

Welcome to Delta Dental of Kansas, Inc.

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

You are free to go to any dentist of your choosing; however, there may be a difference in payment if the dentist is not a participating dentist with Delta Dental. If you receive services from a non-participating dentist, your out-of-pocket expenses may increase. It is to your advantage to choose a **Delta Dental PPO** or **Delta Dental Premier** dentist. Since nearly 4 out of 5 dentists throughout the United States do contract with Delta Dental, the chances are excellent your dentist is already a member.

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

From our website, you can

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

It is our pleasure to be of service to you.

Summary of Dental Plan Benefits

CITY OF LAWRENCE

Group #51610-000-00001-00000

% paid by Plan			Examples of Covered Services	
DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)				
PPO Network 100%	Premier Network 100%	*Non Network 100%	I.	DIAGNOSTIC: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <u>Oral evaluations</u> – two (2) per Calendar year. <u>Diagnostic x-rays</u> – two (2) per Calendar year.
100%	100%	100%	II.	PREVENTIVE: Provides for the following: <u>Prophylaxis</u> (Cleanings) - two (2) per Calendar year.
BASIC (Not Subject to Deductible)				
80%	80%	80%	III.	ANCILLARY: Provides for emergency examinations by the Dentist for the relief of pain.
80%	80%	80%	IV.	ORAL SURGERY: Provides for simple extractions.
80%	80%	80%	V.	REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations, composite (white) resin restorations on all teeth.
80%	80%	80%	VI.	ENDODONTICS: Includes procedures for root canal treatments and root canal fillings.
80%	80%	80%	VII.	PERIODONTICS:
80%	80%	80%		a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluations, counted towards the limitation for prophylaxis. Provides for periodontal cleanings for those enrollees in active periodontal treatment.
80%	80%	80%		b. Surgical periodontal procedures.
80%	80%	80%	VIII.	SEALANTS: Once (1) every four (4) years for dependent children ages five (5) through seventeen (17) when applied only to permanent molars.

% paid
by Plan

Examples of Covered Services

BASIC (Not Subject to Deductible) (continued)

PPO Network	Premier Network	*Non Network		
80%	80%	80%	IX.	FULL MOUTH X-RAYS OR PANORAMIC X-RAYS.
80%	80%	80%	X.	TOPICAL FLUORIDE: For dependent children under age twenty one (21).

MAJOR (Not Subject to Deductible) (Subject to 240 Day Waiting Period of Continuous Coverage)

50%	50%	50%	XI.	**SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	50%	50%	XII.	**PROSTHODONTICS: Includes bridges, partial and complete dentures, including repairs and adjustments.
50%	50%	50%	XIII.	**IMPLANTS: Includes coverage for procedures outlined in Exclusions & Limitations section of this booklet.
50%	50%	50%	XIV.	**SPACE MAINTAINERS: Provides for space maintainers.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (Not Subject to Deductible) (Subject to 240 Day Waiting Period of Continuous Coverage)

50%	50%	50%	XV.	**TMJ: Includes coverage for procedures outlined in Exclusions & Limitations section of this booklet.
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ORTHODONTICS (Not Covered)

None	None	None	XVI.	ORTHODONTICS: Orthodontic appliances and treatment.
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- * Members may be subject to balance billing charges if utilizing out of network providers.
- ** NOTE: 240 Day Waiting Period of Continuous Coverage for All Major Services for new enrollees and enrollees who enrolled on 1/1/2010, who did not have Dental coverage immediately before 1/1/2010 through the City of Lawrence, or for late enrollees.

**SEE SECTION ON EXCLUSIONS AND LIMITATIONS
FOR ADDITIONAL INFORMATION**

Selected Network

The Dental Network is Delta Dental PASSIVE PPO.

Maximum Benefit Per Person

The Maximum Benefit Payment is Unlimited for all Covered Services for each Enrollee in any one Calendar Year.

The maximum payment for covered Implant procedures for each Enrollee is One Thousand Dollars (\$1,000.00) per arch during such person's lifetime.

Payment for Implant Services shall not be included in determining the Maximum Benefit for each Calendar Year.

Deductible Limitations

No benefits covered hereunder are subject to any deductible amount.

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

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

INQUIRIES/COMPLAINTS

Dentists and Enrollees are encouraged to contact DDKS when they have a question concerning a particular claim. Such inquiry should be directed to the Customer Service Department of Delta Dental of Kansas, Inc., in Wichita, Kansas, and should include all of the following information:

1. Employee group number and identification number.
2. Patient name and birth date.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.

