

FARM CREDIT FOUNDATIONS

DENTAL PLAN

WRAP AROUND PLAN DOCUMENT

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FARM CREDIT FOUNDATIONS DENTAL PLAN

PREAMBLE

The Farm Credit Foundations Dental Plan (“Dental Plan”) is sponsored and maintained by AgriBank, FCB (“AgriBank”) and by U.S. AgBank, FCB (“U.S. AgBank”) for the benefit of the eligible employees of each Bank, their affiliated associations and other employers within the federal Farm Credit System, including Northwest Farm Credit Services, who are parties to the Farm Credit System Administrative Agreement Regarding Employee Benefit Plans (“Administrative Agreement”).

Participation in this Dental Plan is limited to employers who are members of the federal Farm Credit System. The Farm Credit System is defined in the Farm Credit Act of 1971, as amended (12 U.S.C. § 2001 *et seq.*), to include “the Farm Credit Banks, the Federal land bank associations, the production credit associations, the banks for cooperatives, and such other institutions as may be made a part of the System, all of which shall be chartered by and subject to regulation by the Farm Credit Administration.” 12 U.S.C. § 2002(a).

Under the provisions of the Farm Credit Act of 1971, AgriBank and U.S. AgBank are defined and declared to be “instrumentalities of the United States.” 12 U.S.C. § 2011(a). Those participating employers that are Production Credit Associations and/or Federal Land Bank Associations are also defined and declared by statute to be “federally chartered instrumentalities of the United States.” 12 U.S.C. § 2071(a); 12 U.S.C. § 2091(a). Those participating employers that are Agricultural Credit Associations and Federal Land Credit Associations are defined and declared to be “instrumentalities of the United States” in the charters issued to them by the Farm Credit Administration.

For this reason, the Dental Plan is intended to be a “governmental plan” as that term is defined in Code § 414(d). As a “governmental plan,” the Dental Plan is not subject to Title I of the Employee Retirement Income Security Act of 1974 (“ERISA”). Because of the close relationship that exists between the employers in the Dental Plan under the provisions of the Farm Credit Act and the terms of their respective charters and because of their status as “instrumentalities of the United States,” the Dental Plan is designed and intended to be a single employer plan. In addition, the Dental Plan is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), although it voluntarily offers continuation coverage similar to that found in COBRA as set forth later this in Dental Plan.

ARTICLE I INTRODUCTION

Section 1.01 Purpose of Dental Plan. The purpose of this Dental Plan is to provide eligible Employees with dental benefits.

Section 1.02 Health Plan Status. The Employer intends this Dental Plan to qualify as a health plan within the meaning of Code § 105(e) and that the benefits payable under this Dental Plan be eligible for exclusion from gross income under Code § 105(b).

Section 1.03 Single Employer Plan Status. Because of the close relationship that exists between the employers in the Dental Plan under the provisions of the Farm Credit Act and the terms of their respective charters and because of their status as “instrumentalities of the United States,” the Dental Plan, consistent with prior historical practice, is designed and intended to be a single employer plan.

Section 1.04 Exclusive Benefit. It is intended that the Dental Plan terms, including those related to coverage and benefits, be legally enforceable and that the Dental Plan be maintained for the exclusive benefit of Employees and their covered Dependents.

Section 1.05 Effect on Prior Plans. Prior to January 1, 2007, AgriBank and its affiliated associations, U.S. AgBank and its affiliated associations, Northwest Farm Credit Services, and other employers within the federal Farm Credit System who are parties to the Administrative Agreement maintained certain welfare benefit plans on a separate basis. Pursuant to the Administrative Agreement, effective January 1, 2007, AgriBank and its affiliated associations and U.S. AgBank and its affiliated associations and other employers within the federal Farm Credit System have agreed to consolidate certain employee benefit plans previously sponsored separately. Effective January 1, 2007, this Dental Plan amends and restates the separate dental benefit plans that were previously sponsored by AgriBank and its affiliated associations and U.S. AgBank and its affiliated associations and other employers within the federal Farm Credit System. As part of this amendment and restatement, the name of the plan is changed to the Farm Credit Foundations Dental Plan.

Section 1.06 Character of Benefits Provided. This Dental Plan does not provide dental treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Benefit Schedule. The fact that a particular dental service may not be eligible for reimbursement under this Dental Plan does not mean that a Participant or other person who is covered under this Dental Plan should not receive that service.

Section 1.07 Funding Policy and Method. The dental benefits under this Dental Plan are funded by the Employer. The cost of providing these dental benefits is paid for by Employer and Employee contributions. The Employer, in its sole discretion, may purchase a group insurance policy to fund some or all of the benefits under this Dental Plan, but shall have no obligation to do so. Salary reduction amounts paid under the Dental Plan are made periodically during the Plan Year based upon the amounts (if any) by which the cost of the selected Dental Plan benefits exceeds the amount of Employer contributions pursuant to the Farm Credit Foundations Flexible Benefits Plan.

