

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. Since nearly 4 out of 5 dentists 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 with Delta Dental, 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 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

CBIZ INC (80)

Group #90604-000-00001-00000

% paid by Plan	Examples of Covered Services	
DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)		
Premier Network 80%	I.	DIAGNOSTIC: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <u>Oral evaluations</u> – two (2) times per Calendar year. <u>Diagnostic x-rays</u> – bitewings two (2) times per Calendar year for dependents under age twenty-five (25) and once each twelve (12) months for adults age twenty-five (25) and over. <u>Full mouth x-rays or panoramic x-rays</u> – once each three (3) years.
80%	II.	PREVENTIVE: Provides for the following: <u>Prophylaxis</u> (Cleanings) – two (2) times per Calendar year. <u>Topical Fluoride</u> – two (2) times per Calendar year for dependent children under age nineteen (19). <u>Space Maintainers</u> for dependent children under age nineteen (19) and only for premature loss of primary molars.
BASIC (Subject to Deductible)		
80%	III.	ANCILLARY: Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
80%	IV.	ANESTHESIA: Nitrous Oxide covered for all dependents three (3) and under.
80%	V.	ORAL SURGERY: Provides for extractions and other oral surgery including pre and post-operative care.
80%	VI.	CONSULTATIONS: Provides for a diagnostic service provided by dentist or physician other than requesting dentist or physician.

% paid
by Plan

Examples of Covered Services

BASIC (Subject to Deductible) (continued)

Premier
Network

80%

VII. REGULAR RESTORATIVE DENTISTRY:
Provides amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).

80%

VIII. ENDODONTICS: Includes procedures for root canal treatments and root canal fillings.

80%

IX. PERIODONTICS:
a. Includes procedures for the treatment of diseases of the tissues supporting the teeth.
If diagnosed with periodontal disease, then eligible for four (4) cleanings per Calendar year.

80%

b. Surgical periodontal procedures.

MAJOR (Subject to Deductible)

40%

X. SPECIAL RESTORATIVE DENTISTRY:
When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.

40%

XI. PROSTHODONTICS: Includes bridges, partial and complete dentures, including repairs and adjustments.

40%

XII. IMPLANTS: Includes coverage for procedures outlined in Exclusions & Limitations section of this booklet.

ORTHODONTICS (Subject to Deductible)

None

XIII. ORTHODONTICS: Orthodontic appliances and treatment.

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 paid 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 is Delta Dental PREMIER.

Maximum Benefit Per Person

The Maximum Benefit for all Covered Services, including Implant procedures, for each Enrollee in any one calendar year is One Thousand Dollars (\$1000.00).

Deductible Limitations

Coverage for oral evaluations, x-rays, prophylaxis, fluoride treatments, space maintainers and sealants is not subject to the Deductible. However, the Deductible shall apply during each calendar year to all other Covered Services which are provided to each Enrollee.

After Covered Employee and his/her Eligible Dependents who are Enrollees have, in any calendar year, each paid either the individual Deductible of Fifty Dollars (\$50.00), 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 calendar year.

Payment of Claims

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

Eligible Dependent Ages

Dependents are eligible for coverage to age 26.

DESCRIPTION OF DENTAL CARE COVERAGE

This Description of Dental Care Coverage is issued to the Covered Employee 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. 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 prosthetic 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 “Non-Duplication of 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

DDKS’s group dental coverage includes services for emergency treatment. Each individual dental office has its own emergency treatment procedure and patients 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

INQUIRIES/APPEALS

Dentists and patients 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.

Patients who have inquiries or an appeal regarding the Agreement are encouraged to write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769. Written inquiries are best 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. Patient’s name and birth date. If the Patient is not the Covered Employee, the Patient’s name and birth date must also be included.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question.

When appropriate, an evaluation will be made by DDKS and, in some cases the Patient may be examined clinically. If necessary, additional information or documents may be requested for a full and fair review. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, Patients 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 Patient will be advised. Generally, a written answer or decision will be sent to the Patient within thirty (30) days thereafter.

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.

