Delta Dental of Kansas, Inc.
Delta Dental Member Certificate

This Booklet is issued under the terms of this Dental Plan.

Your Group has contracted with Delta Dental of Kansas to provide the Benefits described in this Booklet. This Booklet summarizes your dental care benefits and how you may maximize them. This Booklet constitutes a summary only. The Plan is governed by the terms of the Group Contract between your Group and Delta Dental. Those terms govern if information in this Booklet is not the same.

If a word or phrase starts with a capital letter, it has a special meaning in this Booklet. It is defined in the Definition Section, where used in the text, or it is a title. There are key words you will see repeated throughout this Booklet. We've highlighted them here to make the Booklet easier to understand.

We, us, our, and **Delta Dental** refers to Delta Dental of Kansas, Inc.

You, your, and **Enrollee** refers to you and your enrolled Dependents.

Save this Booklet in a convenient place and refer to it whenever you have questions about your dental care coverage.

Contact us

Member Services

1.800.234.3375

Visit us online at:

www.deltadentalks.com

You can search for a Dentist, download forms, or access your online member account.

THIS IS A LIMITED PLAN–READ IT CAREFULLY.
The Summary of Dental Plan Benefits provides only a brief outline of some of the important features of the Plan. The Summary of Dental Plan Benefits is not the insurance contract and only the terms and conditions contained in the Group Contract will control. The Booklet sets forth, in detail, the rights and obligations of both you and us. The Group Contract does not meet the pediatric minimum essential benefits and does not provide certified pediatric dental benefits in accordance with the Affordable Care Act.
IT IS IMPORTANT THAT YOU READ YOUR BOOKLET.

Summary of Dental Plan Benefits

This Summary should be read in conjunction with your Booklet. Your Booklet will provide you with additional information about the Plan, including information about the Plan's exclusions and limitations. If you seek dental care services from an Out-of-Network Dentist, you may have more Out-of-Pocket Costs.

U S D #229 - BLUE VALLEY - Buyup Option
Group #54698

% paid by DDKS PPO Network	% paid by DDKS Premier / Out-of-Network		Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible or Maximum)			
100%	90%	I.	**DIAGNOSTIC:** Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral exams – 2 times each Plan Year. Bitewing x-rays – 2 times each Plan Year. Full mouth or panoramic x-rays – once each 5 years.
100%	90%	II.	**PREVENTIVE:** Provides for the following: Routine Cleanings – unlimited. Topical Fluoride – 2 times each Plan Year Space Maintainers – for Dependent Children under age 14 and only for early loss of baby molars. Sealants – once (1) each tooth per lifetime when applied only to adult molars with no decay or fillings on the chewing surface and intact.
BASIC (Subject to Deductible)			
80%	50%	III.	**ANCILLARY:** Provides for one emergency/limited exam per Plan Year by the Dentist for the relief of pain.
80%	50%	IV.	**ORAL SURGERY:** Provides for removal of teeth including pre and post-operative care, preparation of the mouth for dentures, removal of the vertical band of thin tissue that connects the tongue to the bottom of the mouth, removal of the tissue that attaches the lips to the gum above the top front two teeth, removal of tissue that connects the gums to the insides of the cheeks, and removal of a piece of tissue from a lesion and sent to the lab for testing.
80%	50%	V.	**REGULAR RESTORATIVE DENTISTRY:** Provides silver fillings; resin (white) fillings on all teeth; and stainless-steel crowns for Dependents under age 12.
80%	50%	VI.	**ENDODONTICS:** Includes root canal treatments. When covered, payment for the initial root canal therapy is limited to one per lifetime, per tooth; payment for the retreatment of a root canal is limited to once per 24 months, per tooth.
		VII.	**PERIODONTICS:**
80%	50%		a. Includes procedures for the treatment of diseases of the gums and bones. Periodontal cleaning is unlimited if diagnosed with periodontal treatment history.
80%	50%		b. Surgical periodontal procedures.

Summary of Dental Plan Benefits (Continued)
Group #54698

% paid by DDKS			Examples of Covered Services
*MAJOR (Subject to Deductible)			
50%	40%	VIII.	SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling, provides for individual crowns.
		IX.	PROSTHODONTICS:
50%	40%		a. Includes bridges, partial and complete dentures.
50%	40%		b. Repairs and adjustments of bridges and dentures.
50%	40%		c. Implants.
50%	40%	X.	Night Guards: An appliance that prevents top and bottom teeth from touching, and protects the biting surfaces of teeth when sleeping. Night Guards are allowed once every 5 years.
*ORTHODONTICS (Subject to Deductible)			
50%	50%	XI.	ORTHODONTICS (BRACES): Includes orthodontic appliances and treatment, interceptive and corrective, for adults and Dependent Children who are eligible until the end of the Plan Year in which they turn age 26. Subject to limitations in the Limitations Section.

We will pay your Participating Dentist or reimburse you for Covered Services that we deem a Benefit under the Plan after any Deductible, Coinsurance, waiting periods, annual or lifetime Maximum Benefit, Maximum Plan Allowance, exclusions, limitations, and Benefit frequencies are applied in accordance with the Group Contract.

The Group Contract governs your actual coverage and is binding on all parties and supersedes all other written or oral communications. For more information on how we determine Benefits, please read the Booklet.

Selected Network

The Dental Network for the Plan is Delta Dental PPO. For more information on how to choose a Dentist and how your choice may affect your level of Benefits, review the Choosing a Dentist Section or visit our website at www.deltadentalks.com.

Maximum Benefit Per Enrollee

Regular Services:
The Maximum Benefit for all Covered Services, excluding Diagnostic and Preventive Services, including Implant Services and Night Guard Services, for each Enrollee in any one Plan Year is One Thousand Seven Hundred Dollars ($1,700.00).

Orthodontic Services:
The Maximum Benefit for covered orthodontics procedures for each Enrollee is One Thousand Five Hundred Dollars ($1,500.00) 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 set forth in the Summary of Dental Plan Benefits and Right Start 4 Kids℠ coverage are not subject to the Deductible. However, the Deductible will apply during each Plan Year to all other Covered Services that each Enrollee receives. After Enrollees have 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 payment of any Deductible will no longer apply for any Covered Services for the rest of the then-current Plan Year.

