DELTA DENTAL

Delta Dental Individual and Family™

2027 ENROLLMENT FORM

Thank you for enrolling in your Delta Dental Individual and Family plan. **Please note that your enrollment form and payment must be received on or before the 25th of the month for coverage to start the first of the following month.** If your application is received after the 25th of the month, your first available start date will be on the first of the next month.

CHOOSE YOUR PLAN:

Select Your Plan: ☐ Platinum Plan ☐ Gold Plan ☐ Silver Plan ☐ Bronze Plan

How many people will be covered under your plan?: ☐ Individual (1) ☐ Individual +1 (2) ☐ Family (3+)

Date of Application:_____ **Effective Date:** _____/01/2027 *(Date can be up to three months in the future)*

POLICYHOLDER INFORMATION

The Policyholder is the individual who is authorized to renew, make changes to, and terminate the plan. *You must be at least 18 years of age and a Kansas resident. Your address entered below will be the address we will send plan communication to.*

Last Name:_____ First Name:_____

Address:_____

City:_____, Kansas ZIP:_____

Social Security No.:_____ Date of Birth:_____

Are you, the Policyholder, enrolling to be covered under the dental plan? ☐ Yes ☐ No

Phone:_____ Email:_____

ADDITIONAL COVERED MEMBERS

List all additional covered members/dependents you are enrolling. ***Please note, member ID cards for all covered member will be sent to the address you have provided above.*** *If additional space is required, attach a list of required information to this form (unmarried dependent children are covered through the end of the month in which they turn 26).*

	Last Name	First Name	Social Security No.	Date of Birth (mm/dd/yyyy)
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

PRIOR DENTAL COVERAGE

☐ **Check here if you have been covered under a dental insurance plan within the last 60 days.**

Prior Carrier Name: _____ Prior Policy Number: _____ Termination Date: _____

PAYMENT METHOD

If you enroll using this paper application, you must submit a check or money order for one year of coverage. Please make your check payable to ***Delta Dental of Kansas***. If you prefer to pay automatically each month from a credit/debit card or checking account withdrawal, you may enroll online at **DeltaDentalKS.com/Shop**.

	Platinum		Gold		Silver		Bronze	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
Individual*	$82.53	$990.36	$51.97	$623.64	$43.35	$520.20	$37.39	$448.68
Individual +1*	$159.36	$1,912.32	$100.33	$1,203.96	$83.94	$1,007.28	$74.69	$896.28
Family*	$227.09	$2,725.08	$142.97	$1,715.64	$119.59	$1,435.08	$106.43	$1,277.16

*Delta Dental of Kansas reserves the right to change rates upon the rates being placed on file by the Kansas Insurance Department. Visit DeltaDentalKS.com or call 800.234.3375 to confirm current rates.

Please also complete the back side of this form.

DELTA DENTAL®

Please be sure you have completed the front side of this form.

Please carefully read the terms of the Policy incorporated herein by reference, and review the information provided in this application before signing below. **Your signature is required to complete enrollment**.

Agreement Approval

I represent that I am over the age of 18, a legal resident of Kansas and am legally authorized to apply for dental coverage for myself and for all other persons named in this application. I understand that I am making an application for dental coverage offered by Delta Dental of Kansas (DDKS). I understand that I am responsible for paying premium charges to DDKS for this coverage, and if payment is not made when due, my coverage is subject to termination.

I understand that coverage for the dental care policy applied for will not start until after this application and the required monies for premium are received and accepted by DDKS and an effective date is established by DDKS. All complete applications received and processed by DDKS on or before the 25th of the month may have coverage effective the first of the following month. If my application is received after the 25th of the month, my first available start date will be on the first of the next month. Rates are guaranteed for 12 months from the effective date of coverage under the policy (e.g., rates for individual plans effective April 1st are guaranteed until March 31st of the following year). I understand that written notice of rate changes will be furnished by DDKS at least sixty (60) days prior to the effective date of any such rate change.

I represent that prior to completing this application, I carefully and fully read it and the policy incorporated herein. I represent that the statements and answers set forth are complete, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that DDKS will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, DDKS will be entitled to declare the dental care policy applied for void and refuse to provide benefit coverage to any person thereunder.

Refunds will be issued for any month in which a payment was received by DDKS, but due to the termination of the policy or loss of coverage as set forth in Section 2 of the policy, the Enrollee was not entitled to benefits during that month.

I authorize any health care provider to release medical records to DDKS when reasonably related to the dental coverage for which I have applied. If any law or regulation requires additional authorization for release of dental records, I will give this authorization.

To cancel coverage, DDKS requires at least a five (5)-day written notice prior to the requested termination date.

I further agree to be legally bound by the terms contained in this application and the terms contained in the policy incorporated herein.

Enrollee Signature: _____ Date: _____

Mail to:

Delta Dental of Kansas
PO Box 3806
Wichita, KS 67201-3806

Broker / Agent Code:

_____
(if applicable)

For internal use only

Mailed on:

Effective date:

Delta Dental of Kansas, Inc.

Your Dental Care Benefits Policy

THIS IS A LIMITED POLICY—READ IT CAREFULLY. This Policy is an insurance contract. The Policy sets forth in detail your and our rights and obligations. For this reason, it is important that you **READ YOUR POLICY CAREFULLY!** You have the right to return this Policy to us within 10 days of its issue date and to have the premium you already paid refunded if you are not satisfied with the terms and conditions in this Policy. If you return this Policy to us within the 10-day period, your coverage under this Policy will be void from the beginning as if no Policy has been issued.

This Policy is designed to provide the Enrollee with coverage for dental care. The cost must be due to a covered dental service. Coverage is subject to any applicable Copay, benefit Allowance, frequency limitation, or other limitation that may be set forth in the Policy.

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

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

You and **your** refers to the named Policyholder who entered into this insurance contract with Delta Dental.

Enrollee refers to you as the Policyholder and/or your eligible dependents covered under this Policy.

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

Contact us at:

Member Services

1.866.234.3375

Visit us online at:
http://www.deltadentalks.com/

You can search for a Dentist, download a claim form, or access other personal account information.

Summary of Dental Plan Benefits

1.6 Summary of Individual Dental Benefits

		Platinum Plan			Gold Plan			Silver Plan			Bronze Plan		
Maximum Payment Per Person:	The Maximum Benefit for all Covered Services, including night guards, for each enrollee in any one contract year. Diagnostic & Preventive Services do not apply toward the Maximum Benefit.	$2,500			$1,500			$1,000			$1,000		
Deductible:	Coverage for Diagnostic and Preventive Services as identified in the "Summary of Individual Dental Benefits" are not subject to the Deductible. However, the Deductible shall apply during each Contract Year to all other Covered Services which are provided to each Enrollee. After Enrollees have, in any Contract Year, each paid either the individual Deductible of $50 or have cumulatively paid charges for Covered Services in the amount of $150, the payment of any Deductible shall no longer apply for any Covered Services during the remaining portion of that Contract Year.	$50 x 3			$50 x 3			$50 x 3			$50 x 3		
		Dentist Network Options (% Paid by DDKS):			Dentist Network Options (% Paid by DDKS):			Dentist Network Options (% Paid by DDKS):			Dentist Network Options (% Paid by DDKS):		
		Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Right Start 4 Kids℠ (RS4K)	Children age 12 and under receive coverage at 100% for all services covered under the plan. will receive their claims paid at 100%, for all covered services. Deductible will not apply, but the annual maximum, frequencies, and limitations will apply. Orthodontic (braces) benefits will not change. If a child visits a non-network dentist, normal waiting periods, Deductibles, and copays will apply.	100%	100%	RS4K does not apply	100%	100%	RS4K does not apply	100%	100%	RS4K does not apply	100%	100%	RS4K does not apply
Diagnostic & Preventive (D&P) Services: *(Not subject to deductible; no waiting period applies; RS4K applies to covered services when visiting an in-network dentist):*													
Oral Evaluations:	2 times per contract year.	100%	80%	80%	100%	80%	80%	100%	80%	80%	100%	80%	80%
Bitewing X-rays:	2 times per contract year for dependents under age 18 and 1 each 12 months for age 18 and over.	100%	80%	80%	100%	80%	80%	100%	80%	80%	100%	80%	80%
Full Mouth or Panoramic X-rays:	1 each 5 years.	100%	80%	80%	100%	80%	80%	100%	80%	80%	100%	80%	80%
Prophylaxis (Cleanings):	2 times per contract year.	100%	80%	80%	100%	80%	80%	100%	80%	80%	100%	80%	80%
Topical Fluoride:	2 times per contract year for dependent children under age 19.	100%	80%	80%	100%	80%	80%	100%	80%	80%	100%	80%	80%
Space Maintainers:	For dependent children under age 14 and only for early loss of baby molars.	100%	80%	80%	100%	80%	80%	100%	80%	80%	100%	80%	80%
Sealants:	1 per tooth per lifetime for dependent children under age 16 when applied only to adult molars with no decay or fillings on the chewing surface and intact.	100%	80%	80%	100%	80%	80%	100%	80%	80%	100%	80%	80%
Basic Services: *(Subject to deductible; 6-month waiting period applies; RS4K applies to covered services when visiting an in-network dentist):*													
Limited Oral Evaluation:	Provides for 1 emergency/limited exam per Plan year by the Dentist for the relief of pain. *Waiting Period Waived	80%	70%	70%	80%	60%	60%	50%	40%	40%	80%	60%	60%

