

**FARM CREDIT FOUNDATIONS
DENTAL PLAN BENEFIT SCHEDULE**

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HOW THE BENEFITS ARE PROVIDED

The Farm Credit Foundations Dental Plan (herein called “Plan” or “Dental Plan”) consists of this Farm Credit Foundations Dental Plan Benefit Schedule (“Benefit Schedule”) and the Wrap Around Plan Document. The dental care benefits described in this Benefit Schedule are provided pursuant to the Farm Credit Foundations Dental Plan. This Benefit Schedule is a part of and incorporated into the Dental Plan. The following provisions are addressed in the Wrap Around Document of the Dental Plan and not in this Benefit Schedule:

- Definitions not contained in this Benefit Schedule
- Eligibility and participation in the Dental Plan
- Time and duration of coverage
- Continuation of coverage
- HIPAA medical privacy
- Plan administration
- Claims procedures
- Subrogation / Reimbursement rights of the Dental Plan
- Termination and amendment of the Dental Plan
- Other miscellaneous provisions

This Benefit Schedule and the Wrap Around Plan Document of the Dental Plan should be read together as one Plan document.

All benefits are administered by **Delta Dental of Kansas, Inc.** (herein called DDKS).

DDKS'S TOLL-FREE CUSTOMER SERVICE LINE

DDKS provides a toll-free customer service telephone line for questions regarding benefits, eligibility and claims. Telephone inquiries may be directed to the following numbers: in Wichita, (316) 264-4511, outside of the Wichita area, (800) 234-3375.

ARTICLE I DEFINITIONS

Throughout this Benefit Schedule, many words are used which have a specific meaning when applied to your dental care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Benefit Schedule, please refer to the definitions below, the definitions throughout this Benefit Schedule, or the definitions in the Wrap Around Plan Document of the Farm Credit Foundations Dental Plan because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter that means that the term is also defined in these definitions or elsewhere in the Benefit Schedule. All definitions have been arranged in alphabetical order.

Section 1.01 “**Child**” or “**Children**” when either of such terms is used in the definition of Dependent, includes the Covered Employee’s natural children, adopted children, stepchildren, foster children, or children under the Covered Employee’s legal guardianship by court order.

Section 1.02 “**Contributory Coverage**” means coverage for which a Participant enrolls and agrees to pay all or part of the premium.

Section 1.03 “**Cosmetic**” when describing dentistry, those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory.

Section 1.04 “**Covered Dental Expenses**” has the meaning given in Article II.

Section 1.05 “**Covered Dependent**” means the Dependent of an Employee or Disabled Person who is enrolled in this Plan and any Dependent who timely elects continuation coverage, as set forth in the Wrap Around Plan Document of the Farm Credit Foundations Dental Plan, and for whom the appropriate monthly payment is received by the Plan.

Section 1.06 “**Covered Employee**” means an Eligible Employee who is enrolled in this Plan and any Employee who timely elects Continuation Coverage and for whom the appropriate monthly payment is received by the Plan.

Section 1.07 “**Covered Expenses**” means Covered Dental Expenses.

Section 1.08 “**Covered Person**” means the following:

- (A) An Employee or former Employee enrolled in this Plan or any of such Employee’s or former Employee’s Covered Dependents; and
- (B) A Disabled Person enrolled in this Plan or any of such Disabled Person’s Covered Dependents.

Section 1.09 “**Deductible**” means the amount of Covered Expenses which a Covered Person must pay in each Calendar Year before benefits are payable under this Plan.

Section 1.10 “Dental Hygienist” means a legally qualified individual practicing dental hygiene within the scope of his/her license.

Section 1.11 “Dentist” means a legally qualified individual practicing dentistry within the scope of his/her license.

Section 1.12 “Dependent” has the meaning set forth in the Wrap Around Plan Document of the Farm Credit Foundations Dental Plan.

Section 1.13 “Emergency” means an urgent visit to diagnose or relieve an acute or unexpected dental condition.

Section 1.14 “Employee” has the meaning set forth in the Wrap Around Plan Document of the Farm Credit Foundations Dental Plan.

Section 1.15 “Employee Plus Child(ren) Coverage” means coverage under the Plan whereby an Employee elects coverage for the Employee and the Employee’s Dependent Children.