Section 1.08 Effective Date. The effective date of this Dental Plan as amended and restated is January 1, 2007; provided, however, that if this Dental Plan is subsequently amended, such new or amended provisions shall be effective on a later date as provided in the Plan Sponsor Committee minutes adopting such new or amended provisions.

Section 1.09 Required Forms. The Plan Administrator may require the completion and submission of any form required pursuant to this Dental Plan (e.g., enrollment forms) in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

ARTICLE II DEFINITIONS

Section 2.01 “**Wrap Around Plan Document**” means this plan document, but not the Benefit Schedule which this Wrap Around Plan Document incorporates by reference.

Section 2.02 “**Benefit Schedule**” means the “Farm Credit Foundations Dental Plan Benefit Schedule.” Such Benefit Schedule is a part of this Dental Plan. Any definitions in the Benefit Schedule are incorporated by reference as part of this Dental Plan.

Section 2.03 “**Calendar Year**” means the period of twelve (12) consecutive months from January 1 through December 31.

Section 2.04 “**Claimant**” means a Participant who files a claim for benefits pursuant to this Dental Plan.

Section 2.05 “**Claims Administrator**” means Delta Dental of Kansas, Inc. (“DDKS”).

Section 2.06 “**Code**” means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.07 “**Co-payment**” means a form of cost-sharing whereby the Participant pays a percentage of Covered Expenses.

Section 2.08 “**Dental Plan**” means the Farm Credit Foundations Dental Plan. The Dental Plan consists of this Wrap Around Plan Document and the Benefit Schedule.

Section 2.09 “**Dependent**” means:

- (A) An Employee’s or Disabled Person’s Spouse, but only if the Spouse is not divorced or legally separated from the Employee or Disabled Person;
- (B) An Employee’s or Disabled Person’s Domestic Partner;
- (C) An Employee’s or Disabled Person’s Children if such Children:
 - (1) Are under age 19; and
 - (2) Are unmarried; and
 - (3) Are principally dependent upon the Employee or Disabled Person for financial support; and
 - (4) Are either (a) living with the Employee or Disabled Person in a normal parent-child relationship, or (b) entitled to the provision of medical coverage under this Dental Plan by virtue of a court order under which the Employee or Disabled Person is legally responsible to provide medical coverage;
- (D) An Employee’s or Disabled Person’s Children if such Children:

- (1) Are between the ages of 19 and 25; and
- (2) Are unmarried; and
- (3) Are principally dependent upon the Employee or Disabled Person for financial support; and
- (4) Are either (a) enrolled in and attending an accredited educational or vocational institution with full-time student status, or (b) missionary students who participate full-time on a voluntary, uncompensated basis in a formal, non-profit program whose mission is to provide religious or charitable work.

The requirements of this Section 2.09(D)(4) shall be deemed to be met during any "medically necessary leave of absence" of the Dependent, provided that such leave does not exceed one year, measured from the first day of the "medically necessary leave of absence," and provided that coverage for such Dependent would not otherwise terminate under Section 4.11 of this Plan. A "medically necessary leave of absence" means a leave of absence from a postsecondary educational institution or any other change in enrollment of the Dependent at such institution (e.g., part-time student status) that:

- (a) Commences while such Dependent is suffering from a serious illness or injury; and
- (b) Is medically necessary, pursuant to a treating physician's written certification.

(E) An Employee's or Disabled Person's Children if such Children:

- (1) Are over age 19; and
- (2) Are unmarried; and
- (3) Are principally dependent upon the Employee or Disabled Person as their primary source of financial support at the time the Child would otherwise cease to be eligible because of age; and
- (4) Are incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap.

(F) A Domestic Partner's Children if the Domestic Partner is enrolled in the Plan and such Children:

- (1) Satisfy the requirements of (C), (D), or (E) above; and
- (2) Share the same legal residence as the Employee or Disabled Person.

A Covered Employee's or covered Disabled Person's or covered Domestic Partner's Child is a Dependent only to the extent that each of the conditions under either Subsection (C), (D), (E), or (F) of this Section 2.09 is satisfied. Upon the failure of a Covered Employee's or covered Disabled Person's or a covered Domestic Partner's Child to satisfy any of these conditions, the Child will immediately cease to be a Dependent.

If a Covered Employee or covered Disabled Person or covered Domestic Partner claims a Child as a Dependent under this Section 2.09, the Plan Administrator may require the Covered Employee or covered Disabled Person or covered Domestic Partner to provide proof that each of the conditions under either Subsection (C), (D), (E), or (F) of this Section 2.09 is satisfied.