Written inquiries are best submitted on the copy of the Explanation of Benefits form.

Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511, or outside of the Wichita area, 1-800-234-3375.

Patients who have complaints about the Agreement or about services provided by a Dentist under the Agreement, are encouraged to write their complaints to Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas 67278-9769.

Enrollees may also telephone the Customer Service Department using any of the numbers identified above. Complaints or inquiries may also be presented in person at the business office of Delta Dental of Kansas, Inc., which is located at 1619 N. Waterfront Parkway, Wichita, Kansas 67206.

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 to their inquiries or complaints within twenty (20) days of receipt unless referred to a review committee or other unusual circumstances arise, in which case the patient will be advised and an answer or decision should be received in writing within thirty (30) days.

REEVALUATION AND REVIEW

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

DDKS LIABILITY

DDKS shall have no liability for any conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omission, or any other act, of any person, including but not limited to employees, dentists, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services, and shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee.

RIGHT TO INFORMATION

As a condition precedent to the approval of claims hereunder, DDKS, shall be entitled to receive from any attending or examining Dentist, or from hospitals or clinics in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, and/or treatment rendered to, an Enrollee. DDKS, at its own expense, shall have the right to cause any Enrollee to be examined when and so often as DDKS reasonably deems necessary during the pendency of a claim under the Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under the Agreement constitutes the Enrollee's (and the related Subscriber's, if applicable) automatic and irrevocable consent to the release to DDKS of any and all of the information and records before described, and a full waiver by that Enrollee that any such information and records

that otherwise is privileged. Further, by providing Covered Services to an Enrollee, a Dentist or other service provider consents to, upon request, provide such information and records to DDKS as DDKS requests.

MISREPRESENTATIONS

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

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Agreement prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of the Agreement. Further, and in all events, any action of any kind by any person who is subject to the Agreement must be commenced within two (2) years from the date on which the right, claim, demand, or cause of action shall first accrue.

GOVERNING STATUTES AND LAW

Any provision of the Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such 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 shall be commenced and maintained exclusively in the District Court of Douglas County. Except to the extent preempted by ERISA, the parties irrevocably consent to the exclusive jurisdiction and venue in any court for such purpose and agree not to seek transfer or removal of any action commenced in connection with the Agreement.

DEFINITIONS

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

1. "Agreement" means the agreement between DDKS and Employer, including the Group Application, the attached appendices, endorsements and riders, if any. The Agreement constitutes the entire agreement between the parties.
2. "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.
3. "Benefit Booklet" means this written summary of certain features of the Plan.

4. “Child” means, in addition to the Eligible Employee’s own or lawfully adopted unmarried child or children, any unmarried step-child residing with the Eligible Employee in a regular parent-child relationship. The term “Child” also includes any unmarried person placed with the Eligible Employee for adoption, and any unmarried child of the Eligible Employee 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 “Eligibility of Employees and Their Dependents” Section.

In addition, a Child includes a disabled Child who is: i) unmarried, ii) incapable of earning his or her own living because of mental or physical disability, and iii) principally dependent upon the Eligible Employee 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.

5. “Continuation Coverage” means the coverage provided under the Agreement pursuant to Section 4980B of the Internal Revenue Code of 1986, as amended (“Code”). All of the requirements, definitions and specifications of said Section 4980B of the Code which are necessary in order for this Agreement to satisfy Section 4980B of the Code, are being hereby adopted and incorporated by reference.
6. “Contract Year” means the period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof.
7. “Calendar Year” means the twelve month period commencing on the first day of January and terminating at 11:59 P.M. on the last day of December.
8. “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.
9. “Covered Services” means those dental services, procedures, and products which DDKS is required to provide to an Enrollee pursuant to the terms of the Agreement. A Covered Service only includes the extent to which a service, procedure, or product is to be provided under the Agreement (e.g., if only a portion of the cost of a service or product is covered hereunder, the remaining portion is not a Covered Service).
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 the one of the following networks which is shown 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, as shown in Section 1.6 and/or Section 1.7.
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 the Agreement.