Section 1.16 “Employee Plus Spouse Coverage” means coverage under the Plan whereby an Employee elects coverage for the Employee and the Employee’s spouse.

Section 1.17 “Employer” has the meaning set forth in the Wrap Around Plan Document of the Farm Credit Foundations Dental Plan.

Section 1.18 “Exclusion” means a provision of this Plan which excludes specific expenses for supplies or services from coverage hereunder.

Section 1.19 “Experimental” or “Investigational” when used to describe a dental procedure means that it is unproven or non-standard dental treatment. Determination of Experimental or Investigational is at the discretion of the Claims Administrator.

Section 1.20 “Major Restorative Services” for which benefits are payable are the dental services and procedures listed as covered major dental services in this Plan.

Section 1.21 “Maximum Plan Allowance” shall be defined as the lesser of the following:

- (A) Participating Dentist:
 - (1) The fee submitted by the Participating Dentist for the dental procedure;
 - (2) The fee that such Participating Dentist has filed with DDKS for the dental procedure, if any; or
 - (3) The Delta Participating Dentist Maximum Fee.

- (B) Non-Participating Dentist:
 - (1) The fee submitted by the Non-Participating Dentist for the dental procedure; or
 - (2) The Delta Non-Participating Dentist Maximum Fee.

Section 1.22 “Medically Necessary” when used as a descriptive or qualifying term in connection with any dental service, supply, or treatment, means a dental service, supply or treatment which is:

- (A) Recommended by Dentists;
- (B) Consistent with currently accepted dental practice;
- (C) Generally considered by Dentists to be appropriate for the given dental condition for which it is provided to the Covered Person; and
- (D) Not solely for the convenience of the patient or the patient’s family members, nor solely for the convenience of the patient’s Dentist, dental clinic or their health care provider.

No service, supply, treatment, or expense will be deemed “Medically Necessary” if it is Experimental or Investigational in nature. The Claims Administrator will have full authority to determine whether a particular expense is Medically Necessary.

Section 1.23 “Non-Participating Dentist” is a Dentist who has not entered into a contractual agreement with Delta Dental of Kansas or another Delta Dental Plan service corporation to establish fee limits and claim payment procedures.

Section 1.24 “Orthodontic Charges” are Covered Expenses for Orthodontic Procedures.

Section 1.25 “Orthodontic Procedures” means procedures for the movement of teeth by means of active appliances to correct the position(s) of maloccluded or malpositioned teeth.

Section 1.26 “Participant” has the meaning set forth in the Wrap Around Plan Document of the Farm Credit Foundations Dental Plan. Where the context requires, the term “Participant” shall also include a former Participant.

Section 1.27 “Participating Dentist” means any Dentist who has agreed to render services in accordance with the terms and conditions established by the Plan and has satisfied the Plan that he/she is in compliance with such terms and conditions.

Section 1.28 “Plan” or “Dental Plan” means this Benefit Schedule and the Wrap Around Plan Document of the Farm Credit Foundations Dental Plan, together with any and all amendments and supplements thereto.

**ARTICLE II
COVERED EXPENSES**

Section 2.01 Payment of Benefits. The Plan will pay benefits for Covered Dental Expenses, subject to applicable Deductibles, Co-payment percentages, Maximum Benefit Amounts and applicable Limitations and Exclusions (as set forth in Article III), provided that the procedures for which benefits are sought must be rendered by a Dentist or by a Dental Hygienist, at a time when the recipient was covered for dental benefits for such procedures under this Plan.

Section 2.02 Deductibles. The annual Deductibles for coverage are as follows:

Basic Coverage Option	Comprehensive Coverage Option
\$50 per Covered Person	\$100 per Covered Person

The Deductible does not apply to expenses incurred for Diagnostic and Preventive Dental Care Procedures. The Deductible is applied separately for each Covered Person.

Section 2.03 Incurred Dental Expenses. Dental expenses are deemed to be incurred on the date a service is rendered or a supply is furnished.