If a Covered Employee or covered Disabled Person claims a Child as a Dependent under Subsection (E) of this Section 2.09 (or, similarly, if a covered Domestic Partner claims a Child as a Dependent under (F)), the Covered Employee or covered Disabled Person (or covered Domestic Partner) must provide proof that the Child is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap. Such proof must be provided before coverage is continued under Subsection (E) or (F) of this Section 2.09. Additionally, such proof must be provided on the January 1 of each Calendar Year thereafter, so long as coverage under the Dental Plan continues. The Plan Administrator may require proof of continuing incapacity from time to time, but not more than once each year. A Child who is a Dependent under Subsection (E) or (F) of this Section 2.09 is subject to all other provisions of this Dental Plan.

Further, notwithstanding any other provisions of this Dental Plan, no Dependent may be covered under this Dental Plan as a Covered Dependent of more than one Covered Employee or covered Disabled Person, and no Covered Person may be covered hereunder as both a Covered Employee and a Covered Dependent or as both a covered Disabled Person and a Covered Dependent.

Section 2.10 "Disability Date" means the date an Employee qualifies as a Disabled Person under this Dental Plan.

Section 2.11 "Disabled Person" means an Employee who meets one of the following conditions:

- (A) **Deemed Disabled and Entitled to Benefits.** The Employee is:
 - (1) Deemed totally and permanently disabled pursuant to the Long Term Disability Plan contained within the Farm Credit Foundations Employer Provided Welfare Benefits Plan or under the Employer's policy of workers' compensation insurance; and
 - (2) Entitled to and is receiving benefits under the Farm Credit Foundations Long Term Disability Plan or the Employer's policy of workers' compensation;

or

- (B) **Social Security Administration.** The Employee is certified by the Social Security Administration as having a disability and is, therefore, entitled to

- (1) Submitted a claim for benefits under the Long Term Disability Plan contained within the Farm Credit Foundations Employer Provided Welfare Benefits Plan or the Employer's workers' compensation policy and having such claim denied; or
- (2) Exhausted the appeal process set forth in the Long Term Disability Plan contained within the Farm Credit Foundations Employer Provided Welfare Benefits Plan or the Employer's workers' compensation policy.

Evidence of continued disability status under the Long Term Disability Plan, the Employer's workers' compensation policy, or the Social Security Administration certification will be required and/or re-determination of disability status will be determined in accordance with written procedures established by the Plan Administrator.

If at any time a Disabled Person becomes ineligible for disability status under the Dental Plan, such individual will no longer be an Eligible Disabled Person under this Dental Plan.

Section 2.12 "Domestic Partner" means a person of the same or opposite sex for whom each of the following conditions is met:

- (A) **Age Requirement.** The Employee or Disabled Person and the person are at least age eighteen (18); and
- (B) **Consent to Contract.** The Employee or Disabled Person and the person have attained the legal age to consent to contract according to the laws of the state in which they reside; and
- (C) **No Blood Relationship.** The Employee or the Disabled Person and the person are not related by blood in a degree that is closer than what would be permitted in the state in which they reside if the person and the Employee or Disabled Person desired to be married; and
- (D) **Cohabitation.** The Employee or Disabled Person and the person have lived together for at least six (6) consecutive months in an exclusive committed relationship of mutual caring and support and plan to continue their relationship indefinitely; and
- (E) **No Other Marriage or Domestic Partnership.** Neither the person nor the Employee or the Disabled Person is married to any other person, any prior marriages involving the person and/or the Employee or the Disabled Person have been legally dissolved, the relationship between the person and the Employee or the Disabled Person is exclusive, and there is no other person who is a spousal equivalent or Domestic Partner of either the person or the Employee or the Disabled Person; and

- (F) **Common Welfare and Financial Obligations.** The Employee or Disabled Person and the person are jointly responsible for each other's common welfare and share financial obligations.

A Covered Employee's or covered Disabled Person's domestic partner is a Domestic Partner only to the extent that each of the conditions listed in this Section 2.12 is satisfied. Upon the failure of a Covered Employee's or covered Disabled Person's Domestic Partner to satisfy any of these conditions, the Domestic Partner will cease to be a Domestic Partner on the fifteenth day or the last day of the month coincident with or next following the date on which the loss of eligibility occurs.

If a Covered Employee or covered Disabled Person claims a person as a Domestic Partner under this Section 2.12, the Plan Administrator may require the Covered Employee or covered Disabled Person to provide proof that each of the conditions listed above in this Section 2.12 is satisfied. The Plan Administrator may require proof of continuing Domestic Partnership status from time to time, but not more than once each year. A covered Domestic Partner is subject to all other provisions of this Dental Plan.