		Platinum Plan			Gold Plan			Silver Plan			Bronze Plan		
		Dentist Network Options (% Paid by DDKS):			Dentist Network Options (% Paid by DDKS):			Dentist Network Options (% Paid by DDKS):			Dentist Network Options (% Paid by DDKS):		
		Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Basic Services: *(Subject to deductible; 6-month waiting period applies; RS4K applies to covered services when visiting an in-network dentist):*													
Oral Surgery:	Provides for non-surgical removal of teeth including pre- and post-operative care, preparation of the mouth for dentures, removal of the vertical band of thin tissue that connects the tongue to the bottom of the mouth, removal of the tissue that attaches the lips to the gum above the top front two teeth, removal of tissue that connects the gums to the insides of the cheeks, and removal of a piece of tissue from a lesion and sent to the lab for testing.	80%	70%	70%	80%	60%	60%	50%	40%	40%	80%	60%	60%
Regular Restorative Dentistry:	Provides silver fillings; resin (white) fillings on all teeth; and stainless steel crowns for dependents under age 12.	80%	70%	70%	80%	60%	60%	50%	40%	40%	80%	60%	60%
Major Services: *(Subject to deductible; 12-month waiting period applies; RS4K applies to covered services when visiting an in-network dentist):*													
Endodontics:	Includes root canal treatments. When covered, payment for initial root canal therapy is limited to 1 per lifetime, per tooth; payment for the retreatment of a root canal is limited to 1 per 24 months, per tooth.	70%	50%	50%	50%	40%	40%	50%	40%	40%	Not Covered	Not Covered	Not Covered
Oral Surgery:	Provides for surgical removal of teeth including pre- and post-operative care, preparation of the mouth for dentures, removal of the vertical band of thin tissue that connects the tongue to the bottom of the mouth, removal of the tissue that attaches the lips to the gum above the top front two teeth, removal of tissue that connects the gums to the insides of the cheeks, and removal of a piece of tissue from a lesion and sent to the lab for testing.	70%	50%	50%	50%	40%	40%	50%	40%	40%	Not Covered	Not Covered	Not Covered
Periodontics:	Includes procedures for the treatment of diseases of the gums and bones. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis.	70%	50%	50%	50%	40%	40%	50%	40%	40%	Not Covered	Not Covered	Not Covered
Special Restorative Dentistry:	When teeth cannot be restored with a filling, provides for individual crowns.	70%	50%	50%	50%	40%	40%	50%	40%	40%	Not Covered	Not Covered	Not Covered
Prosthodontics:	Includes bridges, partial and complete dentures, repairs and adjustments of bridges and dentures. Implants covered on Platinum plan only.	70%	50%	50%	50%	40%	40%	50%	40%	40%	Not Covered	Not Covered	Not Covered
Night Guards:	An appliance that prevents your top and bottom teeth from touching, and protects the biting surfaces of your teeth when sleeping. Night guards are allowed once 1 every five 5 years. Night Guards covered under Platinum plan only.	70%	50%	50%	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontics:	Includes orthodontic appliances and treatment, interceptive and corrective.	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

ADDITIONAL DENTAL BENEFITS INFORMATION

Deductible Limitations:
Coverage for Diagnostic and Preventive Services as identified in the "Summary of Dental Plan Benefits" and Right Start 4 Kids℠ ("RS4K") coverage are not subject to the Deductible. However, the Deductible shall apply during each Contract Year to all other Covered Services which are provided to each Enrollee not covered under RS4K. If an Out-of-Network Dentist is seen, RS4K does not apply and the underlying contract applies including waiting periods, deductibles and coinsurance levels. After Enrollees have, in any Contract Year, each paid either the individual Deductible of Fifty Dollars ($50.00), or have cumulatively paid charges for Covered Services in the amount of One Hundred Fifty Dollars ($150.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Contract Year.

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

Eligible Children Ages:
Unmarried children who meet the definition of Children are eligible for coverage to age twenty-six (26). Children ages twelve (12) and under are eligible for RS4K coverage.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION REGARDING YOUR BENEFITS.

Important Notice

Please read the copy of the Application associated with this Policy. Carefully check the Application and if any information shown on it is not correct and complete, please notify us by mail within 10 days at:

Delta Dental of Kansas
Attn: Member Services
P.O. Box 789773
Wichita, KS 67278

The Application is a part of this Policy. This Policy was issued on the basis that answers to all questions and the information shown on the Application are correct and complete.

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This **Delta Dental Subscriber Agreement** ("Policy") is between you, the Policyholder, an individual residing in Kansas (referred to as "Policyholder" "you," or "your"), and Delta Dental of Kansas, Inc., a Kansas not-for-profit corporation (referred to as "Delta Dental," "we," "us," or "our").

THIS IS A LIMITED POLICY—READ IT CAREFULLY! This Policy is an insurance contract. The Policy details Delta Dental and the Policyholder's rights and obligations to each other. For this reason, it is important that you **READ YOUR POLICY CAREFULLY!**

Section 1 – Declarations

1.1 What is the Term of Your Coverage?

The term of this Policy ("Initial Term") commences on the Effective Date and continues for a period of 12 months. **THIS POLICY CANNOT BE TERMINATED BY YOU DURING THE FIRST 12 MONTHS OF COVERAGE.** Upon the expiration of the Initial Term, unless you terminate this Policy in accordance with the terms set forth in Section 9.1, you may keep this Policy in force for additional 12-month periods (each a "Renewal Term" and with the Initial Term, the "Term") by paying us the required premiums in effect at the beginning of each Renewal Term as set forth in Section 1.5.

1.2 What are the Monthly Premium Rates for Each Coverage Level?

	Bronze	Silver	Gold	Platinum
Policyholder:	[$37.39]	[$43.35]	[$51.97]	[$82.53]
Policyholder + One:	[$74.69]	[$83.94]	[$100.33]	[$159.36]
Family:	[$106.43]	[$119.59]	[$142.97]	[$227.09]

These rates listed above will remain in effect during the Initial Term of this Policy. You will receive notice of any rate changes at least 30 days before your renewal date. We reserve the right to change rates upon approval by the Kansas Insurance Department.

1.3 When Does Your Coverage Begin?

Coverage of you and any initially enrolled Dependents under this Policy will commence upon the Effective Date as identified on the enrollment materials based on when we receive your Application and first premium payment.

1.4 When May You Change Your Coverage Level?

You are eligible to change your coverage level only (i.e. changing from Bronze level to Silver level, adding or removing Dependents) once each year by notifying us at least 30 days prior the renewal date for the Renewal Term.

1.5 How Do You Renew Your Coverage?

The Policy shall remain in force on the condition that you pay us the required premiums in effect at the beginning of each Renewal Term as set forth in Section 7.1(b) unless sooner terminated as set forth in Section 9.1. We shall notify you no later than 30 days prior to each Renewal Term of any changes in rates or coverage to the Policy.

If you pay the adjusted premium rates, or take other action indicating continued performance after the Term expires, this Policy shall renew automatically for a successive 12-month Renewal Terms under the same terms and conditions, subject to any changes referenced above.

If you pay premium rates that are not consistent with the adjusted premium rates listed in the renewal notice after the Term expires, we may consider your coverage either: renewed under

the adjusted terms set forth in the renewal notice and bill you for the remaining balance; or not renewed as of the Renewal Term effective date and return the premiums to you.

Section 2 – Eligibility and Changes to Eligibility for Coverage

2.1 What are Your Requirements to be a Policyholder?

To qualify as a Policyholder, you must meet all of the requirements listed below.