NOTICE OF CLAIM

Written notice of claim must be given to DDKS within twenty (20) days after the occurrence or commencement of any claim/loss covered by the Agreement, or as soon thereafter as in reasonably possible. Notice given by or on behalf of the Enrollee or the beneficiary to the Enrollee to DDKS at 1619 N. Waterfront Parkway, Wichita, KS 67206, or to any authorized agent of DDKS, with information sufficient to identify the Enrollee, shall be deemed notice to DDKS.

CLAIM FORMS

DDKS, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time frame fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS

Written proofs of loss/claims must be submitted to the insurer at its office within six (6) months of the date that the Covered Service was provided. But, failure to submit a claim within six (6) months of the date that the Covered Service provided will not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time, provided that such claim is submitted as soon as reasonably possible and in no event,

except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

TIME OF PAYMENT OF CLAIMS

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

DDKS LIABILITY

DDKS shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous 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 this 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 this Agreement constitutes the Enrollee's (and the related Covered Employee'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 shall be commenced and maintained in Wichita, Kansas. Except to the extent preempted by ERISA, the parties irrevocably consent to the exclusive jurisdiction and venue located within Sedgwick County, State of Kansas for such purpose and agree not to seek transfer or removal of any action commenced in connection with this Agreement.

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 or services 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, premedications and relative analgesia, including nitrous oxide; hospital, healthcare facility or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.

- f. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for cosmetic purposes; for splinting or equilibration.
- g. 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; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.
- h. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.
- i. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of the Agreement.
- j. Crowns and endodontic treatment in conjunction with an overdenture.
- k. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" Section.
- l. Replacement of lost or stolen dentures or charges for duplicate dentures.
- m. Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in the "Summary of Dental Plan Benefits" Section.
- 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, a motivating purpose for which is 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 (unless the following documentation is provided to process the claim(s):
 - 1. A copy of proof of licensing for the provider must be attached to the claim form with a receipt of services from the rendering office.
 - 2. The Enrollee must also submit a completed form with all of the following:

- a. Complete name and address, translated into English, of the Enrollee and service provider(s)
- b. Local license identification (if any) of the service provider(s)
- c. Services rendered with U.S. dollar conversion and proof of receipt
- d. Any supporting documentation for processing claims, such as tooth charts and x-rays.

If any of the above steps are omitted, the claim will be denied.)

- r. Benefits or services for control of harmful habits.
- s. Treatment to correct congenital or developmental malformations.
- t. Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in the “Summary of Dental Plan Benefits” Section. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.
- u. Individual crowns unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.
- v. Diagnosis or treatment of temporomandibular joint dysfunction, 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. Some Covered Services may be subject to specific age and frequency limitations. These limitations are generally identified in the “Summary of Dental Plan Benefits” Section.
- c. 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.
- d. Prophylaxis, periodontal maintenance and oral evaluations may be subject to specific time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section. Bitewing x-rays may be subject to

specific age, time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section.

- e. Full mouth and panoramic x-rays may be subject to specific time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.
- f. A seven (7) vertical bitewing series is limited to once (1) every two (2) years.
- g. 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.
- h. Recementation of space maintainers are limited to once (1) per arch or quadrant per lifetime.
- i. Claims not submitted to DDKS within six (6) months of the date that the Covered Service was provided will not qualify as a Covered Service unless it was not reasonably possible to submit the claim within such time and provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.
- j. Sealants are limited to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact. Coverage for sealants is limited to one (1) per lifetime per permanent molar unless the “Summary of Dental Plan Benefits” Section allows for other frequency limitations.
- k. Inlays will automatically receive benefits equal to the corresponding surface of a filling.
- l. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section:
 - (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) Recementation 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 2.2 (1) will apply.
 - (6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.
- m. Prosthetic appliances 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 state 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 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 date the denture or bridge 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) Recementation 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.
- n. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period.
- o. Periodontic procedures are not Covered Service 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 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 once (1) in any six (6) month period; and crown lengthening which carries no frequency limitation.
- p. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services and is limited to a maximum of ninety (90) minutes, per episode.
- q. Procedures for dental implants and associated services will be a Covered Service, but only as follows:
- (1) Coverage should be predetermined and is limited to those Enrollees, age sixteen (16) and over. Enrollees 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.
 - (2) The Dentist must 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 must be received and approved by DDKS before any dental services are performed.
 - (3) As determined by DDKS, the Covered Services may include benefits such as, but 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.
 - (4) Payments are limited to the amount determined by DDKS 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, as appropriate.
- r. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