Payment of Claims
Enrollee must pay any Deductible amounts before we will pay or reimburse any Claims.

Right Start 4 Kids℠ (RS4K)
Children age 12 and under receive their Claims paid at 100% for all Covered Services. Deductibles will not apply, but the annual maximum, frequencies, and limitations will apply. Orthodontic Services (braces) will not change. If a Child visits an Out-of-Network Dentist, normal waiting periods, Deductibles, and Coinsurance will apply.

Eligible Children Ages
Children are eligible for coverage to the end of the Plan Year in which they turn age 26.

***All Major Services and Orthodontic Services are subject to a twelve (12) months waiting period.**

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How the Plan Works

The Plan covers eligible dental care services from Dentists. Your level of Benefits will vary based on where you receive dental care services. Reviewing this Booklet will show you how to access and maximize your Benefits.

It is important that you carry your Delta Dental ID card at all times and present it when you visit any Dentist. Your Delta Dental ID card identifies you as a person covered by us. When you show your Delta Dental ID card to your Dentist, they will file your claims for you in most cases.

Choosing a Dentist

The Plan allows you to choose where you receive dental care services. You may choose a Participating Dentist or an Out-of-Network Dentist. Your level of Benefits and Out-of-Pocket Costs will vary based on what type of Dentist you choose. Our Delta Dental PPO Network shall offer the most significant network discounts and savings. Our Delta Dental Premier Network shall also offer network discounts and savings but our Delta Dental Premier Network discounts shall generally be smaller than our Delta Dental PPO Network discounts. The reimbursement for services you receive from out-of-network dentists shall generally be less than what Delta Dental would pay a Delta Dental PPO or Delta Dental Premier dentist. Delta Dental PPO and Delta Dental Premier Network dentists shall accept Delta Dental's fee determination as full payment for covered services. If you visit an out-of-network dentist, you can be balance billed, and are responsible for the dentist's charges, up to the dentist's full billed amount. Delta Dental shall pay claims directly to in-network participating dentists. Reimbursement for services at out-of-network dentists shall be paid directly to you and you are responsible for paying your dentist. All Delta Dental PPO and Delta Dental Premier Network dentists must follow our processing policies and guidelines and meet our credentialing standards.

You are responsible for verifying if the Dentist you choose is a Participating Dentist. Dentists are regularly added to our Dental Network so a Participating Dentist may not be listed yet. You should always confirm with us that a listed Dentist is still a contracted Participating Dentist.

You may review the Participating Dentists listing on our website at www.deltadentalks.com or contact our Member Services at 1.800.234.3375 to see which Dentists are a Delta Dental PPO Dentist or a Delta Dental Premier Dentist as well as dental care services each Participating Dentist offers.

Participating Dentists

The Dental Network for the Plan is Delta Dental PPO.

There are a few advantages of using a Participating Dentist who is a Delta Dental PPO Dentist or a Delta Dental Premier Dentist.

- We pay the Participating Dentists directly after you pay the applicable Deductibles and Coinsurance. You do not have to pay all the dental charges while at the Dentist's office.
- The Participating Dentist will file your Claims for you and will not bill you for more than the contracted fees or Maximum Plan Allowances.
- If you choose a Participating Dentist, you will maximize your savings on Out-of-Pocket Costs for dental care services through the Plan.

Delta Dental PPO

Delta Dental PPO is our preferred provider option (PPO). This Delta Dental PPO option offers an added advantage to you because Delta Dental PPO Dentists has agreed to accept reduced fees for the dental care services they provide.

These reduced fees are generally lower than the fees charged by other Dentists who are not Delta Dental PPO Dentists. This reduces your Out-of-Pocket Costs because you are required to pay only for the applicable Deductibles and Coinsurance for Benefits. Our Delta Dental PPO Network shall offer the most significant network discounts and savings. Our Delta Dental Premier network shall also offer network discounts and savings, but our Delta Dental Premier network discounts shall generally be smaller than our Delta Dental PPO network discounts. Delta Dental PPO and Delta Dental Premier network dentists shall accept Delta Dental's fee determination as full payment for covered services. Delta Dental shall pay claims directly to in-network participating dentists. All Delta Dental PPO and Delta Dental Premier dentists must follow our processing policies and guidelines and meet our credentialing standards

Delta Dental Premier

Delta Dental Premier Dentists has agreed not to charge you any amount that exceeds the Maximum Plan Allowance, but has not agreed to the same reduced fees that Delta Dental PPO Dentists agreed to.

Delta Dental Premier Dentists has agreed to accept the lesser of: 1) their submitted fee; or 2) the Maximum Plan Allowance. This amount may be more than the charge accepted by a Delta Dental PPO Dentist, but may be lower than the amount charged by an Out-of-Network Dentist.

The Maximum Plan Allowance will be reduced by any Deductible and Coinsurance you are required to pay. Our Delta Dental PPO Network shall offer the most significant network discounts and savings. Our Delta Dental Premier network shall also offer network discounts and savings, but our Delta Dental Premier network discounts shall generally be smaller than our Delta Dental PPO network discounts. Delta Dental PPO and Delta Dental Premier network dentists shall accept Delta Dental's fee determination as full payment for covered services. Delta Dental shall pay claims directly to in-network participating dentists. All Delta Dental PPO and Delta Dental Premier dentists must follow our processing policies and guidelines and meet our credentialing standards.

Out-of-Network Dentist

If you choose to go to a Dentist who is an Out-of-Network Dentist, the amount charged to you may be above the amount generally charged by a Delta Dental PPO Dentist or Delta Dental Premier Dentist. The reimbursements for services you receive from out-of-network dentists shall generally be less than what Delta Dental would pay Delta Dental PPO and Delta Dental Premier dentists. If you visit an out-of-network dentist, you can be balance billed and are responsible for the dentist's charges up to the dentist's full billed amount. Reimbursement for services at out-of-network dentists shall be paid directly to you and you are responsible for paying your dentist.