1. Be a full-time resident of Kansas;
2. Be at least age 18; and
3. Have the legal capacity to enter into an insurance contract.

By applying for and entering into this Policy with Delta Dental, you represent and warrant that you comply with all of the requirements listed above.

You do not have to be an Enrollee of coverage under the Policy to apply for coverage.

2.2 What are the Requirements for Your Dependents to be Covered under This Policy?

To qualify as an eligible Dependent under this policy, an individual must meet one of the requirements listed below.

1. Be your Spouse.
2. Be your Dependent Children.
    a. Dependent Children are your natural children, stepchildren, or legally adopted children who are under age 26.
    b. Newborn Children are automatically covered from the moment of birth. If your coverage is for you by yourself or you and your Spouse only and you want uninterrupted coverage for a newborn Child, you must notify us in writing within 30 days of your child's birth and we will convert this Policy to a Policyholder + One or Family coverage and advise you of the additional premium due.
    c. Coverage will include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment and is dependent on you for care and supervision, and who became disabled while covered under this Policy and before age 26.
    d. We may request proof of your Dependent Child's age, dependency, or disability status during or after enrollment on one or more occasions.
3. Be a dependent relative child or child under your care as a guardian or personal representative.
    a. We may request proof of your official status as guardian or personal representative of the dependent child.

2.3 When May You Add or Remove Dependents under Your Coverage?

You may add an Eligible Dependent if notice and the required premium fees for the additional coverage are provided to Delta Dental within thirty (30) days following the occurrence of one of the below Qualifying Life Events on the condition that you notify us within 30 days of the Qualifying Life Event. We will revise your premium rates according to the number of lives added under your current coverage level and advise you of the revised premium due in accordance with the applicable Qualifying Life Event. Your updated coverage will begin based on the date we receive your revised premium payment as described in Section 1.3.

If you do not experience a Qualifying Life Event, you may not make any changes to add or remove Dependents after the Effective Date during the Initial Term or any Renewal Term, except when you renew this Policy in accordance with Section 1.4.

For the purposes of this section, a "Qualifying Life Event" is any of the events described below.

1. **Legal Marital Status**. A change in your legal marital status, such as marriage or divorce.
2. **Number of Dependents**. A change in your number of Dependents, such as the birth or adoption of a Child.
3. **Gaining or Losing Coverage under an Employer's Plan**. A change in eligibility status that affects your or your Dependent's eligibility for coverage under this Policy, such as becoming eligible as a Policyholder or Dependent under an employer-sponsored dental care plan.

You may remove dependents at any time during the Contract Year at least thirty (30) days prior to the desired effective date of removal. If a Dependent who has been removed is reenrolled prior to a Renewal Date pursuant to a Qualifying Life Event listed above, waiting periods will be waived if the Dependent can provide proof of dental insurance within the sixty (60) days prior to the Effective Date.

2.4 When will Your Dependent's Coverage Terminate?

An Enrollee's coverage ends on the last day of the calendar month in which that Enrollee satisfies one of conditions listed below. For the purposes of this section only, Enrollee means only your Dependents covered under your Policy.

1. The Enrollee no longer qualifies as an eligible Dependent under Section 2.2.
2. The Enrollee is no longer a resident of the state where this Policy was issued.
    a. An Enrollee will not lose coverage solely based on: maintaining a second residence outside of the state where this Policy was issued; is a full-time student attending an out-of-state college; or traveling out-of-state.

If any of the above conditions occur, you must notify us no later than 30 days after the date that condition occurs. Notwithstanding the last sentence, we may terminate coverage if we become aware that any of the above conditions occurred.

2.5 May I make changes to my coverage during the Contract Year?

You may not make changes to your coverage after the Effective Date except upon renewal. You must provide Delta Dental with a notice of an intent to change coverage no later than five (5) days prior to the Renewal Date.

Section 3 – Your Dental Care Benefits

3.1 Covered Services or Benefits under Your Plan

Benefit percentage, benefit coverage, coinsurance, deductibles, annual maximums and plan design shall vary by each individual plan and contract. We will provide Dental Benefits for covered services only to those Enrollees under this Policy based on the amount listed for each Benefit as listed in the Schedule, or the amount that is otherwise payable under this Policy subject to the Limitations and Exclusions as set forth in Section 3.3. A Covered Service will be benefited if payment is made either in whole or in part under the terms of this Plan, or would be benefited excepted for the application of a deductible, co-insurance payment, or other limitation including annual maximum limitations contained in this Plan. For a Covered

Service, Delta Dental will pay the lesser of 1) the percentage of the fee actually charged, otherwise known as the Maximum Plan Allowance (MPA) for a Covered Service; or 2) the amount which is otherwise payable in accordance with the terms of the Plan.

3.2 Selected Dental Network

Delta Dental has two networks: Delta Dental PPO and Delta Dental Premier. The Dental Network for this Plan is Delta Dental PPO which means that the Enrollee may be responsible for a lesser coinsurance percentage for services received by a Delta Dental PPO Dentist. Enrollees have the flexibility to choose from a larger network of dentists by using the Delta Dental Premier network or an Out-of-Network Dentist, however, there may be a larger coinsurance percentage attributed to the Enrollee using this larger network. Reimbursements for procedures performed by Delta Dental Premier Dentists, Delta Dental PPO Dentists, and Out-of-Network Dentists are different and paid according to fee schedules for each network. Our Delta Dental PPO Network shall offer the most significant network discounts and savings. Our Delta Dental Premier Network shall also offer network discounts and savings but our Delta Dental Premier Network discounts shall generally be smaller than our Delta Dental PPO Network discounts. The reimbursement for services you receive from out-of-network dentists shall generally be less than what Delta Dental would pay a Delta Dental PPO or Delta Dental Premier dentist. Delta Dental PPO and Delta Dental Premier Network dentists shall accept Delta Dental's fee determination as full payment for covered services. If you visit an out-of-network dentist, you can be balance billed, and are responsible for the dentist's charges, up to the dentist's full billed amount. Delta Dental shall pay claims directly to in-network participating dentists. Reimbursement for services at out-of-network dentists shall be paid directly to you and you are responsible for paying your dentist. All Delta Dental PPO and Delta Dental Premier Network dentists must follow our processing policies and guidelines and meet our credentialing standards.

> "Delta Dental Premier": The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that Delta Dental offers. All Delta Dental Premier Dentists are considered Participating Dentists and are paid according to Delta Dental Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-Participating Dentists are not considered Delta Dental Premier Dentists, and are paid according to Delta Dental Non-Participating Dentist Maximum Plan Allowance.
>
> "Delta Dental PPO": The Delta Dental PPO network is a subset of Delta Dental 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 Dentists 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 Summary of Dental Plan Benefits, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in Summary of Dental Plan Benefits.

For more information on how to choose a Dentist, please review Section 4 or visit www.deltadentalks.com/.

3.3 Limitations and Exclusions

Unless the "Summary of Individual Dental Benefits" specifically provides for coverage of a benefit, the following dental benefits and services are either subject to a limitation or excluded from coverage altogether as described under the section heading below.

(a) Exclusions

This Policy does not cover the dental care services and materials listed below unless this Policy and Schedule specifies otherwise.

1. Benefits for anyone without active coverage.
2. Treatment of injuries or conditions benefited under any other employer related insurance such as Workers Compensation Insurance. Services which are eligible through any Medicare, Medicaid, or similar federal or state programs.
3. Treatment determined by Delta Dental to be Cosmetic in nature.
4. Benefits for services started prior to the effective date of coverage under this Policy.
5. Prescription drugs and over-the-counter medications.
6. Hospital, medical facility, medical emergency care and lab charges.
7. Charges for a missed appointment.
8. Crowns, bridges, dentures, or fillings for changing the vertical dimension of the upper and lower jaw; for restoring the bite; for teeth without cavities; for the loss of tooth structure or tissue caused by tooth-on-tooth contact, teeth grinding, or wear from aggressively brushing teeth; for stabilizing teeth which have become loose as a result of bone loss; for the reshaping of the teeth to allow them to fit together better.
9. Dental care as a result of injuries or disease caused by willing participation in a riot; any form of civil disobedience, war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war as required by an employer or voluntarily; while in the act of committing a crime; and self-inflicted injuries.
10. Temporary services, appliance and procedures. Placement of interim direct restorations for the relief of pain are not considered a temporary service.
11. Any procedure in whole or in part not covered under this Policy.
12. Services including root canals related to an overdenture.
13. Bridges and dentures, including repairs and adjustments, are not covered under the Bronze Plan.
14. Replacement of lost or stolen appliance (i.e. a denture, partial denture, crown, retainer, etc.) or charges for spare dentures.
15. Orthodontic services and related procedures unless specifically included as a covered benefit.
16. Treatment of injuries or conditions due to a motor vehicle accident if coverage is available under any medical expense from any automobile policy.
17. Dental benefits and services which are not completed.
18. Services received outside of the United States or Canada.
19. Services for control of harmful habits such as thumb sucking.
20. Procedures to diagnose or treat Temporomandibular Joint Dysfunction (TMJ).
21. Individual crowns are not covered under the Bronze Plan.
22. Procedures for dental implants and associated services are not covered under the Bronze, Silver and Gold Plans.
23. Treatment to the gums for tumors, cysts and unusual growths.
24. Variation from normal development present from birth. These conditions include but are not limited to: cleft palate; cleft lip; upper or lower jaw deformity; defective enamel development; enamel discoloration; treatment involving or required by extra teeth; and teeth missing from birth.
25. Services performed by a Relative or by an employer.
26. Experimental or investigational services, procedures, or supplies which are not usual standard of care.