Section 2.04 Covered Dental Expenses. Covered Dental Expenses shall be those dental services, procedures, and products which the Plan is required to provide to a Covered Person pursuant to the terms of this Agreement. A service, procedure, or product is a Covered Dental Expense only to the extent to which the service, procedure, or product is to be provided under this Agreement (i.e., if only a portion of the cost of a service or product is covered hereunder, the remaining portion is not a Covered Dental Expense).

Part I – Coverage Options

Section 2.05 Coverage Options. A Covered Employee must select either the Basic Coverage Option or the Comprehensive Coverage Option as detailed in Parts II and III, respectively, of this Article II.

- (A) **Basic Care Coverage Option.** The Basic Coverage Option provides coverage for the following:
 - (1) Diagnostic and Preventive Dental Care Procedures as set forth in Part II below; and
 - (2) Basic Dental Care Procedures as set forth in Part II below.

- (B) **Comprehensive Care Coverage Option.** The following Comprehensive Coverage Option is identical to the Basic Coverage Option except that it also provides coverage for the following:
 - (1) Comprehensive Dental Care Procedures as set forth in Part III below;

- (2) Orthodontic Dental Care Procedures as set forth in Part III below.

Section 2.06 Changing Coverage Options. An Employee who desires to change from one Coverage Option to another may elect the desired change during the annual open enrollment period, but any such change between Coverage Options **will not take effect until the beginning of the following Plan Year.**

Part II – Basic Coverage Option

Section 2.07 Covered Diagnostic and Preventive Dental Care Procedures. Covered Diagnostic and Preventive Dental Care Procedures are paid at 100% under both the Basic Coverage Option and the Comprehensive Coverage Option.

- (A) Covered Diagnostic Procedures include the following procedures necessary to assist the Dentist in evaluating the conditions existing and the dental care required:
 - (1) **Oral examinations** - limited to two (2) per calendar year.
 - (2) **Diagnostic x-rays** – bitewings limited to two (2) times per Calendar Year. Benefits for seven (7) vertical bitewing series are not provided more frequently than once every two (2) years.
 - (3) **Full mouth x-rays** - limited to once each three (3) years. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.
- (B) Covered Preventive Procedures include:
 - (1) **Prophylaxis (cleanings)** - limited to two (2) per calendar year.
 - (2) **Topical Fluoride** - limited to two (2) treatments per calendar year for Dependent Children under age nineteen.
 - (3) **Space Maintainers** - limited to Dependent Children up to age nineteen.
 - (4) **Sealants** - limited to Covered Dependent children up to age nineteen, once per lifetime, when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.

Section 2.08 Covered Basic Dental Procedures. Covered Basic Dental Procedures are paid at an 80% co-payment under both the Basic and Comprehensive Coverage Options, regardless of whether treatment is received within the PPO network or by a non-PPO provider. These procedures include:

- (A) **ANCILLARY:** Provides for one emergency examination per calendar year by the Dentist for the relief of pain.
- (B) **REGULAR RESTORATIVE DENTISTRY:** Provides amalgam (silver) restorations, composite (white) resin restorations, and stainless steel crowns. If composite (white) fillings are performed on posterior (back) teeth, the Plan will benefit up to the maximum allowable for an equal surface amalgam (silver) filling and the remainder of the fee is not a covered benefit.
- (C) **ORAL SURGERY:** Provides for extractions and other oral surgery including pre and post-operative care.
- (D) **ENDODONTICS:** Includes procedures for root canal treatments and root canal fillings. Payment for root canal therapy is limited to only once in any twenty-four (24) month period.
- (E) **PERIODONTICS:** Includes procedures for the treatment of diseases of the gums and bone supporting the teeth. Periodontic cleanings provided two (2) times per calendar year. Payment is limited to twice in a twelve (12) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.