3. Certain Dental Benefits and Services Provided Are Disallowed under the Plan. When dental benefits or services are disallowed, the fees associated with those items are neither benefited by DDKS nor collectable from the Enrollee by a Participating Dentist. Disallowed services will be so indicated on the applicable Enrollee's Explanation of Benefits.

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. "Child" means, in addition to the Subscriber's own or lawfully adopted unmarried child or children, any unmarried step-child of the Subscriber residing with the Subscriber in a regular parent-child relationship so long as said child is not eligible to enroll in an "eligible employer-sponsored health plan" as defined by federal law. The term "Child" also includes any unmarried person placed with the Subscriber for adoption if such child was placed in the Subscriber's home by a child placement agency as defined by Kansas law, and any unmarried child of the Subscriber 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 "Summary of Dental Plan Benefits, Eligible Dependent Ages" Section.

In addition, a Child includes an unmarried disabled Child who is: i) incapable of earning his or her own living because of mental or physical disability, and ii) principally dependent upon the Subscriber 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: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to DDKS within thirty-one (31) days after Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by DDKS.

4. "Continuation Coverage" means the coverage provided under this 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 this Agreement to satisfy Section 4980B of the Code, are being hereby adopted and incorporated by reference.
5. "Contract Year" means the period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof.

6. “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.
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 Employee” means an Eligible Employee who has enrolled in the Plan during annual open enrollment or other enrollment period established by the Employer following an 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 for whom the required payment is timely made.
9. “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 Agreement.
10. “DDKS” means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Association member company which has agreed to provide to Enrollees the benefits described in this Agreement, or both, as applicable.
11. “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.
12. “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.
3. If Delta Dental PPO is a Passive Network, then co-insurance levels for Delta Dental PPO and Delta Dental Premier are the same and Enrollees can use any Participating Dentist, as shown in the “Summary of Dental Plan Benefits” Section.
13. “Dentist” means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.
14. “Effective Date” means the first day of the initial term of this Agreement.
15. “Eligible Dependent” means i) the spouse of a Covered Employee, ii) a Child of a Covered Employee who satisfies the requirements of the definition of Child in Number 3 of this section, and iii) any such spouse or Child who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS, iv) the Domestic Partner of an Eligible Employee, and v) non-dependent Children of the Domestic Partner of an Eligible Employee.
16. “Eligible Employee” means any person who meets the conditions of eligibility outlined in the “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.
17. “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.
18. “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.

19. “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.
20. “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” Section.
21. “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 the Plan utilizes an Exclusive Network, no benefits are provided.
22. “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.”
23. “Participating Dentist” means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentists 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.
24. “Plan” means the dental benefits arrangement which is offered and administered pursuant to the terms of the Agreement.

ELIGIBILITY OF EMPLOYEES AND THEIR DEPENDENTS

1. Eligible Employee:

To qualify as an Eligible Employee, an individual must meet the Waiting Period set by the Employer and one (1) of the following requirements:

- a. Be a full-time employee who is:
 - 1. actively employed to work for Employer a regularly twenty-five (25) hours per week for at least nine (9) months in a Calendar year, working for CBIZ

and associated companies, including active, full-time employees in MHM P.C. and associated L.L.C. companies;

2. on paid sick leave from such active employment;
 3. on any other approved leave of absence from such active employment; or
- b. 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.
- c. Individuals who receive 1099 transactional based revenue from a broker, dealer or registered investment advisor.

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 Covered Employee.
- 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 Covered Employee, 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 Covered Employee, 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 this 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 determined by the "Non-duplication of Benefits" Section of the Agreement.