27. Corrective jaw surgery, including but not limited to, surgical cutting or removal of bone, and other services or supplies to increase or reduce the upper or lower jawbone.
28. Bone grafting for site preservation after tooth extraction.
29. Administration of drugs before surgical operations to alleviate pain or alleviating pain by breathing in gases (i.e. laughing gas), except when its use is:
    a. In agreement with generally accepted processional standards;
    b. Not furnished primarily for patient anxiety, fear of dental treatment, or the convenience of the patient, the attending Dentist or other dental care provider; and
    c. Due to the existence of a specific medical condition.

(b) Limitations

Benefits under this Policy are limited as listed below unless this Policy specifies otherwise. Typically, when dental benefits and services are limited under the Policy, any amounts not benefited by Delta Dental due to the limitation are the responsibility of the Enrollee, up to the Maximum Plan Allowance (MPA).

1. Bitewings taken within twelve (12) months of a full mouth series of x-rays.
2. A panoramic film taken with a full mouth series of x-rays is not a separate benefit.
3. The replacement of a filling within 24 months is not billable to the patient if performed by the same dentist or dental office.
4. An Inlay will be paid as a filling.
5. Core build-ups, including pins, are covered for permanent teeth lacking enough tooth structure to build a crown.
6. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the Summary of Dental Plan Benefits section. If a covered service:
    a. The five (5) year frequency limitation is measured from the date the crown was placed, whether or not the policy was effective. If replacement is needed because of injury, it is subject to review by a dental consultant.
    b. If a crown is placed on a tooth which has had a filling in the previous twenty-four (24) month period, benefits paid for the crown are reduced by the benefit paid for the prior filling(s).
    c. Permanent crowns are not a benefit by Delta Dental for anyone under twelve (12) years of age.
7. The five (5) year period is measured from the last date of service the dental appliance was last placed whether or not this Policy was in effect at the time of service.
8. Crowns when used for abutment purposes are benefited at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.
9. Oral Surgery services are limited to removal of teeth, preparation of the mouth for dentures, removal of the vertical band of thin tissue that connects the tongue to the bottom of the mouth, removal of the tissue that attaches the lips to the gum above the top front two teeth, removal of tissue that connects the gums to the insides of the cheeks, and removal of a piece of tissue from a lesion and sent to a lab for testing
10. Implants and associated implant procedures are not Covered Services unless specifically included as a Covered Service in the Summary of Dental Plan Benefits section – covered under the Platinum Plan only. When covered, the patient must be nineteen (19) years or older to allow for completed growth and development. It is strongly recommended that implant services by predetermined which consists of the dentist submitting a written report of recommended treatment setting forth the type and number of implants to be used, x-rays to support the implant procedures and

proposed fees for the entire procedure. Implant covered services may include, but are not limited to, consultations and surgical placement of implant devices and/or prostheses provided in conjunction with the dental implant service. Payments are limited to the lesser of:

a. The amount of the maximum available as stated in the Summary of Dental Plan Benefits section; or
b. The amount determined by Delta Dental to be allowable for dentures that are conventionally constructed using standard procedures, and which are of the same magnitude, i.e. complete upper, complete lower, or complete upper and lower, where appropriate.

11. Administration of drugs before surgical operations to alleviate pain is covered for:
    a. One (1) or more surgical extractions due to the following:
        i. Any number of teeth which fail to grow out from the gums;
        ii. Surgical root recovery from sinus; or
        iii. Medical problem that does not allow for local anesthesia.

(c) Alternate Benefits Provision – Specific Policy Limitation

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

(d) Frequencies.

1. Once (1) in twelve (12) months:
    a. Examination for potential risk for cavities;
    b. Four bitewing x-rays (over the age of 17); and
    c. Emergency examination.
2. Two (2) in twelve (12) months:
    a. Routine examination;
    b. Routine cleaning;
    c. Fluoride treatment (under the age of 19);
    d. Periodontal cleaning;
    e. Four bitewing x-rays (under the age of 18);
    f. Crown repairs per crown;
    g. Bridge repairs per bridge; and
    h. Denture adjustments per denture.
    i. Application of a caries arresting medicament per tooth.
3. Once (1) in twenty-four (24) months:
    a. Scaling and root planing per quadrant;
    b. Stainless steel crowns;
    c. Athletic mouthguards (under age 19);
    d. Retreatment of a root canal per tooth;
    e. Retreatment of a root canal per tooth; and
    f. Fillings per surface per tooth.
4. Once (1) in thirty-six (36) months:

a. Detailed (comprehensive) examination;
b. Gum surgery per site;
c. Bone surgery per quadrant;
d. Removal of gum tissue per site;
e. Bone grafts for periodontal purposes;
f. Guided tissue regeneration using materials to direct the growth of new bone and tissue for periodontal purposes;
g. Crown lengthening; and
h. Denture reline and rebase.

5. Twice (2) in thirty-six (36) months:
   a. Tissue conditioning per arch per denture.
6. Once (1) in five (5) years:
   a. Full mouth x-rays;
   b. Panoramic x-rays;
   c. Single crowns and onlays;
   d. Post and core buildups (pre-made and lab-made);
   e. Crown buildup including pins;
   f. Complete or partial dentures; and
   g. Bridges.
7. Once (1) per lifetime:
   a. Re-cementation of space maintainers;
   b. Re-cementation of a crown;
   c. Re-cementation of a bridge;
   d. Root canal per tooth;
   e. Full mouth debridement to enable detailed comprehensive examination;
   f. Pulpal debridement (includes baby and adult teeth);
   g. Therapeutic pulpotomy;
   h. Sealants per permanent first and second molar (ages 3-15 only); and
   i. Preventive resin restorations on first and second molars (ages 3-15) only.

Section 4 – Dentists and Certain Dental Claims.

4.1 Participating or In-Network Dentist

If an Enrollee chooses to receive dental care from one of the Participating Dentist, some Benefits will be covered at no or low cost after any required Copays. The Participating Dentist will file the Claims on the Enrollee's behalf. We will pay the Participating Dentist directly.

(a) Delta Dental PPO Dentists

If Enrollees choose to receive dental care services from Delta Dental PPO Dentists, the amounts charged to these Enrollee are discounted fees. Benefits will be covered after any required Deductibles and Coinsurance resulting in reduced Out-of-Pocket Costs. Delta Dental PPO Dentists will file Claims on these Enrollees' behalf and Delta Dental will pay these Delta Dental PPO Dentists directly. Our Delta Dental PPO Network shall offer the most significant network discounts and savings. Our Delta Dental Premier network shall also offer network discounts and savings, but our Delta Dental Premier network discounts shall generally be smaller than our PPO network discounts. Delta Dental PPO and Delta Dental Premier network dentists shall accept Delta Dental's fee determination as full payment for covered services. Delta Dental shall pay claims directly to in-network participating dentists. All Delta Dental

PPO and Delta Dental Premier dentists must follow our processing policies and guidelines and meet our credentialing standards.