Part III – Comprehensive Coverage Option

Section 2.09 Covered Comprehensive Care Procedures. Covered Comprehensive Care Procedures are paid at a 50% co-payment for Participants who have elected the Comprehensive Coverage Option, regardless of whether treatment is received within the PPO network or by a non-PPO provider. These procedures are not covered under the Basic Coverage Option. Comprehensive Dental Care procedures include:

- (A) **SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns. The following limitations apply to individual crowns:
 - (1) Individual crowns on the same tooth are a covered benefit only once 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 Covered Person whether or not the Covered Person was covered under this Plan;
 - (2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not covered benefits for any person under twelve years of age;
 - (3) Recementation of a crown may be allowed for payment only once in a twelve (12) consecutive month period;

- (4) Only two (2) repairs per crown will be allowed in a twelve (12) month period;
 - (5) Stainless steel crowns are a covered benefit only for Dependent children and are limited to once in a twenty-four (24) month period. If used as a permanent crown, the limitations of subparagraphs (1), (2), (3), and (4) of this subsection will apply; and
 - (6) Coverage for core/crown build-ups, including pins, is limited to permanent teeth having insufficient tooth structure.
- (B) **PROSTHODONTICS:** Includes bridges, partial and complete dentures, including repairs and adjustments.
 - (C) **IMPLANTS:** Implants, implant abutments and implant crowns. Coverage is limited to Covered Persons who are totally edentulous, meaning without natural teeth in the arch for which the dental implants are being contemplated. The Dentist must submit to the Plan 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 the Plan, and the proposed fees for the entire procedure. This treatment plan must be received and approved by the Plan before services are performed. The covered services may include benefits such as, but not limited to, consultations, surgical placement of implant devices, including the device, and prosthesis associated with the procedures as covered services provided in conjunction with the dental implant procedures.

Section 2.10 Covered Orthodontic Procedures. Covered Orthodontic Procedures are paid at a 50% co-payment for Participants who have elected the Comprehensive Coverage Option. Procedures include orthodontic appliances and treatment, interceptive and corrective. Covered Orthodontic Procedures are limited as follows:

- (A) The obligation of the Plan ceases with payment to the date of termination if the treatment plan is terminated for any reason or the Covered Person is no longer eligible for benefits before completion of the case.
- (B) Treatment may be terminated by the Dentist, by written notification to the Plan and to the Covered Person, for lack of patient interest and cooperation.
- (C) Related services for orthodontic purposes, such as but not limited to, x-rays, extractions, space maintainers, and study models, shall be payable at the orthodontic co-payment percentage as specified above.
- (D) The Plan will not pay for the repair or replacement of an orthodontic appliance.

- (E) Payment shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of treatment.

Part IV – Maximum Benefit Amounts

Section 2.11 Maximum Annual Benefit Limit.

- (A) **Basic Care Coverage Option.** The maximum benefit under the Basic Coverage Option for Covered Diagnostic and Preventive Dental Care and Basic Dental Care Procedures is seven hundred fifty dollars (\$750) per Covered Person per Calendar Year.
- (B) **Comprehensive Care Coverage Option.** The maximum benefit under the Comprehensive Coverage Option is one-thousand five hundred dollars (\$1,500) per Covered Person per Calendar Year, for Covered Diagnostic and Preventive Dental Care, Basic Dental Care Procedures, and Comprehensive Dental Care combined. This limit does not apply to Covered Expenses for Orthodontic Procedures.

Section 2.12 Maximum Lifetime Benefit for Orthodontic Procedures.

- (A) **Basic Care Coverage Option.** The Basic Coverage Option does not cover Orthodontic Procedures.
- (B) **Comprehensive Care Option.** The maximum lifetime amount of benefits payable for Orthodontic Procedures provided to any Covered Person under the Comprehensive Coverage Option is two-thousand dollars (\$2,000).

ARTICLE III LIMITATIONS AND EXCLUSIONS

Section 3.01 General Exclusions. The dental benefits and services provided shall NOT include the following:

- (A) Coverage for any patient who has been, but no longer is, a Covered Person.
- (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 Plan to be Cosmetic surgery or dentistry for Cosmetic reasons.
- (D) Prescription drugs, premedications and relative analgesia; hospital, healthcare facility or medical emergency room charges; laboratory charges; general anesthesia for restorative dentistry; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.
- (E) Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the patient became a Covered Person hereunder, except orthodontics, and then only if such orthodontic coverage was provided under the Employers' group dental program in effect immediately preceding the Effective Date and if orthodontic services are included as a covered dental benefit.
- (F) Benefits and services which 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 or maintaining occlusion, for replacing tooth structure lost by attrition or abrasion, for aesthetic purposes, splinting, or equilibration.
- (H) Dental care injuries or disease caused by riots or any form of civil disobedience if the Covered Person 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.
- (I) Treatment to correct congenital or developmental malformations.
- (J) Services performed for the purpose of full mouth reconstruction. Extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the program.