You are responsible for filing your Claims in accordance with the How to File a Claim Section. When Benefits are payable for dental care services by Out-of-Network Dentists, we will reimburse you the lesser of: 1) the submitted fee; or 2) the Maximum Plan Allowance. You will then be responsible for any Balance Billing amount charged by the Out-of-Network Dentist over the Benefits we will pay you in addition to any Deductibles, Coinsurance, and maximums specified by the Plan.

Denied Claims and Not Billable to You Claims

We will deny claims for dental care services that are not covered under the Plan. If you receive dental care services that are not covered under the Plan, you are responsible for paying the Dentist for the charges associated with those dental care services. However, another advantage of choosing a Participating Dentist is that certain dental care services rendered by a Participating Dentist that we do not pay or reimburse for may not be billed to you.

Participating Dentists have agreed not to collect fees associated with these dental care services from you that we consider not billable to you. We will inform you of which dental care services are not

billable to you in the Explanation of Benefits that we will send to you. The Plan's plan design and all additional applicable processing policies, procedures, exclusions, limitations, rules, conditions, guidelines and agreements contained in the Delta Dental Dentist Handbook, DeltaUSA Policies Manual/Delta Dental National Account Processing Policies and as set forth by the Delta Dental Plans Association, as revised from time to time, are incorporated by reference in and constitute part of the Plan to the same extent and with the same force as if fully set forth in this Booklet.

The processing policies documents can be found on Delta Dental's website at www.deltadentalks.com under the portal.

What the Plan Covers

The Summary of Dental Plan Benefits describes the Benefits available to you from Participating Dentists and Out-of-Network Dentists. The Plan will pay or otherwise discharge the following percentages listed in the Summary for each Benefit, or the amount that is otherwise payable under the Plan subject to the exclusions and limitations set forth in the What is not Covered or Limited Under the Plan Section. Benefit percentage, benefit coverage, coinsurance, deductibles, annual maximums and plan design shall vary by each group plan and contract.

Below is an example of how Benefits may be payable based on each type of Dentist:

You need to visit a Dentist for a non-surgical extraction which is covered under the Plan. The non-surgical extraction has an 80% Coinsurance. You already met your Deductible and your Maximum Benefit has not been exceeded.

1. Delta Dental PPO Dentist

   Your PPO Dentist submitted a Claim for $150 for a non-surgical extraction. We agreed to a reduced fee of $100. We would pay for 80% of the $100. You would pay for 20% of $100. We pay your PPO Dentist $80, and you pay them $20.

2. Delta Dental Premier Dentist

   Your Premier Dentist submitted a Claim for $150 for a non-surgical extraction. We agreed to a Maximum Plan Allowance of $135. We would pay for 80% of the $135. You would pay for 20% of the $135. We pay your Premier Dentist $108, and you pay them $27.

3. Out-of-Network Dentist

   You filed your Claim for $150. We would reimburse you for 80% of the Maximum Plan Allowance of $135. We pay you $108 which means after we reimbursed you, your Out-of-Pocket Cost is $42.

What is not Covered or Limited under the Plan

Unless the Summary of Dental Plan Benefits specifically provides for coverage of a Benefit, the listed Benefits and dental care services are either excluded from coverage or subject to a limitation as described below.

What the Plan does not Cover (Exclusions)

The Plan does not cover the dental care services and materials listed below unless the Group Contract and Summary of Dental Plan Benefits specifies otherwise.

1. Benefits for anyone without active coverage.
2. Treatment of injuries or conditions benefited under any other employer-related insurance such as Workers Compensation Insurance. Services which are eligible through any Medicare, Medicaid, or similar federal or state programs.
3. Treatment determined by us to be Cosmetic in nature when form and function are otherwise satisfactory unless that treatment is listed as covered in the Summary.
4. Benefits for dental care services started prior to the Effective Date of your coverage under the Plan.
5. Prescription drugs and over-the-counter medications.
6. Hospital, medical facility, medical emergency care, and lab charges.
7. Charges for a missed appointment.
8. Crowns, bridges, dentures, or fillings for changing the vertical dimension of the upper and lower jaw; for restoring the bite; for teeth without cavities; for stabilizing teeth which have become loose as a result of bone loss; and for the reshaping of the teeth to allow them to fit together better.
9. Dental care services as a result of injuries or disease caused by willing participation in a riot; any form of civil disobedience, 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 as required by an employer or voluntarily; while in the act of committing a crime; and self-inflicted injuries.
10. Temporary services, appliances, and procedures.
11. Any procedure in whole or in part not covered under the Plan.
12. Services including root canals related to an overdenture.
13. Replacement of lost or stolen appliance (i.e. a denture, partial denture, crown, retainer, etc.) or charges for spare dentures.
14. Treatment of injuries or conditions due to a motor vehicle accident if coverage is available under any medical expense from any automobile policy.
15. Dental care services which are not completed.
16. Services received outside of the United States or Canada.
17. Services for control of harmful habits such as thumb sucking.
18. Procedures to diagnose or treat Temporomandibular Joint Dysfunction (TMJ).
19. Individual crowns are not covered under the Plan.
20. Treatment to the gums for tumors, cysts, and unusual growths.
21. Variation from normal development present from birth. These conditions include, but are not limited to: cleft palate; cleft lip; upper or lower jaw deformity; defective enamel development; enamel discoloration; treatment involving or required by extra teeth; and teeth missing from birth.
22. Services performed by a Relative or by an employer.
23. Experimental or Investigational Services, procedures, or supplies which are not usual standard of care.
24. Corrective jaw surgery, including but not limited to, surgical cutting or removal of bone, and other services or supplies to increase or reduce the upper or lower jawbone.

25. Bone grafting for site preservation after tooth extraction.
26. Administration of drugs before surgical operations to alleviate pain or alleviating pain by breathing in gases (i.e., laughing gas), except when its use is:
    a. In agreement with generally accepted processional standards;
    b. Not furnished primarily for patient anxiety, fear of dental treatment, or the convenience of the patient, the attending Dentist or other dental care provider; and
    c. Due to the existence of a specific medical condition.