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 Covered Employee, or ii) the date such person satisfies the requirements to become an Enrollee.
- b. With respect to a person who is an Eligible Dependant who is not an Enrollee on the Effective Date, then coverage hereunder shall begin upon the later of i) the Covered Employee with respect to whom such person is a dependent becoming a Covered Employee, 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 Covered Employee with respect to whom such person is a dependent becoming a Covered Employee, ii) the date upon which such person satisfies the requirements to become an Enrollee.

5. Commencement of Coverage for Domestic Partners:

Be a same sex or opposite sex domestic partner of an Eligible Employee. To be eligible for this coverage, the Employer must receive from employee and his/her domestic partner either:

- (1) a properly completed "Declaration of Domestic Partner Status" form provided by the Employer on which both partners represent that they have, contemporaneously with the application for domestic partner status, exchanged words spoken in the present tense with the specific purpose of creating a common-law spousal relationship (i.e. legal marriage) with each other to the extent permitted under current law or if the couple is not permitted to marry under current statute, the partners must establish that they have assumed legal responsibility for each other's common welfare and financial obligations, lived together for at least six (6) months, are not blood relatives, share utility, rent or

mortgage payments, and are not married to or claimed by anyone else as a partner;

- (2) evidence satisfactory to the Employer that the employee and domestic partner are two adults who are registered as domestic partners with a government entity within the United States pursuant to state or local law authorizing this registration.

Domestic partner status will be effective as of the date as of which the Employer approves such status.

6. Termination of Benefits:

- a. If, at any time, a Covered Employee fails to satisfy all of the requirements of the Agreement, coverage under the Agreement shall terminate for such Covered Employee, and each dependent of such Covered Employee, in the following manner:
 - 1) If the Covered Employee qualifies for, timely elects and timely pays for Continuation Coverage, then the Covered Employee 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 Covered Employee 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 Covered Employee first ceases to satisfy such requirements.
- b. If, at any time, an Enrollee who is not the Covered Employee 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 Covered Employee upon whom such person is dependent ceases to constitute a Covered Employee, 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.

7. Non-Duplication of Benefits:

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has dental care coverage under more than one plan. The term “plan” is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed one hundred percent (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. However, 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 insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$200 per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident type coverage; and Medicare or other governmental benefits, as permitted by law.
 - (b) The term “plan” does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of \$200 or less per day; medical benefits under group or individual automobile contracts; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

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

- (2) The order of benefit determination rules determine whether the plan is a “primary plan” or “secondary plan” when compared to another plan covering the person.

When the plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When the plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

- (3) "Allowable expense" means a dental care service or expense, including deductibles and co-payments, or co-insurance 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, (for example an HMO) 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. The following are examples of expenses or services that are not allowable expenses:
 - (a) If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
 - (b) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second opinions, precertification requirements, and preferred provider arrangements.
- (4) "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under the plan, or before the date the COB provision or a similar provision takes effect.
- (5) "Closed panel plan" is a plan that provides 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 limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- (6) "Custodial parent" means a 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 without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES.

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

- (1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- (2) A plan that does not contain a coordination of benefits, maintenance of benefits, or non-duplication of benefits provision that is consistent with this Section is

always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are 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.

- (3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- (4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - (a) The plan that covers the person other than as a dependent, for example as an employee, member, Covered Employee or retiree is primary and the plan that covers the person as a dependent is secondary. 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 the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, Covered Employee or retiree is secondary and the other plan is primary.
 - (b) The order of benefits when a child is covered by more than one plan is:
 1. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - a. The parents are married;
 - b. The parents are not separated (whether or not they ever have been married); or
 - c. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - d. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 2. If the specific terms of a court decree state that one of the parents is responsible for the 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 claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - a. The plan of the custodial parent;
 - b. The plan of the spouse of the custodial parent;
 - c. The plan of the noncustodial parent; and then
 - d. The plan of the spouse of the noncustodial parent.
- (c) The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the order described in “C. Order of Benefit Determination Rules 4(a).”
- (d) If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, Covered Employee or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (e) The plan that covered the person as an employee, member, Covered Employee or retiree longer is primary.
- (f) If a health plan includes coverage for dental procedures under the major medical provisions of the plan, that plan is primary.
- (g) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

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 claim determination period are not more than one hundred percent (100%) of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

- (a) Determine its obligation to pay or provide benefits under its contract;
- (b) Determine whether a benefit reserve has been recorded for the covered person; and
- (c) Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero (0). A new benefit reserve must be created for each new claim determination period.