(b) Delta Dental Premier Dentists

If Enrollees choose to receive dental care services from Delta Dental Premier Dentists, the amounts charged to these Enrollees may not exceed the Maximum Plan Allowance. Delta Dental Premier Dentists will file Claims on these Enrollees' behalf and Delta Dental will pay these Delta Dental Premier Dentists directly. When Benefits are payable for dental care services by Delta Dental Premier Dentists, Delta Dental will pay these Delta Dental Premier Dentists the lesser of: 1) the submitted fee; or 2) the Maximum Plan Allowance reduced by any applicable Deductible and Coinsurance. Our Delta Dental PPO Network shall offer the most significant network discounts and savings. Our Delta Dental Premier network shall also offer network discounts and savings, but our Delta Dental Premier network discounts shall generally be smaller than our Delta Dental PPO network discounts. Delta Dental PPO and Delta Dental Premier network dentists shall accept Delta Dental's fee determination as full payment for covered services. Delta Dental shall pay claims directly to in-network participating dentists. All Delta Dental PPO and Delta Dental Premier dentists must follow our processing policies and guidelines and meet our credentialing standards.

The Enrollee should review the Dentist listing on our website to see what services each Dentist offers.

4.2 Out-of-Network Dentist

If Enrollees choose to receive dental care services from Out-of-Network Dentists, the amounts charged to these Enrollees may be above the amounts generally charged by Participating Dentists resulting in higher Out-of-Pocket Costs. The reimbursements for services you receive from out-of-network dentists shall generally be less than what Delta Dental would pay Delta Dental PPO and Delta Dental Premier dentists. If you visit an out-of-network dentist, you can be balance billed and are responsible for the dentist's charges up to the dentist's full billed amount. Reimbursement for services at out-of-network dentists shall be paid directly to you and you are responsible for paying your dentist. These Enrollees are responsible for filing their Claims in accordance with Section 6. If Benefits are payable for dental care services by Out-of-Network Dentists, Delta Dental will reimburse these Enrollees the lesser of: 1) the submitted fee; or 2) the Maximum Plan Allowance. These Enrollees will then be responsible for any Balance Billing amounts charged by the Out-of-Network Dentist over the Benefits Delta Dental will pay that Enrollee in addition to any Deductibles, Coinsurance, and maximums specified by the Plan. Enrollees must exclusively use Delta Dental PPO Dentists in order to receive Benefits under the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all dental care service costs incurred resulting in higher Out-of-Pocket Costs.

4.3 Denied Claims and Not Billable to the Patient Claims

We will deny claims for dental care or services that are not covered under this Policy. If an Enrollee receives dental care or services that are not covered under this Policy, that Enrollee is responsible for paying the Dentist for the charges associated with those dental care or services.

In some instances, certain dental care or services rendered by a Network Dentist that we do not pay or reimburse for may not be billed to the Enrollee. The Network Dentist has agreed under their agreement with Delta Dental not to collect fees associated with such dental care or services from that Enrollee that is considered to be not billable to the Enrollee. We will

inform you of which dental care or services are not billable to the Enrollee in the Explanation of Benefits (EOB) that we will send to you. Your Policy's plan design and all additional applicable covenants, processing policies, procedures, exclusions, limitations, rules, conditions, guidelines and agreements contained in the Delta Dental Dentist Handbook, DeltaUSA Policies Manual/Delta Dental National Account Processing Policies and/or as set forth by the Delta Dental Plans Association, as revised from time to time, are hereby incorporated by referenced in and constitute part of the Plan to the same extent and with the same force as if fully set forth in this contract. The processing policies documents can be found on Delta Dental's website at www.deltadentalks.com under the portal.

We may refuse to pay for or reimburse any dental care or services covered under the Plan which are provided in a manner that is inconsistent with the generally accepted applicable standard practice of dentistry.

Section 5 – Claims Filing Procedures

5.1 Filing Claims

When an Enrollee receives dental care from a Dentist, they should present their Delta Dental ID card. The Dentist will generally file a claim on the Enrollee's behalf unless that Enrollee is visiting an Out-of-Network Dentist.

5.2 Policyholder Filed Claims

If there is ever a need to file a claim yourself, you must follow the four (4) steps listed below.

1. Pay the Dentist the full amount of the bill. Request a copy of the itemized bill that shows the amounts for each service.
2. To obtain a copy of a Claim Form, contact Member Services at 1.866.234.3375. Once we receive a request for a Claim Form, we will furnish that to you within fifteen (15) days after such request is made of Delta Dental.
3. Complete and sign the claim form. Include copies of any itemized bills for dental care. Each itemized bill must contain the following:
    - Full name of patient.
    - Date of service.
    - Each service received and the amount paid.
    - Name and address of the Dentist.
4. Mail copies of the completed claim form and itemized bills to:

    Delta Dental of Kansas
    Attn: Member Services
    P.O. Box 789773
    Wichita, KS 67278

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

5.3 Prompt Filing of Claims

Regardless of who files the Claims, all Claims should be filed no later than 6 months after the date of service. A Claim is not deemed complete and payable until it contains all of the information we need to process the Claim, including any necessary supporting documentation such as chart notes and/or x-rays. Failure to submit a Claim within 6 months will not invalidate or reduce the Claim if you submit that Claim as soon as possible. However,

we will not pay or reimburse any Claim if we receive that Claim more than one year from the date of service unless the Enrollee subject to that Claim is legally incapacitated.

5.4 Claim Processing

We process submitted Claims within the time permitted by federal and state law, but generally no longer than 30 days after we receive it. We may extend this period for an additional 15 days if needed for matters beyond our control, including cases where a Claim is deemed not complete. If we need additional information to process the claim, or if we need an extension, we will notify you before the end of the initial 30-day period.

We may deny a Claim if you do not provide all the information we need to process the Claim. An Adverse Benefit Determination will be sent to let you know what additional information we need to process the Claim. You must submit the requested information to us no later than 45 days from the date of the request. We will process the Claim and send you a Benefit determination no later than 15 days after we receive the requested information.

The procedure for appealing an Adverse Benefit Determination is set forth in Section 6.

5.5 Predetermination of Benefits

We strongly encourage Enrollees to request that their Dentist submit a Predetermination of Benefits prior to receiving Covered Services such as prosthodontics, individual crowns, surgical procedures (periodontal and oral), and endodontics in order to determine our and Enrollee's respective coverage and/or payment for such services in order to avoid surprises upon filing a claim for payment once services have been received. A Predetermination of Benefits does not obligate us to provide benefits associated that Predetermination of Benefits if the Enrollee is no longer eligible to receive such benefits at the time the Covered Services are performed. Predeterminations of Benefits are only effective for up to six (6) months from the date submitted.

5.6 Right to Information from the Dentist

On one or more occasions, we may require information from the Dentist who provided dental care and services to an Enrollee in order to review and process a Claim. When you accept coverage under this Policy, you automatically and irrevocably consent to the release of the information we need to process a Claim. Also, when the Dentist provides Covered Services to an Enrollee and submits a Claim, that Dentist consents to provide the information we need in order to process that Claim.

5.7 Emergency Treatment

If you are covered under the Silver Plan, Gold Plan, or Platinum Plan, those three plans include coverage for emergency dental treatment. Each individual dental office has its own emergency treatment protocol so Enrollees should contact their Dentist to 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 Services under this Policy.

5.8 Fraudulent Claims

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Section 6 – Complaint and Appeal Procedure

We have established the following process to review and address your questions, comments, complaints, and appeals. If you have designated an Authorized Representative, that person may act on your behalf.

If you have a question or complaint, you should first try to resolve the issue by contacting our Member Services at 1.866.234.3375. In most cases, a Member Services agent will be able to help you with your issue. If you are not able to resolve your issue through an informal exchange, you may request a formal review of the issue through our appeal process described in Section 6.3.

6.1 Claims Processing Procedure

We shall have the authority to determine Benefits in accordance with this Policy. We will receive, review, and process Claims in accordance with our established guidelines.

You have the right to seek and obtain a full and fair review by us of the Benefit determinations in accordance with the procedures set forth in this Policy.

6.2 What Do We Do if We Deny a Claim or Do not Pay in Full?

On one or more occasions, we may deny all or part of your Claim. If we deny a Claim in whole or in part, you will receive a written notice from us with the following information, if applicable:

1. The reasons for the determination.
2. A reference to the provisions of this Policy that the determination is based on, or the administrative basis or criterion for the determination.
3. A description of the information we need to perfect the Claim and why we need it.
4. A description of our internal review and appeal procedures and their time limits.
5. The right to request reasonable access to and copies of the documents, records, and other information relevant to the Claim at no charge.
6. Any internal rule, guideline, or criterion we relied on in the determination, and a statement that we will provide a copy of such rule, guideline, or criterion upon request at no charge.

6.3 Claim Appeal Procedures

(a) How Do You File an Appeal of a Denied Claim?