- (K) Treatment rendered outside of the United States or Canada.
- (L) Claims not submitted to the Plan within twelve (12) months of the date of service provided.
- (M) X-rays taken in conjunction with non-covered services, such as, but not limited to, temporomandibular joint dysfunction (TMJ) cases.
- (N) Temporary services and procedures, including, but not limited to, temporary filling, sedative fillings, and bases, temporary crowns and temporary prosthetic devices.
- (O) Any service which is not specifically provided under the Plan.
- (P) Individual crowns unless included as a covered dental benefit.
- (Q) Crowns and endodontic treatment in conjunction with an overdenture.
- (R) Bridges and dentures, including repairs and adjustments, unless included as a covered dental benefit.
- (S) Replacement of lost or stolen dentures or charges for duplicate dentures.
- (T) Orthodontic procedures and procedures related to orthodontic services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless orthodontics is specified as a covered benefit.
- (U) Dental benefits and services resulting from accidental injuries arising out of a motor vehicle accident 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 automobile insurance policy. The excluded expenses cannot be used for any purpose under the Plan.
- (V) 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.
- (W) Dental benefits and services which are not completed.
- (X) Diagnosis or treatment of temporomandibular joint dysfunction.
- (Y) Any expenses actually paid or payable under the Farm Credit Foundations Medical Plan, or any other medical or dental plan, if the Participant incurring such expenses has actual coverage in effect under such medical or dental plans.

Section 3.02 Predetermination of Benefits. Treatment plans that involve prosthetic and orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics, and oral surgery except for simple extraction of a single tooth, should be submitted to the Plan for predetermination of benefits. Failure to do so may result in a loss of benefits if, in the professional judgment of the Plan's consulting Dentists, such treatment is not necessary or a lesser procedure could have restored the tooth to contour and function.

Predetermination of benefits does not obligate the Plan if the Covered Person is no longer eligible for benefits at the time the services are performed. Treatment must commence within ninety (90) days of the date the treatment plan is approved by the Plan, or a new treatment plan must be obtained by the patient and resubmitted by the Dentist to the Plan.

Section 3.03 General Limitations. The dental benefits and services provided shall be limited as follows:

- (A) If there is selected a more expensive service or benefit than is needed, the Plan will pay the applicable percentage of the fee for the service or benefit which is needed to restore the tooth or dental arch to contour and function. The remainder of the fee is not a covered benefit and cannot be used for any purpose under the Plan.
- (B) Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are a dental benefit under the Plan.
- (C) Some procedures and treatments may have specific age and frequency limitations. These limitations are identified above.
- (D) When services in progress are interrupted and completed later by another Dentist, the Plan will review the claim to determine the allocation of payment to each Dentist.
- (E) Charges for services or supplies for which no charge is normally made or for which no charge would be made but for this Benefit Schedule are not covered benefits.
- (F) Payment is made for a surface only once within a twenty-four (24) month period regardless of the number or combinations of restorations placed therein.
- (G) Recementation of space maintainers are covered one (1) per lifetime.
- (H) Benefit payment for veneers will be made for the restorative procedure appropriate to the degree of tooth breakdown.
- (I) All inlays are benefited on the basis of the Participating Dentist's filed fee for an equal surface amalgam (silver restoration) with the patient being responsible for the difference in cost, if any.