- (2) If a covered person is enrolled in two (2) 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.

ERISA Information

Plan Sponsor: Century Business Services, Inc.
P.O. Box 632886
Cincinnati, OH 45263
(216) 447-9000

Employer Identification Number (EIN): 22-2769024

Plan Administrator: Same as Plan Sponsor

Designated Agent for service of legal process: Same as Plan Sponsor

Plan Contributions: Employer and Employee, jointly

Dental Claims Administrator: Delta Dental Plan of Kansas, Inc.
P.O. Box 789769
Wichita, KS 67278-9769

Appeal Procedure

If a claim is denied in whole or in part as recommended by the *Dental Claims Administrator* the following claims appeal procedure shall be observed:

- (a) The *claimant*, or the *claimant's* duly authorized representative, may appeal the denial by submitting to the *Plan Administrator* or the *Dental Claims Administrator* a written request for review of the claim within 60 days after receiving written notice of such denial from the *Dental Claims Administrator*. Failure by the *claimant* to submit a request for review within 60 days after receiving the denial of benefits shall constitute a waiver by the *claimant* of the right to appeal the decision. The *Plan Administrator* or the *Dental Claims Administrator* shall, upon the *claimant's* request, give the *claimant* an opportunity to review pertinent documents, other than legally privileged documents, in preparing such request for review.
- (b) The request for review must be in writing and shall be addressed as follows:

Delta Dental Plan of Kansas, Inc.
P.O. Box 789769
Wichita, KS 67278-9769
- (c) The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the *claimant* deems pertinent. The *Plan Administrator* or the *Dental Claims Administrator* may require the *claimant* to submit, at the expense of the *claimant*, such additional facts, documents or other material as are necessary or advisable in conducting the review.

- (d) The *Dental Claims Administrator* shall act upon each request for review within 60 days after receipt thereof unless special circumstances require further time for processing, but in no event shall the recommendation or review be rendered more than 120 days after the *Dental Claim Administrator* receives the request for review. Written notice of an extension of time beyond 60 days shall be furnished to the *claimant* prior to the commencement of the extension.
- (e) In the event the *Plan Administrator* confirms the denial of the claim for benefits in whole or in part, written notice of the *Plan Administrator's* decision shall be given to the *claimant*. Such notice shall be written in a manner calculated to be understood by the *claimant* and shall contain the specific reasons for the denial.
- (f) In the event the *claimant* remains aggrieved after receiving notice of the *Plan Administrator's* decision to confirm the denial, the *claimant* may again appeal the denial. The procedure outlined in parts (a) through (e) above shall also apply to the second appeal.

STATEMENT OF ERISA RIGHTS

As a *Participant* in the *Plan* you are entitled to certain rights and protections under Employee Retirement Income Security Act of 1974 (*ERISA*). *ERISA* provides that all *Plan Participants* shall be entitled to:

Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as work sites and union halls, all *Plan* documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the *Plan* with the U.S. Department of Labor, such as detailed annual reports and *Plan* descriptions.

Obtain copies of all *Plan* documents and other *Plan* information upon written request to the *Plan Administrator*. The administrator may make a reasonable charge for the copies.

Receive a summary of the *Plan's* annual financial report if the *Plan* covers 100 or more *Participants*. The *Plan Administrator* is required by law to furnish each *Participant* with a copy of this summary annual report.

In addition to creating rights for *Plan Participants*, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of you and other *Plan Participants* and beneficiaries. No one, including your *Employer*, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the *Plan* reviewed and your claim reconsidered.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request materials from the *Plan* and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in state or federal court. If it should happen that the *Plan* fiduciaries misuse the *Plan's* money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your *Plan*, you should contact the *Plan Administrator*. If you have any questions about this statement or about your rights under *ERISA*, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

The following provisions are only applicable to *Employers* with 20 or more employees.