You or an Authorized Representative may file an appeal of a denied claim. If an Authorized Representative is filing an appeal on your behalf, we must receive a notice signed by you before we will recognize a person as an Authorized Representative. You may contact us at the number on your Delta Dental ID card if you need an Authorized Representative Form.

If you believe we incorrectly denied all or part of your Claim, you may request a review of the denial. We will review your claim appeal in accordance with the following procedure:

1. Your request for review should be in writing and received by us no later than 180 days after you receive a denied claim. If you do not receive a benefit determination 30 days after submitting a Claim, you may request a review no later than 180 days after that initial 30-day period. You should mail all requests for appeals to:

   Delta Dental
   Attn: Member Services
   P.O. Box 789773
   Wichita, KS 67278

2. You need to state the reasons why you do not agree with the denial. You may submit any statements, documents, or written arguments in support of your Claim review. You should include a copy of the denial and the information listed below.
    a. Delta Dental ID number.
    b. Enrollee's name and date of birth. If the Enrollee is not you, you must include your name and date of birth.
    c. Claim number.
    d. Date of Service.
    e. Description of the dental care received.
    f. The charged amount.
    g. Name and address of the Dentist.

3. We shall acknowledge receipt of your mailed appeal request promptly.

(b) How Do We Review Your Appeal?

We shall conduct a new review of your Claim, appeal, and all the information you submit with no deference to the initial denied Claim. Our agent reviewing your appeal will not be the same agent who decided the initial claim denial. A licensed dental care professional will review appeals involving a clinical determination. We will give you the opportunity to review relevant documents, and to submit any statements, documents, or written arguments in support of your appeal. The review of claims and supporting documentation may require review by regional dental consultants to examine the claim from a clinical perspective. Where appropriate, examinations may also be conducted at the request of an Enrollee, a treating dentist, or for other reasons determined by us.

We shall resolve and respond to your appeal as soon as practical, but no later than 60 days after we receive your appeal.

We will notify you in writing of your appeal determination. You will receive a written notice from us with the following information, if applicable:

1. The reasons for the determination.
2. A reference to the provisions of this Policy that the determination is based on, or the administrative basis or criterion for the determination.
3. The right to request reasonable access to and copies of the documents, records, and other information relevant to the Claim at no charge.
4. Any internal rule, guideline, or criterion we relied on in the determination, and a statement that we will provide a copy of such rule, guideline, or criterion upon request at no charge.
5. An explanation of the criterion that we used in the determination and the rationale.

6.4 Right of Recovery

We may correct Benefit payments that we made in error. You agree to reimburse us for Benefits we have paid and for which you were not eligible under the terms of this Policy. We may recover any overpayment of Benefits from your Dentist that we determine to have benefited from the payment error. The payment amount includes the reasonable cash value of any Benefit. We shall make additional payments if we made any underpayments of Benefits.

You shall return to us any overpayments of Benefits we made to you. You may be required to cooperate with us to secure our right to recover any excess payments made on your behalf, or on behalf of another Enrollee covered under your coverage.

6.5 Limitation on Right to Recovery

We will not seek recovery of any excess or erroneous payment made more than 18 months after we made that payment, unless: we made that payment because of fraud committed by you or another person; or you or the Dentist have otherwise agreed to refund us for our overpayment of a Benefit.

6.6 Time Limit on Certain Defenses

No misstatements, except for fraudulent misstatements, that you made in the Application shall be used to void this Policy or deny a Claim after your coverage has been in effect for 2 or more years.

6.7 Fraud and Misrepresentation to Obtain Coverage

If any person obtains coverage, Benefits, or payments in connection with this Policy because of any direct or indirect act of fraud or material misrepresentation (including misrepresentation by omission), that person shall make restitution to Delta Dental, and pay any direct or indirect fees, expenses, losses, or other damages suffered by Delta Dental as a result of that act of fraud or material misrepresentation in that amount. We may take additional action against that person as we deem necessary or appropriate, including, but not limited to, retroactively terminating that individual's coverage under this Policy.

Section 7 – Obligations of Each Party

7.1 Your Obligations as Policyholder

(a) Enrollment Information and Other Information

1. On or before the Effective Date, you shall provide us the following information below.
    a. Accurate initial enrollment information, including any required identification numbers, regarding you and all Enrollees, if any, entitled to receive Benefits.
2. You shall provide us any other information that we may on one or more occasions request in connection with this Policy.
3. After the Effective Date, you shall promptly provide us with an accounting of all changes, if any, to the required information in (1) of this subsection and to the requested information if needed in (2) of this subsection.

(b) When Are Your Premium Payments Due?

You shall pay to us all premiums as listed below.

1. Payment Methods allowed:
    a. Payments made by personal check, cashier's check or certified check must apply to the entire annual premium.
    b. Payments made by credit card, debit card or bank withdrawal may apply to either the monthly or annual premiums.
2. If you applied for coverage online and pay your monthly or annual premiums via credit card, debit card, or bank withdrawal:
    a. Initial premium – before the Effective Date in accordance with Section 1.3.
    b. Subsequent premiums – on or before the 10th day of each month after the Effective Date. This 10-day period will be deemed a grace period, and during that grace period, the policy shall continue in force in accordance with Section 9.1.
3. If you applied for coverage via paper application and pay your annual premiums via personal check, cashier's check, certified check, or money order.
    a. Initial premium – before the Effective Date in accordance with Section 1.3.

b. Subsequent premiums – on or before the annual renewal date in accordance with Sections 1.3 and 1.5. A grace period of 31 days will be granted for annual premium policies, during which grace period the policy shall continue in force in accordance with Section 9.1.

(c) What You Should Do if Your Enrollment Information Needs Correction?

If you discover any clerical errors or delays regarding changes in your enrollment information, you must notify us as soon as possible of those changes. We will adjust the premium amounts and enrollment information for the affected months of the then-current Term, but we may not refund any amounts based upon more than two months of retroactive information.

(d) What Are Your Obligations to the Enrollees?

You shall facilitate the effective coverage of all Enrollees under your Policy by adhering to the requirements set forth below.

1. You shall not interfere with the professional relationship between the Dentists and Enrollees.
2. You shall provide each Enrollee with a copy of this Policy.
3. You shall encourage each Enrollee to notify their Dentist at the time of their office visit that they are covered by this Policy.

(e) What You Should Do When Your Coverage Ends?

In the event this Policy expires or terminates under Section 9.1, you shall notify the Enrollees of the effective date of the discontinuation of your coverage.

7.2 Our Obligations

(a) Our Obligations as the Claims Administrator

We shall administer Claims under this Policy by adhering to the requirements set forth below.

1. We shall require prompt submission of a Claim that complies with our claims procedures before we provide payment for the Claim.
2. We shall not provide payment for any dental care rendered to an individual who is not an Enrollee at the time of that service.
3. We will make payment for Covered Services directly to a Participating Dentist if the Enrollee receives services from a Participating Dentist. We will make payment for Covered Services directly to you as Policyholder for each Benefit received by an Enrollee from an Out-of-Network Dentist. We will not make payment directly to an Out-of-Network Dentist for Covered Services on your behalf.

(b) Copies of the Policy and Changes to the Policy

We shall post current copies of this Policy on our website for you to review and share with the Enrollee(s). We may send you a paper copy of this Policy upon request at no charge. The copy of the Policy shall summarize the features of your coverage, including the eligibility rules, benefits, and methods of securing payments for Claims. We shall update the copy of this Policy on our website and notify you whenever there is a change to the Policy that affects your coverage.

Section 8 – General Provisions

8.1 Benefits Under this Policy

We provide the Benefits listed in this Policy only. Only Enrollees may be entitled to Benefits from us. No one may transfer or assign their rights to Benefits to anyone else. We will cover Benefits listed in this Policy only for those Dentists described in this Policy.

8.2 Prior Approval of Benefits

We shall not give prior approval for or guarantee one or more Benefits to the Enrollee or other persons making such request.

8.3 Notice of Claim and Claim Forms

We must receive notice of claim no later than 20 days after the occurrence or commencement of any covered claim or loss. We consider notice of claims containing enough information to identify the Enrollee adequate for the purposes of this section. No later than 15 days after the receipt of that notice of claim, we shall furnish the required form for filing Claims to you. If we do not furnish that form within 15 days, you will be deemed to have complied with the requirements as to proof of loss upon submitting written proof covering the occurrence and the loss.