What is Limited under the Plan (Limitations)

Benefits under the Plan are limited as listed below unless the Group Contract specifies otherwise. Generally, when Benefits and dental care services are limited under the Plan, you are responsible for any amounts not benefited by us due to the limitation up to the applicable Maximum Plan Allowance.

1. Bitewings taken within 12 months of a full mouth series of x-rays.
2. A panoramic film taken with a full mouth series of x-rays is not a separate benefit.
3. The replacement of a filling within 24 months is not billable to you if performed by the same Dentist or dental office.
4. An Inlay will be paid as a filling.
5. Core build-ups, including pins, are covered for permanent teeth lacking enough tooth structure to build a crown.
6. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the Summary. If a Covered Service:
    a. The 5-year frequency limitation is measured from the date the crown was placed, whether or not your coverage under the Plan was effective. If replacement is needed because of injury, it is subject to review by a dental consultant.
    b. If a crown is placed on a tooth which has had a filling in the previous 24-month period, Benefits paid for the crown are reduced by the Benefit paid for the prior fillings.
    c. Permanent crowns are not a benefit by Delta Dental for anyone under the age of 12.
    d. The 5-year period is measured from the last date of service the dental appliance was last placed whether or not the Plan was in effect at the time of service.
7. Crowns when used for abutment purposes are benefited at the same Coinsurance percentage as provided under the Plan for bridges and complete and partial dentures.
8. Oral Surgery services are limited to removal of teeth, preparation of the mouth for dentures, removal of the vertical band of thin tissue that connects the tongue to the bottom of the mouth, removal of the tissue that attaches the lips to the gum above the top front two teeth, removal of tissue that connects the gums to the insides of the cheeks, and removal of a piece of tissue from a lesion and sent to a lab for testing.
9. Implants and associated implant procedures are not Covered Services unless specifically included as a Covered Service in the Summary. When covered, you must be over 19 years or older to allow for completed growth and development. Predetermination of Benefits are strongly recommended for implant services which consists of the Dentist submitting a written report of recommended treatment setting forth the type and number of implants to be used, x-rays to support the implant procedures and proposed fees for the entire procedure. Implant covered services may include, but are not limited to, consultations and surgical placement of implant devices and/or prostheses provided in conjunction with the dental implant service. Payments are limited to the lesser of:
    a. The amount of the maximum available as stated in the Summary; or
    b. The amount determined by us to be allowable for dentures that are conventionally constructed using standard procedures, and which are of the same magnitude, i.e. complete upper, complete lower, or complete upper and lower, where appropriate.
10. Administration of drugs before surgical operations to alleviate pain is covered for:
    a. One or more surgical extractions due to the following:

i. Any number of teeth which fail to grow out from the gums;
ii. Surgical root recovery from sinus; or
iii. Medical problem that does not allow for local anesthesia.

11. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in the Summary. If Orthodontic Services is a Covered Service:
    a. Orthodontic Benefits will end if the treatment plan is terminated for any reason, or you are no longer eligible for Benefits before treatment ends.
    b. Related services, including, but not limited to x-rays, extractions, and study models, could be subject to the orthodontic Coinsurance percentage as specified in the Summary.
    c. Maximum Benefit for Orthodontic Services:
        i. Notwithstanding anything contained in the Group Contract or any Endorsement, the Maximum Benefit for Orthodontic Services payable in any Plan Year, as applicable, or any portion thereof, shall be the amount indicated in the Summary.
        ii. If Orthodontic Services are a Covered Service, payment shall be limited to the Maximum Benefit per Enrollee as specified in the Summary. We shall set up an orthodontic schedule to help pay the initial fee (your down payment) and monthly payments automatically over the course of treatment. A separate orthodontic Deductible may apply.
        iii. Rebonding, recementing and/or repair of fixed retainers is included in the orthodontic case fee. A separate fee from the same dentist office within 24 months is not allowed.

Orthodontic Services Take-Over Limitation

If Orthodontic Services take-over is a Benefit under the Plan, the listed conditions shall apply:

1. Your Group covered Orthodontic Services immediately prior to the effective date of the Plan;
2. That coverage for Orthodontic Services were similar to the Plan;
3. You were covered under your Group's prior dental plan immediately prior to the effective date of the Plan; and
4. You are not a new hire, re-hire or added to the Plan due to a Qualifying Life Event with Orthodontic Services already started prior to enrolling in the Plan.

Alternate Benefits Provision – Specific Plan Limitation

A Least Expensive Professionally Acceptable Treatment clause (LEPAT) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by your Dentist. For example, an alternate benefit of a partial denture may be applied in place of your implant coverage when there are bilaterally missing teeth (i.e., teeth missing on both sides of the upper or lower jaw), and payment will be made for the alternate benefit and not for the implants. The LEPAT does not force the you to accept the less costly treatment. However, if you and Dentist choose the more expensive treatment, you are responsible for additional charges over those allowed for the LEPAT.

What are the Frequencies for Benefits under the Plan

The frequencies for Benefits under the Plan are listed below unless the Group Contract specifies otherwise. Generally, when you exceed the listed frequency for any Benefit, you are responsible for any amounts not benefited by us due to the frequency limitation.