Section 2.13 "Eligible Disabled Person" means a Disabled Person who was enrolled in the Dental Plan on his/her Disability Date.

Section 2.14 "Eligible Employee" means a Regular Full-Time Employee or a Regular Part-Time Employee, subject, however, to the following:

- (A) **Status During Leaves of Absence.** An Employee's status as an Eligible Employee shall be deemed to continue during any paid leave of absence approved by the Employer not to exceed six (6) months, during an unpaid leave of absence not to exceed six (6) months, or, if FMLA is applicable to the Employer, during a leave of absence taken pursuant to FMLA.
- (B) **Status During Military Service.** An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less.

Section 2.15 "Employee" means an individual employed by the Employer as a common law employee, excluding the following:

- (A) **Temporary Employees.** A Temporary Employee is a person who is employed on a temporary or contract basis to meet unusual workloads or demands or to fill in while a regular Employee is on extended, sick, or annual leave.
- (B) **Leased Employees.** A Leased Employee is a person classified by the Employer on its payroll records as "leased employees" as that term is used in Code § 414(n); and
- (C) **Part-Time Without Benefits Employees.** A "Part-Time Without Benefits Employee" is an employee who is regularly scheduled to work less than twenty (20) hours per week. A Part-Time Without Benefits Employee is not an Employee for purposes of participation in the Dental Plan and, therefore, is not eligible to participate in this Dental Plan.

Section 2.16 “**Employer**” means AgriBank, FCB, U.S. AgBank, FCB, Northwest Farm Credit Services, and each employer within the federal Farm Credit System who, with the permission of the Farm Credit Foundations Plan Sponsor Committee, has executed a Participation Agreement for this Dental Plan and the Participation Agreement remains in effect. Pursuant to the terms of the Administrative Agreement, the Plan Sponsor Committee is responsible for handling all settlor functions on behalf of the Employer under this Dental Plan.

Section 2.17 “**FMLA**” means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.18 “**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.19 “**Participant**” means an Eligible Employee or Eligible Disabled Person who has entered the Dental Plan pursuant to Article III and whose participation in the Dental Plan has not been terminated pursuant to Article IV.

Section 2.20 “**Plan Administrator**” means the Farm Credit Foundations Trust Committee. The Farm Credit Foundations Trust Committee may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to this Dental Plan in a manner consistent with the terms of this Dental Plan.

Section 2.21 “**Plan Year**” means the fiscal year of this Dental Plan, the twelve (12) consecutive month period beginning every January 1 and ending the subsequent December 31.

Section 2.22 “**Regular Full-Time Employee**” means an Employee who is regularly scheduled to work at least thirty-two (32) hours per week. Such status may be deemed to continue during any paid or unpaid leave of absence approved by the Employer or during any leave taken in accordance with the Family and Medical Leave Act of 1993 (“FMLA”).

Section 2.23 “**Regular Part-Time Employee**” means an Employee who is regularly scheduled to work at least twenty (20) hours per week, but not ordinarily equaling or exceeding thirty-two (32) hours per week. Such status may be deemed to continue during any paid or unpaid leave of absence approved by the Employer or during any leave taken in accordance with FMLA.

Section 2.24 “**Severance Period**” means the period of time following an Employee’s termination of employment during which the Employee continues to receive compensation from the Employer pursuant to a plan or policy of the Employer providing such compensation to Employees whose employment has been involuntarily terminated.

Section 2.25 “**Spouse**” means a person of the opposite sex to whom the Participant is legally married. A common law marriage to a person of the opposite sex shall be considered to be a legal marriage if the common law marriage was entered into in a state that recognizes common law marriage and if the common law marriage is recognized as valid under the laws of that state. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of legal marriage (including, as may be applicable, the existence of a common law marriage).

Section 2.26 “**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Section 2.27 “**Western District Association**” means one of the following employers: AgCredit Financial, ACA, American AgCredit ACA, Farm Credit Services of Colusa-Glenn, ACA, Farm Credit Services of Hawaii, ACA, Farm Credit Services Southwest, ACA, Farm Credit West, ACA, FLBA of Kingsburg, Federal Land Credit Association, Fresno-Madera Farm Credit, ACA, Idaho Agricultural Credit Association, Northern California Farm Credit, ACA, Sacramento Valley Farm Credit, ACA, Western AgCredit, ACA, Yosemite Farm Credit, ACA.