8.4 Payment of Benefits

You authorize us to make payments directly to Participating Dentists providing dental care for which we provide Benefits. We reserve the right to make payments directly to you for services received by an Out-of-Network Dentist. You may not assign your right to receive payment to anyone else at any time. Once a Dentist performs dental care that is covered, we will not honor a request not to pay the submitted Claim.

8.5 Prompt Payment of Claims

We shall pay or reimburse a Claimant no later than 30 days after we receive a completed Claim. We may suspend or delay the payment or reimbursement of a Claim beyond the initial 30-day period if that Claim does not include the required information. However, we shall pay or reimburse all accrued Benefits payable during the continuance of that period subject to the terms of this Policy.

8.6 Legal Actions

No legal action may be taken to recover Benefits within 60 days after a Claim has been filed. No such legal action may be taken later than five years after expiration of the period in which a Claim is required by this Policy.

8.7 Premium Rates Calculations

On one or more occasions, we may change the rate table used for this Policy, and in any event the premium rates will not change during the Initial Term or any Renewal Term. We will notify you before the end of a Term if there are any rate changes for the upcoming Renewal Term. On each premium's due date, the premium will be based on the rate table in effect in the state where this Policy was issued. The Policy plan, Enrollee's age, and type and level of Benefits are some of the factors that may be used in determining your premium rates. We will not make any changes to your premium solely because of Claims made under this Policy or a change in an Enrollee's dental condition.

8.8 Statements

No statements made by you or any other person, will be deemed a warranty or used in defense of a claim or in any other dispute under this Policy, unless it is contained in a written instrument, a copy of which has been agreed to in writing by you and us.

8.9 Our Liability Regarding Dental Care

We do not provide dental care to you. We only provide Benefits for dental care you receive from Dentists which are covered under this Policy. Dentists are not employees, agents, or other legal representatives of us. We are not liable for any act or omission of any Dentist or any other third party. Our reference to Dentists as Network Dentists and Out-of-Network Dentists are not an endorsement or guarantee of their professional abilities or experience.

8.10 Governing Law

The laws of the Kansas where this Policy was issued shall govern all matters relating to this Policy, without reference to its choice of law rules.

8.11 No Waiver

Any failure by either party to enforce the other party's strict performance of this Policy will not constitute a waiver of their right to enforce any terms of this Policy.

8.12 Severability

If any term of this Policy is held invalid under any law, such invalidity will not affect any other terms of this Policy that can be given effect without the invalid term. All terms of this Policy will be deemed enforceable to the extent permissible under law, and, when needed, the parties shall request the court to reform any and all terms to give them that effect. Each party's obligations under this Policy are in addition to, and not exclusive of, any and all of its other obligations to the other party, whether express, or implied, in fact or in law.

8.13 Controlling Document

This Policy is the controlling document for all Benefits and terms of the insurance arrangement between you and us as set forth in Section 8.5.

8.14 Entire Contract and Changes

This Policy, including any attached documents, if any, constitutes the entire contract. This Policy supersedes all prior agreements, representations, and warranties on the subject matter of this Policy. Nothing can be incorporated by reference.

8.15 Changes to Policy

No agent has authority to change this Policy or to waive any of its terms. No changes to this Policy will be valid until approved by one of our executive officers and supported by an endorsement. If this Policy conflicts with any other document, the terms of the then-current Policy will control.

The parties have not relied on any agreement, statement, or warranty of the other party or of any other person on that party's behalf, including any agreements, or warranties arising from statute or in law, except for those expressly contained in this Policy or a Statement in accordance with Section 8.8.

8.16 Notices; Electronic Communication

The parties must send all notices in writing and give all consents in writing (collectively referred to as "Notice"). A Notice occurs is effective when the intended recipient receives it unless an alternate prospective date is specified in that Notice. We shall send all Notices to you at the address set forth in the Application, unless you designate a different contact person and address under this section. You shall send all Notices to us at the following address:

Delta Dental
Notice Re: Individual Dental Benefits Plan

1619 N. Waterfront Pkwy
Wichita, KS 67206

Notwithstanding this section, we may deliver Notices to you in electronic form. You shall have the right to receive Notices in electronic form or paper form. You may consent or withdraw your consent on one or more occasions without consequences subject to the terms of this Policy. If you want to change your consent or update your information needed to contact you or both, you shall comply with the then-current contact information until we notify you that we updated your contact information and manner of contact.

8.17 Confidentiality/Protected Health Information Considerations

Delta Dental understands that it has Protected Health Information (PHI) as defined under 45 C.F.R. Parts 160-164 also known as the HIPAA Privacy Rule (Privacy Rule), and has issued its Notice of Privacy Practices which is located at https://deltadentalks.com/privacy. Information specifically located in its Notice of Privacy Practices highly is summarized here, so please view the Notice regarding any specific definitions of the information in this section. Delta Dental may use and disclose your PHI without your prior written authorization for payment, treatment and health care operations purposes pursuant to the Privacy Rule. Delta Dental may also use and disclose your PHI without your prior written authorization for the following purposes as permitted or required by law: Business Associates, Legal Requirements, Public Health Activities, Health Oversight Activities, Health or Safety, Judicial and Administrative Proceedings, Law Enforcement Purposes, Victims of Abuse, Neglect or Domestic Violence, Specialized Government Functions, Persons Involved in Your Care, Emergency Notification, Disaster Relief, Worker's Compensation, Fundraising, Underwriting, and Other Uses and Disclosures as allowed for under the Privacy Rule. There are certain Uses and Disclosures that specifically require your authorization which we will obtain prior to using or disclosing your PHI for any of those purposes not listed in this Notice or as otherwise permitted by law. This generally includes obtaining your authorization prior to using or disclosing your PHI for marketing purposes, sale of PHI and PHI involving psychotherapy notes. If you provide us with an authorization in writing for the use or disclosure of your PHI, you may revoke that authorization in writing at any time. Upon receipt of that written revocation, Delta Dental will stop using or disclosing your PHI. Your revocation will not affect any use or disclosure permitted by your authorization while your authorization was in effect. You have specific rights with respect to your PHI including the following: the right to inspect and copy your PHI, the right to amend incorrect or incomplete PHI, the right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice, and a right to a breach notification. Additionally, if you have questions about your privacy rights, disagree with a decision that we made regarding access to your PHI, or believe that we may have violated your privacy rights, you may contact us at the address listed in this Policy. Finally, you have the right to request an Individual Rights Form and to File a Complaint and will not be penalized in any way if you choose to file a complaint.

Delta Dental agrees to use appropriate safeguards to prevent the unauthorized use or disclosure of PHI and ensures that its agents, including such third parties hired by Delta Dental to perform some it is duties, agrees to the same restrictions and conditions that apply to Delta Dental regarding PHI. Delta Dental enters into Business Associate Agreements with its third parties it supplies PHI to in order to perform its duties.

Section 9 – Termination and Effect of Termination

9.1 Termination

This Policy shall remain in full force and effect for the Term unless one of the provisions listed below applies.

1. You do not pay your premiums due to us within the:

    a. 10-day grace period if you applied for coverage online and pay monthly via credit card, debit card, or bank withdrawal.

    b. 31-day grace period if you applied for coverage via paper application or mail application and pay annually via personal check, cashier's check, certified check, or money order.

    In such event, we shall consider you in default and your coverage will terminate effective on the last day of the last calendar month in which you paid the full premium rate ("Default Date").

2. This Policy may be terminated at the expiration date of the Term if either you or Delta Dental notifies the other of its intent not to renew in writing at least 30 days before the end of the then-current Term.

3. This Policy may be terminated at any time if either you or Delta Dental notifies the other of its intent to terminate in writing at least 30 days before the desired termination date.

4. You breach any material representation, including those related to enrollment, or do not comply with the terms of this Policy.

9.2 Effect of Termination

(a) No Release

The expiration or termination of this Policy, for any reason, shall not release either you or Delta Dental from any obligations or liability to the other, including any payment and delivery obligation, that:

a. Has already accrued under this Policy;

b. Comes into effect due to the expiration or termination of this Policy; or

c. Otherwise survives the expiration or termination of this Policy.

The party terminating this Policy, or in the case of the expiration of this Policy, each party, shall not be liable to the other party for any damage of any kind (whether direct or indirect) incurred by the other party because of the expiration or termination of this Policy.

Following the termination of this Policy, Delta Dental shall promptly invoice you for any outstanding amounts due and owing under this Policy, and you shall pay all those amounts to us under the payment terms set forth in this Policy. If an advance payment has been made by you for any Benefits that have not and will not be delivered to you following the expiration or termination of this Policy, we shall promptly refund that payment to you.