1. Unlimited:
    a. Routine cleaning; and
    b. Periodontal cleaning.
2. Once (1) in twelve (12) months:
    a. Examination for potential risk for cavities;
    b. Four bitewing x-rays (over the age of eighteen (18)); and
    c. Emergency examination.
3. Two (2) in twelve (12) months:
    a. Routine examination;
    b. Fluoride treatment;
    c. Four bitewing x-rays;
    d. Crown repairs per crown;
    e. Bridge repairs per bridge; and
    f. Denture adjustments per denture.
4. Once (1) in twenty-four (24) months:
    a. Scaling and root planing per quadrant;
    b. Stainless steel crowns;
    c. Athletic mouthguards (under age of nineteen (19));
    d. Retreatment of a root canal per tooth;
    e. Retreatment of a root canal per tooth; and
    f. Fillings per surface per tooth.
5. Once (1) in thirty-six (36) months:
    a. Detailed (comprehensive) examination;
    b. Gum surgery per site;
    c. Bone surgery per quadrant;
    d. Removal of gum tissue per site;
    e. Bone grafts for periodontal purposes;
    f. Guided tissue regeneration using materials to direct the growth of new bone and tissue for periodontal purposes;
    g. Crown lengthening; and
    h. Denture reline and rebase.
6. Twice (2) in thirty-six (36) months:
    a. Tissue conditioning per arch per denture.
7. Once (1) in five (5) years:
    a. Full mouth x-rays;
    b. Panoramic x-rays;
    c. Single crowns and onlays;
    d. Post and core buildups (pre-made and lab-made);
    e. Crown buildup including pins;
    f. Complete or partial dentures; and
    g. Bridges.
8. Once (1) per lifetime:
    a. Re-cementation of space maintainers;
    b. Re-cementation of a crown;
    c. Re-cementation of a bridge;
    d. Root canal per tooth;
    e. Full mouth debridement to enable detailed comprehensive examination;
    f. Pulpal debridement (includes baby and adult teeth);
    g. Therapeutic pulpotomy;
    h. Sealants per permanent first and second molar; and
    i. Preventive resin restorations on first and second molars (ages three (3) through fifteen (15) only).

How to Use the Plan (Claims and Payments)

How We Pay Your Claims

If you go to a Participating Dentist, they will file your Claims for you. We will pay them for any Allowances. You are responsible for any Deductible, Coinsurances, and remaining balances.

If you use an Out-of-Network Dentist, you may have to file your Claims yourself. You should file your Claims as soon as you can. We will pay you promptly after we receive all the information we need to process your Claim. We may reimburse you up to the Maximum Plan Allowance. The reimbursement you may receive is the lesser of the Maximum Plan Allowance and the amount charged after the Plan's Deductible, Coinsurances, maximums, and frequencies listed in the Plan is applied.

In all cases, our payment relieves Delta Dental of any further liability for the dental care services you received.

How to Get an Estimate of Your Out-of-Pocket Costs (Predetermination of Benefits)

We strongly encourage you to request a Predetermination before you receive expensive dental care services such as prosthodontics, individual crowns, surgical procedures (periodontal and oral), and endodontics to determine your coverage and possible Out-of-Pocket Costs to avoid any billing surprises. You may obtain a Predetermination by requesting your Dentist to file a Predetermination with us listing the dental care services before you receive any treatment.

We will predetermine the amount of Benefits payable under the Plan for the listed dental care services. Predeterminations are valid for up to 6 months from the date your Dentist files them, but not beyond the date your eligibility ends.

How to File a Claim

If you need to file a Claim, follow these 4 steps:

1. Pay the Dentist the full amount of the bill. Request a copy of the itemized bill that shows the amounts for each service.
2. To obtain a copy of the Claim form:
    - Visit our website at www.deltadentalks.com to access your online member account to download a Claim form.
    - Call our Member Services at 1.800.234.3375 to have a Claim form sent to you within 15 days.
3. Complete and sign the Claim form. Make sure you include copies of any itemized bills for Covered Services. Each itemized bill must contain the following:
    - Full name and address of the Enrollee.
    - Date of service.
    - Name and address of the Dentist.
    - Each dental care service received and the amount paid.
4. Mail copies of the completed Claim form and itemized bills to:

    Delta Dental of Kansas
    Attn: Member Services
    PO Box 789769
    Wichita, KS 67278-9769

We will not accept cancelled checks, cash register receipts, personal itemizations, and statements that only show the balance due. When you file your Claim, you should keep copies of all bills and receipts for your own records.

Deadline for Filing Claims

You should submit your Claims no later than 6 months after the completion of services. Delta Dental will not pay any Claims that are submitted more than 12 months after the completion of services.

How Your Claim is Processed

We process your Claims based on established guidelines and criteria to ensure the Plan's coverage determinations are applied consistently. Your filed Claims are processed within the time permitted by federal and state law, but generally no longer than 30 days after receipt. We may extend this period for an additional 15 days if needed for matters beyond our control, including cases where a Claim is incomplete. If we need an extension, we will notify you before the end of the initial 30-day period.

The Plan may deny a Claim if you do not provide the information we need to process the Claim. The claim denial will let you know what additional information we need to finish processing the Claim. You or your Dentist must submit the additional information to us no later than one year after the date of service or 45 days from the date we notified you that we needed additional information, whichever is later. Once the Plan processes your Claim, we will send you an Explanation of Benefit promptly.

If your claim is denied, you will receive an Adverse Benefit Determination. The Adverse Benefit Determination will include:

1. The reasons for the denial.
2. The Plan provisions that the denial is based on.
3. A description of any additional material or information we need to reopen the Claim for consideration and an explanation of why that material or information is needed.
4. A description of the Plan's appeal procedures and time limits.

If all or part of a Claim was not covered, you have the right to see, upon request and at no charge, any rule, guideline, or criterion that the Plan relied upon in making the coverage decision.

Our Right to Information from Your Dentist

On one or more occasions, we may require information from Dentists who provided dental care services to you in order to review and process your Claims. By enrolling yourself and your Eligible Dependents in the Plan, you automatically and irrevocably consent to the sharing of information between us and your Dentist in order to process your Claims.

Recovery of Overpayment

We may recover any overpayment of Benefits from any persons or organizations listed that we have determined to have benefited from the overpayment.

- Any person to, or for whom those payments were made;
- Any insurance company;
- A facility or provider; or
- Any other organization.

The payment amounts may include the reasonable cash value of any Benefit.

Dentists and you have the responsibility to return any overpayments to us. You may be required to cooperate with us to secure Delta Dental's right to recover any excess payments made on your behalf, or on behalf of other Enrollees enrolled under your family coverage.

We have the responsibility to make additional payments if we made any underpayments of Benefits.

How to Ask Questions about the Plan and Claims

If you have any questions, comments, or information about the Plan or any Claims, you may call our Member Services at 1.800.234.3375 or visit our website at www.deltadentalks.com to access your online member account.

How to Appeal a Claim

If your Claim is denied, in whole or in part, you or your Authorized Representative may request a review of the Adverse Benefit Determination. The request for review should be in writing and received by us no later than 180 days after your notice of the denial. If you do not receive an Explanation of Benefits 30 days after submitting your Claim, you may request a review no later than 180 days after that initial 30-day period.