15. “Eligible Dependent” means i) the spouse of an Eligible Employee, ii) a Child of an Eligible Employee who satisfies the requirements of the definition of Child in Paragraph 4 of this section of this booklet, and iii) any such spouse or Child who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.
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 this Agreement, and such members of the Employer’s controlled or affiliated group which are specifically listed in the 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. “Full-Time Student” means any eligible unmarried Child who i) meets age requirements in this Agreement, ii) is attending school on a full-time basis, and iii) is principally dependent upon the Eligible Employee for support. School vacation periods during any calendar year which interrupt but do not terminate what otherwise would have been a continuous course of study in that calendar year shall be considered part of school attendance on a full-time basis. DDKS may adopt rules and interpretations regarding the requirements of ii) and iii) of this Section 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.”
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, or
 - ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or
 - iii) if this 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 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.
- 25. “Subscriber” means an Eligible Employee who has enrolled in the Plan and timely paid the required premium.

EXCLUSIONS AND LIMITATIONS

- 1. **Unless the “Summary of Dental Benefits” Section Specifically Provides for Coverage, the Following Dental Benefits and Services are NOT Covered:**
 - 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 the 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. Benefits and services that are not necessary and customary as determined by the standards of generally accepted dental practice.
- g. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for cosmetic purposes; for splinting or equilibration.
- h. Benefits or services for control of harmful habits.
- i. Treatment to correct congenital or developmental malformations.
- j. 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.
- k. 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; injuries intentionally self-inflicted; and injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting therefrom.
- l. Treatment rendered outside of the United States or Canada.
- m. Claims not submitted to DDKS within six (6) months of the date that the Covered Service was provided, however, if it was not reasonably possible to submit a claim within such six (6) month period, such claim shall be excluded only if it is either not submitted to DDKS as soon as reasonably possible or within one (1) year of the date of service, whichever is the earlier.
- n. X-rays taken in conjunction with services which are not Covered Services such as, but not limited to, temporomandibular joint dysfunction (TMJ) cases.
- o. Temporary services and procedures, including, but not limited to, temporary filling, temporary crowns and temporary prosthetic devices. Sedative fillings are not a covered benefit if a definitive restoration is done on the same surface the same day as the sedative filling.
- p. Any service which is not a Covered Service.
- q. Individual crowns unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.
- r. Crowns and endodontic treatment in conjunction with an overdenture.

- s. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.
- t. Replacement of lost or stolen dentures or charges for duplicate dentures.
- u. 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. If included as a Covered Service, Orthodontic Services will not be subject to this exclusion, but only if:
 - i) the Employer maintained a group dental program which was in effect immediately preceding the Effective Date, and
 - ii) such program provided substantially the same coverage for Orthodontic Services as this Plan provides, and
 - iii) the Enrollee was covered under such prior program immediately preceding the Effective Date.
- v. Dental benefits and services resulting from accidental injuries arising out of a motor vehicle accident, including motorcycles, to the extent such benefits and services are payable under any medical or dental expense payment provision (by whatever terminology used – including such benefits mandated by law) of any motor vehicle insurance policy. Such excluded expenses cannot be used for any purpose under the Agreement.
- w. 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.
- x. Dental benefits and services which are not completed.
- y. Charges for Covered Services or related supplies which no charge is normally made, or for which no charge would be made but for the Agreement, are not Covered Services.

2. The Dental Benefits and Services Provided Shall Be Limited as Follows, unless the “Summary of Dental Plan Benefits” Section specifies other limitations:

- 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. The remainder of the fee is not a Covered Service and cannot be used for any purpose under the Plan.

- b. Some Covered Services may have 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 a Covered Service under the Agreement and then only if specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.
- d. When Covered Services which are in progress are interrupted and completed later by another Dentist, DDKS will review the claim to determine the allocation of payment to each Dentist.
- e. 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.
- f. 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.
- g. Benefits which are available for 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 once (1) every four (4) years per permanent molar unless the “Summary of Dental Plan Benefits” Section allows for other frequency limitations.
- h. Posterior (back), Composite (white) fillings may be a Covered Service, but only if specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.
- i. Anterior inlays will automatically receive benefits equal to surface anterior composites. Posterior inlays will automatically receive benefits equal to surface amalgams. If the Agreement contains posterior composite coverage as specified in the “Summary of Dental Plan Benefits” Section – posterior inlays will automatically receive benefits equal to surface posterior composites.
- j. 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 states different limitations:

- (1) Not more than one full upper and one 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 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) Crowns when used for abutment purposes are a Covered Service at the same co-payment percentage as provided under the Agreement for bridges and complete and partial dentures.
 - (4) 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, the remainder of the fee is not a Covered Service.
- k. Payment for anesthesia and IV (intravenous) sedation is allowed only for covered surgical extractions which are Covered Services and is limited to a maximum of ninety (90) minutes, per episode.
- l. Procedures for dental implants and associated services will be a Covered Service, but only as follows:
- (1) Coverage must be predetermined and is limited to those Enrollees who are totally edentulous, meaning without 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) Benefits are limited to the lesser of: i) the amount of the lifetime maximum as stated above, or ii) 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. Benefits in excess of such amounts are not Covered Services.