**ARTICLE III
ELIGIBILITY AND PARTICIPATION**

Section 3.01 Requirements to Become a Participant. In order to participate in this Dental Plan, an Employee must be an Eligible Employee or an Eligible Disabled Person as defined in Article II. If the Employee is an Eligible Employee, the Eligible Employee must complete the waiting period as set forth in Section 3.02 and complete and return the applicable enrollment forms as set forth in Section 3.04. If the Employee is an Eligible Disabled Person, there is no waiting period and there are no new enrollment forms to complete. If these requirements are met, the Employee or Disabled Person shall become a Participant as set forth in Article IV. In addition, the following rules apply:

- (A) **Rehired Participants.** If a Participant terminates employment, is later rehired, and becomes an Eligible Employee after being rehired, the former Participant will again become a Participant in the Dental Plan pursuant to the provisions of this Section 3.01.
- (B) **Employees of Affiliating Employers.** In the case of any Employee of a Farm Credit System Employer that affiliates with AgriBank or U.S. AgBank and becomes an Employer under this Dental Plan in accordance with Section 2.16 of this Dental Plan, such Employee will become a Participant as provided in the affiliation agreement entered into between AgriBank or U.S. AgBank and such Farm Credit System Employer.
- (C) **Employees Changing Classification Status.** An Employee whose classification status changes from a Part-Time Without Benefits Employee, as defined in Section 2.15(C), to Regular Part-Time Employee or Regular Full-Time Employee will become a Participant in the Dental Plan on the first day of the next pay period coincident with or next following the change in classification status.

Section 3.02 Waiting Period/Plan Entry Date. An Eligible Employee may become a Participant on the first day or the sixteenth day of the first month coincident with or next following the Eligible Employee's first day of employment with the Employer, provided that the proper enrollment forms have been signed and received by the Plan Administrator within 45 days of the date the Employee becomes eligible to participate in this Dental Plan. If such forms are received after the Eligible Employee's first day of employment and *after* the first or sixteenth day of the month but *before* the expiration of 45 days, then such Eligible Employee will enter the Dental Plan on the first day or the sixteenth day, as applicable, of the next calendar month following the first day of employment with the Employer. In addition, an Eligible Employee's coverage will be delayed until the date he /she returns to work if he/she is absent from work due to sickness, injury, or a temporary leave of absence on the date coverage would otherwise have been effective.

In determining when an Eligible Employee may enter this Dental Plan, any Employee who begins active employment on the first business day of the Employer during a calendar month shall be treated as having begun such employment on the first day of such calendar month. Similarly, if the sixteenth day of the month is not a business day of the Employer and an Eligible Employee begins active employment on the first business day following the sixteenth day of the month, the Employee shall be treated as having begun such employment on the sixteenth day of such calendar month.

Section 3.03 Special Rule for Retirees. An individual, other than an Employee, a Disabled Person, a former Employee on continuation coverage, or a Dependent, who was participating in this Dental Plan on December 31, 2006 or who retired from a Western District Association on December 31, 2006, will automatically remain a participant or be permitted to participate in this Dental Plan. Such individual's coverage shall continue until the date this Dental Plan is terminated or until the end of the period for which the last required contribution was paid, whichever occurs earlier.

Section 3.04 Election to Participate. In order to participate in this Dental Plan, the proper enrollment forms must be signed and received by the Plan Administrator within 31 days of the date the Employee becomes eligible to participate in the Dental Plan. An Eligible Employee who does not timely sign and return the proper enrollment forms to the Plan Administrator shall not be eligible for coverage until the following Plan Year unless the Employee exercises special enrollment rights or experiences a change in status event pursuant to the provisions of Article IV. The Plan Administrator may require the enrollment process to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

Section 3.05 Employee Dependent Eligibility. Except as provided in Section 3.07 below, an Eligible Employee's Dependent(s) will be eligible to participate in the Dental Plan on the later of the following:

- (A) The same date on which the Eligible Employee satisfies the eligibility requirements of Sections 3.02 and 3.04; or
- (B) The date when such person(s) first come within the definition of Dependent(s) of an Eligible Employee as set forth in the Benefit Schedule.

Provided that an eligible Dependent is enrolled within 31 days of his/her eligibility date and, unless the special enrollment rules described in Article IV permit retroactive enrollment, an eligible Dependent's coverage will begin the first day or the sixteenth day of the first month coincident with or next following the later of (a) the first day of the Participant's continuous active employment with the Employer or (b) the completion and submission of proper enrollment forms within the 31-day period specified above.

Section 3.06 Disabled Person Dependent Eligibility. Except as provided in Section 3.07 below, an Eligible Disabled Person's Dependent(s) will be eligible to participate in the Dental Plan on the later of the following:

- (A) The same date on which the Eligible Disabled Person satisfies the eligibility requirements of Sections 3.02 and 3.04; or
- (B) The date when such person(s) first come within the definition of Dependent(s) of an Eligible Disabled Person as set forth in the Benefit Schedule.

Section 3.07 Dependents Ineligible for Dependent Coverage. Notwithstanding any other provision of this Dental Plan, an Employee's Dependent is not eligible for coverage under this Dental Plan if such Dependent is a member of the armed forces of any country, or if such Dependent is covered under this Dental Plan as an Employee or Disabled Person.