When you submit a written request for review, please include a copy of the Explanation of Benefits if you have a copy and the information listed below.

1. Group number and Delta Dental ID number.
2. Enrollee's name and date of birth. If the Enrollee is not a Member, the Member's name and date of birth must be included.
3. Name of the Dentist who provided the service.
4. Date of service.
5. Description of the service provided.
6. The charged amount.
7. Claim number.

You may state the reasons you believe that the claim denial was in error. You may submit any statements, documents, or written arguments in support of the Claim.

You or your Authorized Representative should mail all requests for appeals to:

Delta Dental of Kansas
Attn: Member Services
PO Box 789769
Wichita, KS 67278-9769

How We Handle Your Appeal

We will review your appeal and all information you submit. We will conduct a new review of the Claim with no deference to the initial coverage decision. The person reviewing your appeal will not be the same person who decided the initial claim denial, and will not be that person's subordinate. Appeals involving Medical Necessity will be reviewed by a licensed dental care professional. We will give you the opportunity to review relevant documents, submit any statements, documents, or written arguments in support of the Claim.

We will acknowledge receipt of your appeal promptly and will resolve and respond to it within 60 days for Claims after the date of service.

If the initial coverage decision is upheld, we will provide you a notice listing the reasons, the Group Contract provisions that the decision is based on, and a statement of your right to bring suit under

ERISA § 502(a) if the Plan is governed by ERISA. You will be entitled to request and receive, at no charge, the following:

- Reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- Any rule, guideline, or criterion relied upon in the coverage decision;
- The explanation of the scientific or clinical judgement as it relates to the patient's medical condition if the coverage decision was based on the Medical Necessity or experimental nature of the care; and
- The identity of the experts who consulted with the Plan regarding the appeal.

Coordination of Benefits

A. General

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

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

4. 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.

5. "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 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.

6. "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.

7. "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:

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

         b) 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:

         a) 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;

         b) 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.

         c) 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

         d) 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:

            i) The plan covering the custodial parent;
            ii) The plan covering the spouse of the custodial parent;
            iii) The plan covering the non-custodial parent; and then
            iv) 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 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.

b. 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.

c. 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.

d. 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.

e. 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. Delta Dental 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. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Delta Dental 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, Delta Dental 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. Delta Dental 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 Delta Dental 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.

Eligibility, Enrollment, Changes, and Termination

Who is an Eligible Employee

Unless otherwise specified in the Group Contract, the Benefits described in this Booklet will be given to persons who:

- Meet the definition of an Eligible Employee as specified by the Group Contract.
- Have applied for this coverage and received an eligibility determination from the Group and the Plan.

The date you become eligible is the date you satisfy the eligibility provision specified by your Group. Check with your Group Administrator for eligibility requirements that apply to your coverage.

Who is an Eligible Dependent

An Eligible Dependent is defined as:

- Your Spouse.
- Your Dependent Child.
    - The Plan may request proof of a Dependent Child's age, dependency, or disability status upon Enrollment on one or more occasions.
    - We cover your newborn Dependent Child from birth date for the first 31 days. You must pay the required premiums for your newborn Dependent Child within 31 days after the birth date to continue your newborn Dependent Child's coverage beyond that 31-day period.
    - We cover your disabled Dependent Child beyond the limiting age if you submit satisfactory proof of that Dependent Child's disability status.
    - If you and your Spouse are both employed by the Group, one of you may enroll as a Member and the other as a Dependent, or both of you may enroll as Members. You may cover your Children under your coverage or your Spouse's coverage, but not both.
- Dependents may be enrolled under one Member only.

Applying for Coverage

You may apply for coverage in the Plan for yourself or your Dependent or both of you.

You may enroll in or change plans for yourself or your Dependent or both of you during one of the following enrollment periods.

Initial and Annual Open Enrollment Periods

Your Group will designate initial and annual open enrollment periods during which you may apply for or change coverage in a plan for yourself or your Dependent or both of you. Your and your Dependents' Effective Dates will be assigned by the Plan under the terms of the Group Contract. Your Group is responsible for determining your waiting period. If you have questions about your waiting period, contact your Group Administrator.

Special Enrollment Periods

The Plan includes special enrollment periods during which you may enroll in or change coverage in the Plan for yourself or your Dependent or both of you who declined coverage in the past. You must apply for coverage no later than 30 days after any Qualifying Life Event.

Coverage under special enrollment will be effective no later than the first day after the Plan receives your application for enrollment for yourself or your Dependent or both of you.

Eligibility Changes

It is your responsibility to notify the Plan of any change to an Enrollee's name or address. You may call Member Services at 1.800.234.3375 or visit our website at www.deltadentalks.com to access your online member account.

Any change will be effective at the end of the month during which eligibility changes, except as otherwise provided in the Group Contract.

Continuation Coverage

Enrollees may be eligible to continue coverage under Continuation Coverage. Check with your Group Administrator to determine if your Group is subject to Continuation Coverage.

Eligibility for Continuation Coverage

Qualifying Life Events means events that cause an Enrollee to lose coverage under the Plan. The type of Qualifying Life Event determines who the qualified beneficiaries are for that event and the period that the Plan must offer Continuation Coverage. When a Qualifying Life Event occurs, eligibility under the Plan may continue for you or your Eligible Dependent or both of you who were covered on the date of the Qualifying Life Event.

You or your Eligible Dependent is responsible for notifying the Group Administrator no later than 60 days after the occurrence of the Qualifying Life Events listed below.

- Your divorce or legal separation.
- Your Dependent Child's loss of Dependent status under the Plan.
- The birth, adoption, or placement for adoption of a Child while you are covered under Continuation Coverage.

Election of Continuation Coverage

You or your Eligible Dependent or both of you must elect Continuation Coverage no later than 60 days after the last to occur of the two listed dates.

- The date the Qualifying Life Event would cause you or your Dependent or both of you to lose coverage.
- The date your Group Administrator notifies you or your Eligible Dependent or both of you of your Continuation Coverage rights.