A *Participant's* participation in the *Plan* may be continued if:

- a. The *Participant* notifies the Employer within 60 days of the *qualifying* event of the desire to continue participation, and
- b. The entire cost, at the group rate, is paid by, or on behalf of,. The *Participant* continuing participation.

Qualifying event means any event that results in a loss of participation in the *Plan* for which continuance under the Special Federal Continuance Provisions is available.

This continuance is subject to all other terms and conditions of the *Plan*.

Continuance for Participants

A *Participant*, including any covered dependents, may continue participation in the *Plan* if the *Participant* stops *active work* due to any of the following *qualifying* events:

- a. the *Participant's* employment ends for any reason except gross misconduct;
- b. the *Participant* retires;
- c. the *Participant's* work hours are reduced to less than *full-time*; or

The *Participant's* continued participation in the *Plan*, including participation for any *covered dependents*, will end on the earliest of:

- a. the date the *Participant* fails to make any required contribution;
- b. the date the *Participant* becomes covered under any *other group dental expense coverage*. The *Participant's* participation may be continued if the new group dental plan excludes or limits a current condition as a pre-existing condition or for a specific waiting period. Continued participation will end when the *Participant* satisfied the new plan's pre-existing limitation or waiting period.
- c. the date the *Plan* ends; or
- d. 18 months after the date continuance began, or 29 months after the date continuance began, if, before the end of the 18-month period the *Participant* or a *covered dependent* are determined to have been disabled for Social Security benefits when the continuance began.

Continuance for Dependent Children

Participation under the *Plan* for a covered dependent child may be continued of the child ceases to be an *eligible dependent* due to any of the following *qualifying events*:

- a. the child ceases to be dependent upon the *Participant*;
- b. the child ceases to be a full-time student in an accredited school;
- c. the child attains the age limit for dependent participation as described in the Eligible Dependents provision;
- d. the child gets married;
- e. the *Participant* dies; or
- f. the *Participant* divorces or legally separates from his spouse.

Continuance for Dependent Spouses

Participation under the *Plan* for a *covered dependent* spouse may be continued if he ceases to be an eligible dependent due to any of the following qualifying events:

- a. the dependent spouse becomes divorced or legally separated from the *Participant*; or
- b. the *Participant* dies.

When Continuance for Dependents Ends

Continued participation under the *Plan* for dependents will end on the earliest of:

- a. the date any required contribution is not made by, or on behalf of, the *covered dependent*;
- b. the date the *covered dependent* becomes covered under any *other group dental expense coverage*. The dependent's participation under the *Plan* may be continued if the new group dental plan excludes or limits a current condition as a pre-existing condition or for a specific waiting period. Continued coverage will end when the dependent satisfies the new plan's pre-existing limitation or waiting period.
- c. the date the *Plan* ends; or
- d. 36 months after the date continuance began.

Retired Participants

A *Participant* who is retired from active work with the *Employer* and any *covered dependents* may continue participation under the Plan when the *Employer* files a Chapter 11 Bankruptcy Petition. Participation under the *Plan* may continue for the *Participant* and any *covered dependents* for the lifetime of the retired *Participant*. The *Participant's covered dependents* may continue participation under the *Plan* for an additional period of 36 months after the *Participant's* death. If the spouse of a deceased *Participant* is participating under the *Plan* as a *covered dependent* at the time the *Employer* files a Chapter 11 Bankruptcy Petition, the spouse may continue participation under the *Plan* for the remainder of his lifetime. The *Participant* and any *covered dependents* must make any required contributions to continue participation under the *Plan*.

Additional Continuance Provisions

If more than one *qualifying event* occurs to one person, that person's participation will not continue, under this provision, for more than 36 months after the first *qualifying event* occurred.

**DELTA DENTAL OF KANSAS, INC.
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, Inc.
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.

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.

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. 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.

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 and, you may be charged a fee to cover expenses associated with your request.

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 person 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.

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

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.

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>.

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 April 14, 2003. 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.

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