Section 3.08 Employee/Dependent or Disabled Person/Dependent. If a husband and wife or Domestic Partners are both Eligible Employees and/or Eligible Disabled Persons, they may elect one of the following options:

- (A) The husband and wife or Domestic Partners may each enroll in the single coverage;
- (B) Either the husband or the wife or the Domestic Partner may enroll in employee plus spouse coverage and cover the other Spouse or Domestic Partner as a Dependent; or
- (C) Either the husband or the wife or the Domestic Partner may enroll in family coverage (if there is more than one Dependent) covering the other Spouse or Domestic Partner and any additional Dependents.

An Employee or Disabled Person who also qualifies as a Dependent may elect to be covered either as an Employee/Disabled Person or as a Dependent, but not as both an Employee/Disabled Person and a Dependent simultaneously. Further, under no circumstances will any Dependent be covered as a Dependent of more than one Employee and/or Disabled Person.

Section 3.09 Requirement of Documentation. The Plan Administrator reserves the right to require whatever documentation is necessary to determine, to the satisfaction of the Plan Administrator, an individual's status as a Dependent or as an Employee/Disabled Person.

**ARTICLE IV
TIME & DURATION OF COVERAGE**

Section 4.01 Employee Coverage. An Employee's or Disabled Person's coverage under this Dental Plan shall become effective on the date of the Employee's or Disabled Person's eligibility as provided in Article III.

If an Eligible Employee meets the eligibility conditions set forth in Section 3.02 but does not timely sign and return the proper enrollment forms to the Plan Administrator as set forth in Section 3.04, the Employee shall not be eligible for coverage until the following Plan Year unless the Employee meets one of the exceptions provided below in this Article IV. This paragraph does not apply to Disabled Persons.

Section 4.02 Special Enrollment Period. The occurrence of either of the following two events described in Subsections (A) and (B) below shall result in a Special Enrollment Period of limited duration for the Employee or Dependent who is not already enrolled and covered under this Dental Plan:

(A) **Loss of Other Health Coverage.** Notwithstanding any provision in this Article IV to the contrary, an Employee or Dependent who does not elect coverage under this Dental Plan because such Employee or Dependent was covered under another group health plan or had other dental insurance coverage may enroll in this Dental Plan if such alternative coverage terminated because of either Subsection (1) or (2) below:

- (1) There was a loss of eligibility for such alternative coverage. A loss of eligibility includes the following:
 - (a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment or reduction in the number of hours of employment, or exhaustion of the maximum COBRA period;
 - (b) Loss of eligibility due to the incurrence of a claim causing the individual to meet or exceed a lifetime limit on all benefits;
 - (c) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area; or
 - (d) Loss of eligibility for Medicaid coverage or coverage under a state's children's health insurance program ("SCHIP"), on or after April 1, 2009.

A loss of eligibility does not include a loss resulting from the failure of the Employee or Dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud).

or

- (2) Employer contributions toward such other coverage ceased.

The Special Enrollment Period expires 31 days after the alternative coverage terminates, except that the Special Enrollment Period expires 60 days after the coverage described in Section 4.02(A)(1)(d) above terminates. Coverage elected during this Special Enrollment Period will commence on the first day or the sixteenth day of the month coincident with or next following timely receipt by the Plan Administrator of the proper enrollment forms.

- (B) **Eligibility for a State Premium Assistance Subsidy Under the Dental Plan from Medicaid or SCHIP.** An Eligible Employee or his/her Spouse or Dependent may enroll in this Dental Plan if, on or after April 1, 2009, he/she becomes eligible for a state premium assistance subsidy under this Dental Plan from Medicaid or a SCHIP.

The Special Enrollment Period expires 60 days after the Eligible Employee or his/her Spouse or Dependent becomes eligible for the state premium assistance subsidy. Coverage elected during this Special Enrollment Period will commence on the first day or the sixteenth day of the month coincident with or next following timely receipt by the Plan Administrator of the proper enrollment forms.

Section 4.03 Enrollment Mid-Year Due to a Change in Status. A Participant or his/her covered Dependent may be eligible to begin or cease coverage before the end of the Plan Year if the individual meets one of the change in status events set forth in Article V of the Farm Credit Foundations Flexible Benefits Plan.

Section 4.04 Coverage of Dependents Enrolled Simultaneous with Employee. If an Employee has one or more eligible Dependents on the date he/she becomes a Participant in this Dental Plan, and he/she elects "Family Coverage" (or "Employee Plus Spouse Coverage" or "Employee Plus Child(ren) Coverage"), the enrolled Dependents' coverage under this Dental Plan shall become effective on the same date on which coverage was effective for such Employee.