- (J) Individual crowns are not a covered benefit unless specified as a covered dental benefit. If a covered benefit:
- (1) Individual crowns on the same tooth are a covered benefit only once 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 Covered Person whether or not the Covered Person was then covered under this Plan.
 - (2) Porcelain crowns, porcelain fused to metal, or resin processed to metal type crowns are not covered benefits for any person under twelve years of age.
 - (3) Recementation of a crown may be allowed for payment only once in a twelve (12) consecutive month period.
 - (4) Only two (2) repairs per crown will be allowed in a twelve (12) month period.
 - (5) Stainless steel crowns are a covered benefit only for dependent children and are limited to once in a twenty-four (24) month period. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection will apply.
 - (6) Coverage for core/crown build-ups, including pins, is limited to permanent teeth having insufficient tooth structure.
- (K) Prosthetic appliances are not a covered benefit unless specified as a covered dental. If a covered benefit:
- (1) Not more than one full upper and one full lower denture shall be constructed in any five (5) year period for any one Covered Person. Said time period is to be measured from the date the denture was last supplied to the Covered Person whether or not the Covered Person was then covered under this Plan.
 - (2) A partial denture, fixed bridge, or removable bridge may not be provided under the Plan for any Covered Person 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 Covered Person whether or not the Covered Person was then covered under this Plan.
 - (3) Denture relines and rebase (jumps) is a covered benefit only once in any thirty-six (36) month period for any one Covered Person.
 - (4) Denture adjustments are a covered benefit only two (2) times in any twelve (12) month period for any one Covered Person.

- (5) No replacement will be made of any existing denture which in the opinion of Plan's consultants is satisfactory or can be made satisfactory.
 - (6) Crowns when used for abutment purposes are covered at the same co-payment percentage as provided under this agreement for bridges and complete and partial dentures.
 - (7) Recementation of a bridge may be allowed for payment only once in a twelve (12) consecutive month period.
 - (8) 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 benefit.
 - (9) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.
 - (10) Benefits for tissue conditioning are limited to no more than two (2) per arch each thirty-six (36) months.
- (L) Payment for anesthesia and IV (intravenous) sedation is allowed only for covered surgical extractions and is limited to a maximum of ninety (90) minutes, per episode.
- (M) Maximum Payment:
- (1) Anything contained in the Plan or any appendix to the contrary notwithstanding, the maximum benefit payable in any one calendar year or contract term, as applicable, or any portion thereof, shall be the amount indicated above.
 - (2) With respect to the Deductible amount specified in Section 2.02, the Plan shall not be obligated to pay for, or otherwise discharge, in whole or in part, the first fees, up to the Deductible amount.
- (N) Harmful habit appliances are limited to one per Covered Person per year.

**ARTICLE IV
NON-DUPLICATION OF BENEFITS**

Section 4.01 Benefits Subject to this Article. All of the benefits provided under this Plan are subject to this Article IV.

Section 4.02 Definition of Plan. For purposes of this Article IV entitled Non-Duplication of Benefits, "This Plan" means that portion of this Dental Plan which provides the benefits that are subject to this provision. "This Plan" will not duplicate benefits for dental care service for which Covered Persons are entitled under any of the following plans:

- (A) Group, blanket, or franchise insurance.
- (B) Group practice, individual practice, and other prepayment coverage on a group basis. (This includes group contracts issued by Plan.)
- (C) Labor-management trustee plans.
- (D) Union welfare plans.
- (E) Employee benefit organization programs.
- (F) Coverage under government programs.

Section 4.03 Definition of Covered Service. For purposes of this Article IV, a Covered Service means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made or service provided, recognizing services covered in scope by either plan within general compartmental categories of dental services. When the benefits are provided in the form of services, the cost value of these services will be used to determine the amount of benefits received.

Section 4.04 Effect on Benefit. This Article IV shall apply in determining the benefits as to a person covered under "This Plan" for any Calendar Year if, for the Covered Services incurred as to such person during such period, the sum of:

- (A) The benefits that would be payable under "This Plan" in the absence of this provision: and
- (B) The benefits that would be payable under all other plans in the absence therein of a provision of similar purpose to this Article IV would exceed such Covered Services.

Section 4.05 Benefit Reduction. As to any Calendar Year with respect to which this Article IV is applicable, the benefits that would be payable under “This Plan” in the absence of this Article IV for the Covered Services incurred as to such person during such Calendar Year shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Covered Services under all other plans, except as provided in Section 4.06 below, shall not exceed the total of such Covered Services. Benefits payable under another plan include the benefits that would have been payable had a claim been duly made therefore.

Section 4.06 Determination of Benefits. If another plan which is involved in Section 4.05 and which contains a provision coordinating its benefits with those of “This Plan” would, according to its rules, determine its benefits after the benefits of “This Plan” have been determined, and the rules would require “This Plan” to determine its benefits before such other plan, then the benefits of such other plan will be ignored for the purposes of determining the benefits under “This Plan”.

