3375) 번으로 전화해 주십시오.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-234-3375 (TTY: 1-800-234-3375).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-234-3375 (رقم هاتف الصم والبكم: 1-800-234-3375).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-234-3375 (TTY: 1-800-234-3375).

သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-800-234-3375 (TTY: 1-800-234-3375) သုိ႔ ေခၚဆိုပါ။

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-234-3375 (TTY: 1-800-234-3375).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-234-3375 (TTY: 1-800-234-3375) まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-234-3375 (телетайп: 1-800-234-3375).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-234-3375 (TTY: 1-800-234-3375).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-234-3375 (TTY: 1-800-234-3375) تماس بگیرید.

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-234-3375 (TTY: 1-800-234-3375).