Section 4.05 Newly-Elected Coverage of Newly-Acquired (or Newly-Eligible) Non-Newborn Dependents. If an Employee or Disabled Person acquires one or more Dependents (other than newborn infants described in Section 4.06 below and other than a Domestic Partner) after the Employee's or Disabled Person's date of coverage (as determined under Section 4.01 or 4.02), or if the Employee's or Disabled Person's Spouse or child comes into conformity with the definition of Dependent after the Employee's or Disabled Person's date of coverage, and the Employee or Disabled Person thereupon or thereafter elects "Family Coverage" (or "Employee Plus Spouse Coverage" or "Employee Plus Child(ren) Coverage"), coverage for each such Dependent enrolled under this Dental Plan shall become effective on the first day or the sixteenth day of the month coincident with or next following the date such Dependent qualifies as an eligible Dependent, provided the enrollment forms (or Status Benefit Change forms) have been received by the Plan Administrator prior to such date. If such forms are late, then coverage shall become effective on the first day or the sixteenth day of the month next following the date the applicable forms are received by the Plan Administrator. In any event, the enrollment forms and payment of the coverage rate for Dependent Coverage (or Status Benefit Change forms) must be received within 31 days after the date such Dependent qualifies as an eligible Dependent. If the enrollment forms (or Status Benefit Change forms) are not received within 31 days after the date such Dependent qualifies as an eligible Dependent, such Dependent will not be eligible for coverage until the following

Plan Year, at which time such Dependent will be subject to any pre-existing condition limitations imposed by the terms of this Dental Plan.

Section 4.06 Newly-Elected Coverage of Newborn Dependents Acquired by Birth or Adoption. If an Employee or Disabled Person first acquires a newborn Dependent after the Employee's or Disabled Person's date of coverage (as determined under Section 4.01 or Section 4.02), and thereon or thereafter elects "Family Coverage" (or "Employee Plus Child(ren) Coverage") each such newborn Dependent's coverage under this Dental Plan shall be made effective as of the date of such Dependent's birth or adoption, as applicable, if enrollment forms and payment of the coverage rate for Dependent coverage are received by the Plan Administrator within 31 days after the date of the Dependent's birth or the date of the Dependent's adoption, as applicable. However, if, after 31 days, the Employee or Disabled Person has not elected a coverage option sufficient to include the new Dependent, enrolled such Dependent and paid the appropriate premium, the child will not be covered hereunder as a Covered Dependent from the date of birth or adoption, as applicable. Rather, such Dependent will not be eligible for coverage until the following Plan Year, at which time such Dependent will be subject to any pre-existing condition limitations imposed by the terms of this Dental Plan.

Section 4.07 Extension of Existing Family Coverage. With respect to an extension of existing Family Coverage to newly-acquired or newly-eligible Dependents, such Dependents' coverage will become effective as follows:

- (A) **Newly-Acquired Adopted or Newborn Dependents By Birth or Adoption.** If the Employee or Disabled Person has Family Coverage and thereafter acquires a newborn Dependent by birth or adoption, coverage for such newborn Dependent (and any other Dependent who enrolls pursuant to Section 4.08 below) becomes effective on the date such new Dependent becomes an eligible Dependent under Article III, if the Status Benefit Change forms are received by the Plan Administrator within 31 days of said date.
- (B) **Dependents Newly-Eligible for Reasons Other than Birth or Adoption.** If the Employee or Disabled Person has Family Coverage and thereafter the Employee's or Disabled Person's Spouse or Child not eligible or covered as a Dependent comes into conformity with the definition of "Dependent" (as set forth in the Benefit Schedule), coverage for such newly-eligible Dependent (and any other Dependent who enrolls pursuant to Section 4.08 below, other than a Domestic Partner) becomes effective on the date such newly-eligible Dependent becomes an eligible Dependent under Article III, if the Status Benefit Change forms are received by the Plan Administrator within 31 days of said date.

Section 4.08 HIPAA Special Enrollment and the "Tag-Along Rule." If an Employee or Dependent enrolls in this Dental Plan pursuant to Sections 4.02 or 4.07, all other Dependents of the Employee (other than a Domestic Partner) who are eligible but not enrolled in the Dental Plan may enroll pursuant to this Article IV.

Section 4.09 **Duration of Employee Coverage.** An Employee's coverage as a Covered Employee under the Dental Plan shall terminate on the earliest of:

- (A) The date this Dental Plan terminates; or
- (B) The fifteenth day or the last day of the month coincident or next following the date the Employee no longer satisfies the Dental Plan's Employee eligibility requirements; or
- (C) The date the Employee becomes covered under this Dental Plan as a Disabled Person; or
- (D) The end of the period for which a required Employee contribution was last paid; or
- (E) The fifteenth day or the last day of the month coincident with or next following the date on which the Employee's employment terminates; or
- (F) The date on which the Employee becomes covered as a Dependent hereunder; or
- (G) The date on which the Employer's participation in the Administrative Agreement is terminated.