If you have questions about Continuation Coverage, ask your Group Administrator.

When Your Coverage Ends under the Plan

In general, your coverage will end when you cease to be eligible or the required premiums are not paid within the 10-day grace period each month in accordance with the Group Contract. Unless otherwise agreed to in writing by us, your coverage ends on the last day of the month the last payment was made. Your coverage ends on the last day of the month during which eligibility ceases. All Benefits cease when your coverage is terminated.

Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or misrepresentation of fact in applying for or obtaining coverage under the Group Contract. Your coverage will end immediately if you file a false Claim.

If your premiums are not paid, your coverage will stop at the end of the month that your premiums were last paid, except as otherwise provided in the Group Contract.

The Plan will continue until terminated by either your Group or us. Termination of the Group Contract ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of that termination. Your coverage will end whether or not that notice is given.

Important Information about the Plan

Changes in the Plan

Your Group and Delta Dental may change your Benefits on one or more occasions. Any changes to the Plan will take effect on the date of that change.

Notices

If we change the Plan, we will send you written notice. Any notice required under the Plan must be in writing. Notice given to your Group will be sent to your Group's address. Notice given to you will be sent, at our option, to your Group or to your address as it appears on our records. Your Group or you may change your address for giving notice.

Legal Action

You may not bring any legal action against us no earlier than 60 days after a Claim is filed, on the condition that you exhaust the internal administrative appeal rights stated in this Booklet before bringing that legal action. All legal action by any person subject to the Group Contract must be commenced no later than 5 years after the date that Claim first arises. This time limit applies to matters relating to the Plan, to our performance under the Plan, or to any statement made by an employee, officer, or director of Delta Dental regarding the Plan or the Benefits available to you.

Our References to Dentists are Not an Endorsement

We provide Benefits to you for dental care services rendered by Dentists only. We will not be deemed practicing dentistry. Our reference to Dentists as Participating Dentists and Out-of-Network Dentists will not be deemed an endorsement or guarantee of these Dentists' professional abilities or experience.

Definitions

This section defines terms that have special meanings in this Booklet. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in this section or where used in the text or if it is a title.

Adverse Benefit Determination

An Explanation of Benefit issued when a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation.

Allowance

A fixed amount or fixed percentage that may be applied toward the payment for dental care services as specified by the Benefit.

Authorized Representative

The person entitled to act on behalf of you or any other Enrollee for a Claim or appeal. The Plan must receive a written and notarized notice signed by you or an Enrollee before the Plan will recognize a person as an Authorized Representative.

Balance Billing

Any amounts that a Dentist bills an Enrollee for charges, other than Deductibles, Coinsurance, or any other amount that may exceed the Maximum Plan Allowance for a Benefit. If an Enrollee receives dental care services from an Out-of-Network Dentist, the Out-of-Network Dentist may Balance Bill for the difference between the Maximum Plan Allowance and the billed charges.

Benefit

Dental care services that is listed as Covered Services and eligible for payment or reimbursement under the Plan in accordance with the Group Contract.

Booklet

This document given to the Member that describes the Benefits covered by the Group Contract. This document contains Coinsurance requirements, exclusions, limitations, dental care coverage details, and the responsibilities of both you and us.

Calendar Year

A 12-month period beginning on the first day of January and ending on the last day of December.

Child (or Children)

In addition to the Member's own or lawfully adopted child or children, any step-child of the Member. The term also includes the following:

- any newly born child adopted by the Member from the moment of birth if a petition for adoption as provided under state law was filed within 31 days of the birth of the child;
- any person placed with the Member for adoption if such child was placed in the Member's home by a child placement agency as defined by state law; and
- any child of the Member who is recognized as an alternate recipient under a qualified medical child support order.

A child is eligible for coverage under the Plan if the child meets the age requirements as set forth in the Plan. In addition, a child includes a disabled child who is:

- incapable of earning his or her own living because of mental or physical disability; and
- principally dependent upon the Member for support at the time the child would otherwise cease to be eligible for coverage by the Plan because of age.

A disabled child shall continue to be an Eligible Dependent for the duration of the disability, provided:

- his or her status as an Eligible Dependent does not terminate for any other reason; and
- proof of disability is furnished to us within 31 days after child attains the age which would otherwise be disqualifying.

Claim

A request for payment or reimbursement of dental care services on a Claim form that your Dentist or you submit to us when you get dental care you believe are covered.

Coinsurance

A percentage of the fee that you must pay for some Covered Services. Refer to the Summary of Dental Plan Benefits for any Coinsurance that applies to your coverage.

Continuation Coverage

Extended coverage provided under the Plan under Consolidated Omnibus Budget Reconciliation Act (COBRA) or similar state continuation laws that may allow you to temporarily extend your coverage under the Plan after your employment ends, you lose coverage as an Eligible Dependent of the Member, or another Qualifying Life Event. If you elect to temporarily extend your coverage under the Plan in accordance with Continuation Coverage, you pay all of the premiums, including the share of your premiums that the Group used to pay, plus a small administrative fee of not more than 2% of premiums.

Contract Year

A 12-month period beginning on the effective date of the Group Contract and ending on the last day of the initial term of the Group Contract. Upon the expiration of the initial term, Contract Years continue for successive 12-month periods.

Cosmetic

Any aesthetic dental care services that focuses on improving appearance and facial self-image.

Covered Services

The dental services, procedures, and products which are covered under the Plan in accordance with the terms and conditions contained in the Group Contract.

Deductible

The dollar amount you are responsible to pay for Covered Services before we will pay for a Benefit if that Covered Service is subject to the Deductible. Specific information regarding the Deductible as it relates to the Plan's Covered Services is listed in the Summary of Dental Plan Benefits.

Delta Dental

Delta Dental of Kansas, Inc. and its agents.

Delta Dental Dentist Handbook

The Delta Dental Dentist Handbook contains general processing policies that we must adhere to except to the extent prohibited under applicable law. The general processing policies in the Delta

Dental Dentist Handbook apply to each CDT code and associated descriptor, and specific processing policies, exclusions and limitations, that apply to each code.