- m. Coverage for Temporomandibular Joint Dysfunction (TMJ) must be predetermined and is limited to:
- (1) Those intra-oral services which would normally be provided by a Dentist in the relief of oral symptoms associated with malfunctions of the TMJ, but shall not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
 - (2) The following procedures which are specified as intra-oral:
07820—Closed reduction of dislocation
07880—Occlusal Orthotic Device
09951—Occlusal adjustment (limited)
09952—Occlusal adjustment (complete)
- The above services require prior authorization by DDKS.
- (3) Benefits for fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under the Agreement are excluded.
 - (4) The repair and/or replacement of any appliances furnished in whole or in part under TMJ coverage is not covered under the Agreement.

ELIGIBILITY OF EMPLOYEES AND THEIR DEPENDENTS

1. Eligible Employee:

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

1. be a full-time employee, part-time employee, regular or extra-board employee; or
2. on paid sick leave from such active employment; or
3. on any other approved leave of absence from such active employment;

2. Commencement of Coverage for Employee:

- a. With respect to a person who is an Eligible Employee on the Effective Date, coverage hereunder shall begin upon such person becoming a Subscriber.
- b. With respect to a person who is not an Eligible Employee on the Effective Date, if the Employer elects annual open enrollment, then coverage hereunder shall begin upon the later of i) such person becoming a Subscriber, or ii) the effective date associated with such open enrollment period.

c. With respect to a person who is an Eligible Employee who experiences a “qualifying event,” such Eligible Employee may make a new election within thirty-one (31) days of the qualifying event that corresponds to the gain or loss of eligibility and/or coverage under the Plan, or a plan of the Spouse’s or Dependent’s employer, that was caused by the occurrence of such qualifying event. Changes in coverage will become effective on the first day of the month coincident with or following the later of i) the month in which the Eligible Employee becomes a Subscriber, ii) the effective date specified in the election, or iii) the submission of any required enrollment information and the payment of any required premium to DDKS. For purposes of this Section III, 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 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 dental plan sponsored by the Employer, shall be covered under the plan of the Employee as explained in “Non-duplication of Benefits” section.

4. Commencement of Coverage for Dependent:

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

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

5. Termination of Benefits:

- a. If, at any time, a Subscriber fails to satisfy all of the requirements of the Agreement, coverage under the Agreement shall terminate for such Subscriber, and each dependent of such Subscriber, in the following manner:
 - 1) If the Subscriber qualifies for, timely elects and timely pays for Continuation Coverage, then the Subscriber shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter coverage shall terminate;
 - 2) If the Subscriber fails to qualify for, timely elect or timely pay for Continuation Coverage, then coverage shall terminate at the end of the premium period in which the Subscriber first ceases to satisfy such requirements.
- b. If, at any time, an Enrollee who is not the Subscriber ceases to qualify as Eligible Dependent, coverage under the Agreement shall terminate:
 - 1) If the Enrollee qualifies for, timely elects, and timely pays for Continuation Coverage, then the Enrollee shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter the coverage shall terminate;
 - 2) If the Enrollee fails to qualify for, timely elect, or timely pay for Continuation Coverage, then coverage shall terminate at the end of premium period in which the Subscriber upon whom such person is dependent ceases to constitute a Subscriber, or at the end of the month such dependent ceases to qualify as an Eligible Dependent, whichever occurs first.
- c. At termination of coverage under the Agreement, operative procedures which are then in progress and i) which are completed within thirty (30) days of the termination of coverage, and ii) submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges. Operative procedures are considered in progress only if all procedures for commencement of lab work have been completed.

6. 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 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; medical benefits under group or individual automobile contracts; 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; school accident type coverage, 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 this plan is a “primary plan” or “secondary plan” when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan’s benefits. When this 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 this plan, or before the date this 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 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 Number 6.1 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, subscriber 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, subscriber 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, subscriber 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, subscriber 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 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 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. A new benefit reserve must be created for each new claim determination period.

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

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

F. FACILITY OF PAYMENT.

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

G. RIGHT OF RECOVERY.

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

**DELTA DENTAL OF KANSAS, 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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