Section 4.07 Primary and Secondary Coverage. To avoid duplicate benefit payments, one plan will be “Primary” and the others will be “Secondary”.

- (A) Primary. When “This Plan” is Primary, benefits will be paid without regard to other coverage.
- (B) Secondary. When “This Plan” is Secondary, the benefits under this Plan may be reduced. The benefits for Covered Services will be no more than the balance of charges remaining after the benefits of other plans are applied to Covered Services.

Section 4.08 Order of Determination. For purposes of Section 4.06 above, the rules for establishing the order of benefit determination are as follows:

- (A) “This Plan” is Secondary when:
 - (1) The Covered Person is covered as a Dependent under this Plan but is covered as an employee under another plan; or
 - (2) The benefits of “This Plan” which covers the person on whose expense the claim is based as a Dependent of a person whose date of birth, excluding year of birth, occurs earlier in the Calendar Year, shall be determined before the benefits of another plan which covers such person as a dependent of a person whose date of birth, excluding the year of birth, occurs later in a calendar year, except for cases of a person for whom a claim is made as a dependent Child whose parents are separated or divorced. However, if the other plan does not have the provisions of the preceding sentence regarding dependents, which would result either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of the immediately preceding sentence shall not apply and the rule set forth in the plan which does not have the provisions of the immediately preceding sentence shall determine the order of benefits.

- (B) When the parents are separated or divorced and the parent with custody of the Child has not remarried, the plan which covers the Child as a dependent of the parent with custody of the Child will be Primary and the plan which covers the Child as a dependent of the parent without custody will be Secondary.
- (C) When the parents are divorced and the parent with the custody of the Child has remarried, the plan which covers the Child as a dependent of the parent with custody shall be Primary and the plan that covers the Child as a dependent of the step-parent will be Secondary, and both such plans shall be Primary to a plan which covers that Child as a dependent of the parent without custody.
- (D) Notwithstanding (A) and (B) above, if there is a Court decree which would otherwise establish financial responsibility for the dental care expenses with respect to the Child, the plan which covers the Child as a dependent of the parent with such financial responsibility, if such plan has actual knowledge of the terms of such Court decree, shall be Primary as it relates to any other plan which covers the Child as a dependent Child.
- (E) When the rules under (A) through (D) above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time provided that:
 - (1) The benefits of a plan covering the person on whose expenses the claim is based as a laid-off or a retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, or dependent of such person; and
 - (2) If either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (E)(1) shall not apply.

Section 4.09 Benefits Payable. Benefits of other plans which will be applied to Covered Services under this Article IV include all benefits which would be payable if the Covered Person made claim for them.

Section 4.10 Right to Receive and Release Information. To determine the applicability and implementing of the terms of this Article IV or any provisions or similar purpose of any other plan, the Plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this Article IV.

Section 4.11 Facility of Payment. Whenever payments which should have been made under this Plan in accordance with the preceding provisions have been made under any plan or plans, Claims Administrator shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments in order to satisfy the intent of these provisions, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, Plan shall be fully discharged from liability under this Plan.

Section 4.12 Right of Recovery. Whenever payments have been made by the Plan with respect to covered benefits in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article IV, the Plan shall have the right to recover such payments, to the extent of such excess. The Plan reserves the right to determine from whom (e.g., a Covered Person, insurance company, or other organization or entity) the recovery should be made.

ARTICLE V MISCELLANEOUS

Section 5.01 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.

Section 5.02 Inquiries and Complaints. Dentists and Covered Persons are encouraged to contact the Plan when they have a question concerning a particular claim.

- (A) In General. Any inquiries or complaints should be directed to the Customer Service Department 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.
- (B) Written Inquiries. Written inquiries are best submitted on the copy of the Explanation of Benefits form.
- (C) Telephone Inquiries. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511, outside of the Wichita area, 1-800-234-3375.
- (D) Written Complaints. Covered Persons who have complaints about the Plan or about services provided by a Dentist under the Plan are encouraged to write their complaint to Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas, 67278.
- (E) Complaints by Telephone. Covered Persons may also telephone the Customer Service Department using any of the numbers identified above.
- (F) In Person Inquiry or Complaint. Inquiries or complaints 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.