Notwithstanding this subsection, if you die, we shall: terminate your coverage as of the date of your death; prorate the premiums you paid for that period; and refund the remainder of the prorated premiums you paid to the last listed address in accordance with Section 8.16.

(b) Reinstatement

If you do not pay us for any amounts that are then due or that become due under this Policy, your coverage will terminate on the Default Date as set forth in Section 9.1. We may accept any late premiums and reinstate your coverage if you pay after the applicable grace period expired only if that payment satisfies your outstanding balance. If we reinstate your coverage, the effective date of the reinstated Policy will be 10 calendar days after the date of reinstatement. In no event will we cover Benefits for any period for which you have not paid premiums before obtaining dental care.

(c) Waiting Period

If your coverage under this Policy terminates before the end of the then-current Term and your coverage is not reinstated under Section 9.2(b), you are subject to a 12-month waiting period before you may enroll in an individual Delta Dental policy or plan.

Section 10 – Coordination of this Policy's Benefits with Other Benefits:

A. GENERAL.

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

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

B. DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

C. ORDER OF BENEFIT DETERMINATION RULES.

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

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

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

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

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

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

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

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

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

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

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

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

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

b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph C(3)(b)(1) above shall determine the order of benefits.

c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph C(3)(b)(1) above shall determine the order of benefits; or

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

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

3. For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph C(3)(b)(1) and C(3)(b)(2) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

D. EFFECT ON THE BENEFITS OF THIS PLAN.

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

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

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

F. FACILITY OF PAYMENT.

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

G. RIGHT OF RECOVERY.

If the amount of the payments made by DDKS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be

responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 11 – Definitions

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

Allowance

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

Application

The initial completed form from the Policyholder requesting coverage under this Policy that states all the information Delta Dental requires to effect coverage under this Policy, including, but not limited to requested Plan coverage, Eligible Dependents' information, and any other information Delta Dental may request on one or more occasions.

Benefit

Dental care that is listed as a covered service, subject to the terms of this Policy.

Claim

A request for payment or reimbursement of dental care for which we may provide Benefits that we receive on an approved form.

Child (or Children)

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

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

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

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

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

- his or her status as an Eligible Dependent does not terminate for any other reason; and

- proof of disability is furnished to Delta Dental within thirty-one (31) days after Child attains the age which would otherwise be disqualifying.

Such proof of disability must be updated from time to time as required by Delta Dental.

Contract Year

The twelve (12) month period beginning on the first day of the Policy (or Effective Date) and terminating at 11:59 P.M. on the last day of the twelve (12) month period.

Copay (or Copayment)

A percentage of the fee for the covered service that the Enrollee is responsible for paying.

For example, you are covered under the Gold Plan and you visit a Delta Dental PPO Dentist and need a non-surgical extraction. The fee for a non-surgical extraction may be $100. Delta Dental would pay for 80% of the $100, or $80. The Enrollee would be responsible for the remaining 20% of the $100, or $20. Delta Dental will pay the Network Dentist $80, and the Enrollee will be responsible to pay the Network Dentist the remaining $20.

Cosmetic

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

Covered Services

The dental services, procedures, and products which are covered under a specific Plan subject to the terms and conditions contained in this Policy.

Deductible

The dollar amount the Enrollee is responsible to pay for Covered Services before Delta Dental will begin paying for services if such service is subject to the deductible. Specific information regarding the Deductible as it relates to the Plan's Covered Services is listed in the Summary of Dental Plan Benefits, Summary of Dental Plan Benefits.

Delta Dental Dentist Handbook

The Delta Dental Dentist Handbook contains general processing policies that Delta Dental must adhere to except to the extent prohibited under applicable law. The general processing policies in the Delta Dental Dentist Handbook apply to each CDT code and associated descriptor, and specific processing policies, exclusions and limitations, that apply to each code.

DeltaUSA Policy Manual/Delta Dental National Processing Policies

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

Delta Dental Plans Association

Delta Dental Plans Association is a not-for-profit organization comprised of a network of Delta Dental member companies operating in all 50 states, Puerto Rico and other U.S.

territories. Delta Dental Plans Association establishes standards and guidelines, including the Delta Dental National Processing Policies, which apply to all member companies and which are incorporated by reference herein and constitute part of this Policy. Compliance is required in order to maintain membership in the Association.

Dental Network

One of the following networks as identified in Section 3.2:

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

Delta Dental PPO: The Delta Dental PPO network is a subset of Delta Dental 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 Dentists 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 Summary of Dental Plan Benefits and/or Section 3, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in Summary of Dental Plan Benefits and/or Section 3.

Dentist

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

Effective Date

This Policy is effective as of the first of the month following enrollment in this Policy and coincides with your desired effective date option you selected during the enrollment process as set forth on the enrollment materials.

Eligible Dependent

An individual, such as a Spouse or a Child or Grandchild, who is eligible to enroll or be enrolled under this Policy.

Enrollee

Policyholder and/or their Eligible Dependents who are enrolled and covered under this Policy.

Experimental or Investigational Services

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

Maximum Plan Allowance (or MPA)

The lesser of the following:

a. In the case of a Participating Delta Dental Premier Dentist:
    i) the fee submitted by the Participating Delta Dental Dentist for the Covered Service; or

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

b. In the case of a Participating Delta Dental PPO Dentist:
   i) the fee submitted by the Participating 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 an Out-of-Network Dentist:
   i) the fee submitted by the Dentist for the Covered Service; or
   ii) the Delta Dental Out-of-Network Dentist Maximum Plan Allowance.

Medicare

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

Medicaid

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

Out-of-Network Dentist

A Dentist who has not executed a Delta Dental Participating Dentist Agreement and has not agreed to provisions within the Delta Dental Participating Dentist Agreement regarding services that Delta Dental considers not billable to the patient. If the Enrollee sees an Out-of-Network Dentist, the Dentist may bill the Enrollee for services that would otherwise be considered not billable to the Enrollee if seen by a Delta Dental Participating Dentist.

Orthodontic Services

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

Qualifying Life Event

A change in your situation, such as having a baby, getting married, or losing dental coverage, that can make you eligible for a special enrollment period.

Participating Dentist or In-Network Dentist

A Dentist who has agreed to provide dental services as a Delta Dental Premier and/or Delta Dental PPO Dentist and has executed a Delta Dental Participating Dentist Agreement or Delta Dental PPO Agreement with Delta Dental. Such Dentist agrees to provide dental services as established by Delta Dental and agrees to the terms and conditions of the agreement(s) such as accepting services that are not billable to the patient and accepting the Maximum Plan Allowance for payment where applicable.

Plan

The dental coverage levels offered under this Policy and are collectively referred to throughout this Policy as "Plan". The dental coverage levels offered are: Bronze; Silver; Gold; and Platinum.

Policy

This agreement is between Delta Dental and the Policyholder, including the Application.

Policyholder

An individual who meets the requirements stated in Section 2.1 and has agreed to the terms and conditions contained in this Policy.

Predetermination of Benefits

A written request for verification of benefits submitted by a Dentist before rendering dental care services to an Enrollee.

Right Start 4 Kids℠ (RS4K)

Children age twelve (12) and under will receive their claims paid at 100%, for all covered services, excluding Orthodontics. Deductible will not apply, but the annual maximum, frequencies, and limitations will apply. Children must see a Participating Premier or PPO Dentist. If a child visits a non-network dentist, normal waiting periods, Deductibles, and Copays will apply. Exclusions and Limitations outlined in the Policy apply.

Relative

A person connected by blood, marriage, or adoption.

Resident

A person who maintains their permanent home or residence in Kansas, and to where, whenever that person is absent, that person intends to return.

Policyholder

The individual who enrolled in a Plan under this Policy and has paid their required premiums on time.

Spouse

A significant other in a legal marriage recognized under the laws of the state in which the Policyholder resides.

Workers Compensation

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

Signature Page

YOU HEREBY ACKNOWLEDGE THAT BY COMPLETING THE APPLICATION FOR INDIVIDUAL DENTAL COVERAGE THROUGH DELTA DENTAL AND SUBMITTING THE APPLICABLE PREMIUM PAYMENT TO US, YOU AGREE TO THE TERMS SET FORTH IN THIS DELTA DENTAL SUBSCRIBER AGREEMENT.

To evidence our agreement to this Policy, we have signed this Policy on the date of signing below.

Delta Dental of Kansas, Inc.

By: _____

Name: Dean Newton

Title: President and CEO

Date: January 1, 2026