Delta Dental Plans Association

Delta Dental Plans Association is a not-for-profit organization comprised of a network of Delta Dental member companies operating in all 50 states, Puerto Rico, and other U.S. territories. Delta Dental Plans Association establishes standards and guidelines, including the Delta Dental National Processing Policies, which apply to all member companies and which are incorporated by reference in this Booklet and constitute part of the Group Contract. Compliance is required in order to maintain membership in the Association.

DeltaUSA Policy Manual/Delta Dental National Processing Policies

DeltaUSA Policy Manual/Delta Dental National Processing Policies describe general policies related to the processing of dental procedure codes. Participating Dentists agree to abide by all national processing policies for all Delta Dental member companies. The processing policies should not be interpreted as encompassing all possible exclusions and limitations.

Dental Network

One or more of our networks of Participating Dentists as identified in the Participating Dentist Section.

Dental Plan (or Plan)

This dental care coverage plan offered to you by your Group in accordance with the Group Contract.

Dentist

A dental care provider who has the required training and maintains appropriate licenses at the time and place that dental care provider renders dental care services.

Dependent

A person other than the Member, such as a Spouse, an unmarried Child under the age of 26, and an unmarried Child of any age who is medically certified as disabled and dependent on the Member, as shown in the Eligibility, Enrollment, Changes, and Termination Section.

Effective Date

The date your dental care coverage under the Plan begins.

Eligible Dependent

A person, such as a Spouse or a Child of an Eligible Employee, who meets one or more conditions set forth in Who is an Eligible Dependent Section and is eligible to enroll under the Plan, and any person who no longer meets these conditions, but qualifies for and promptly elects Continuation Coverage and promptly pays the required premiums.

Eligible Employee

A person who meets one or more conditions set forth in Who is an Eligible Employee Section, and any person who no longer meets those conditions, but qualifies for and promptly elects Continuation Coverage and promptly pays the required premiums.

Endorsement

An amendment to the Group Contract, such as adding, modifying, or removing some Covered Services.

Enrollee

An Eligible Employee and their Eligible Dependents who are enrolled and covered under the Plan.

Experimental or Investigational Services

Dental care services that have not been proven to provide the desired result.

Group

The person or entity, usually your employer, that contracts with us on behalf of you and other employees.

Group Administrator

The person or group of people, identified by your Group, who are responsible for managing this Dental Plan.

Group Application

The written request for dental care coverage by your Group to us. The Group Application includes all required data and related information that we may require on one or more occasions to establish and maintain the Plan in accordance with the Group Contract.

Group Contract

The agreement between your Group and us, the Group Application, and any other Endorsements attached to the agreement under which Benefits are provided through the Plan.

Maximum Benefit

The highest dollar amount the Plan will pay towards specified Covered Services in accordance with the Group Contract.

Maximum Plan Allowance (or MPA)

The total dollar amount we will pay for specific Benefit reduced by any applicable Deductible and Coinsurance you are required to pay. The MPA may vary based on if you choose a Participating Dentist or an Out-of-Network Dentist.

Medicare

U.S. government insurance program for people over 65 or with certain disabilities.

Medicaid

U.S. government insurance program for people within certain income limits.

Member

An Eligible Employee who is enrolled and covered under the Plan.

Orthodontic Services

Appliances and treatments, interceptive and corrective, to correct irregularly placed or located teeth. X-rays, removal of such teeth, and other dental care services provided as part of these treatments are also considered Orthodontic Services.

Out-of-Network Dentist

A Dentist who has not executed a Participating Dentist Agreement and has not agreed to terms contained in the Participating Dentist Agreement regarding dental care services that we consider not

billable to the you. If you see an Out-of-Network Dentist, the Dentist may bill you for dental care services that would otherwise be considered not billable to you if you visited a Participating Dentist.

Out-of-Pocket Costs

Your dental care expenses that are not reimbursed under the Plan. These costs include Deductibles, Coinsurance, and all costs for dental care services that are not covered under the Plan in accordance with the Group Contract.

Plan (or Dental Plan)

This dental care coverage plan offered to you by your Group in accordance with the Group Contract.

Plan Year

A 12-month period of Benefits coverage under this Dental Plan. This 12-month period may not be the same as a Calendar Year. To find out when the Plan begins and ends, you may check the Plan documents or ask your Group Administrator.

Participating Dentist

A Dentist who has executed a Participating Dentist Agreement with us and has agreed to provide dental care services as a Delta Dental PPO Dentist and/or Delta Dental Premier Dentist. Those Dentists agreed to provide dental care services as established by us and to comply with the terms and conditions of the Participating Dentist Agreement such as accepting that certain dental care services are not billable to you and accepting the Maximum Plan Allowance for payment where applicable.

Predetermination of Benefits (or Predetermination)

A written request for verification of Benefits submitted by a Dentist before they render dental care services to you. We suggest that you request a verification of your Benefits before you receive dental care services that are usually expensive.

Qualifying Life Event

A change in your situation — like getting married or losing dental care coverage — that can make you eligible for a special enrollment period, allowing you to enroll in the Plan outside the annual open enrollment period.

Relative

A person connected to you by blood, marriage, or adoption.

Right Start 4 Kids℠ (or RS4K)

Enrolled Children who are under the age of 12 and under will receive their Claims paid at 100%, for all Covered Services, excluding Orthodontics Services on the condition that they see a Participating Dentist. When visiting a Participating Dentist, Deductible will not apply, but the annual maximum, frequencies, exclusions, and limitations under the Plan will apply. When visiting an Out-of-Network Dentist, they are not eligible for RS4K for that visit and are subject to normal waiting periods, Deductibles, and Coinsurance.

Spouse

The Member's significant other in a legal marriage recognized under the laws of the state where the Member resides.

Summary of Dental Plan Benefits (or **Summary**)

An easy to read overview that summarizes dental care services that are covered under the Plan in accordance with the Group Contract that helps you make comparisons of dental care coverage between Participating Dentists and Out-of-Network Dentists. This summary may help you determine your possible Out-of-Pocket Costs, Benefits, and other Plan features that may be important to you.

Workers Compensation

Form of insurance providing medical and other benefits to employees injured while at work.

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 و البكم: 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).