If an Employee is on a leave of absence in accordance with FMLA and coverage lapses during the leave due to nonpayment of premiums, coverage shall be reinstated on the date the Employee "returns to active employment." In addition, where continuation coverage is elected under the Dental Plan by a terminated Participant, such terminated Participant will not cease participation in this Dental Plan until the date such continuation coverage terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Dental Plan if and to the extent such individual elects continuation of benefits under the rules in Article VI.

Upon termination of an Employee's coverage, the Plan Administrator, or its designee, shall provide the Employee with a Certificate of Creditable Coverage, provided such Employee does not become covered under this Dental Plan as a Disabled Person.

Section 4.10 **Duration of Disabled Person Coverage.** A Disabled Person's coverage as a covered Disabled Person under the Dental Plan shall terminate on the earliest of:

- (A) The date this Dental Plan terminates; or
- (B) The fifteenth day or the last day of the month coincident with or next following the sixty-fifth birthday of the Disabled Person; or
- (C) The fifteenth day or the last day of the month coincident with or next following the date the Disabled Person no longer satisfies the Dental Plan's eligibility requirements for Disabled Persons; or

- (D) The end of the period for which a required Disabled Person's contribution was last paid; or
- (E) The date on which the Disabled Person becomes covered as a Dependent hereunder; or
- (F) The date on which the Employer's participation in the Administrative Agreement is terminated; or
- (G) The Disabled Person's death.

Upon termination of a Disabled Person's coverage, the Plan Administrator, or its designee, shall provide the Employee with a Certificate of Creditable Coverage.

Section 4.11 Duration of Dependent Coverage. A Dependent's coverage under the Dental Plan shall terminate on the earliest of:

- (A) The date of termination of coverage of the Employee or Disabled Person through whom the Dependent is covered; or
- (B) The fifteenth day or the last day of the month coincident with or next following the date the Dependent no longer meets the Dental Plan's definition of "Dependent" or no longer satisfies the Dental Plan's eligibility requirements; or
- (C) The fifteenth day or the last day of the month coincident with or next following the date the Dependent enters active service in the armed forces of any country, except temporary active service of two weeks or less; or
- (D) The end of the period for which an Employee or Disabled Person's required contribution was last paid; or
- (E) The date upon which the Dependent becomes covered hereunder as an Employee or Disabled Person.

Upon termination of a Dependent's coverage, the Plan Administrator, or its designee, shall provide the Dependent with a Certificate of Creditable Coverage.

ARTICLE V DENTAL BENEFITS

Section 5.01 Dental Benefits. Dental benefits under this Dental Plan are identical to those described in, and shall be paid pursuant to the terms of, the current Farm Credit Foundations Dental Plan Benefit Schedules (“Benefit Schedule”) prepared for the Employer. The provisions of the Benefit Schedule, as it may be amended from time to time, are incorporated herein by reference and the rights and conditions with respect to the benefits payable under this Dental Plan shall be determined from the Benefit Schedule; provided, however, that should there be any contradictions between the Benefit Schedule and this document, this document will control.

Section 5.02 Election to Participate.

- (A) **Benefit Election Form.** If an Eligible Employee wishes to participate in this Dental Plan, the Employee must complete the benefit election form provided by the Plan Administrator and if necessary, elect, in accordance with the terms of the Farm Credit Foundations Flexible Benefits Plan, to reduce the Employee’s Compensation in the amount of the applicable premium under Section 5.03. The Plan Administrator may require the enrollment process to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

- (B) **Effective Date of Election.** An Employee becomes a Participant in this Dental Plan on the date specified on the Employee’s benefit election form, provided the form has been properly completed and returned to the Plan Administrator, or on the date the Employee becomes eligible to participate in this Dental Plan, whichever is later.

Section 5.03 Cost of Coverage. The Participant’s monthly premiums are determined by the Employer. The Employer may change the premiums from time to time. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant. If the Participant is a covered Disabled Person, his/her coverage shall be subsidized by the Employer for two years, measured from his/her Disability Date. After the two-year period, the covered Disabled Person must pay for the full cost of his/her coverage option.

**ARTICLE VI
CONTINUATION OF COVERAGE**

Section 6.01 Continuation of Coverage. If a “qualified beneficiary” loses (or would lose) coverage under this Dental Plan as a result of a “qualifying event” the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a continuation of coverage election form and by paying the applicable premium. The qualified beneficiary’s right to continue coverage under this Dental Plan is subject to the following:

- (A) **Qualified Beneficiary.** For purposes of this Section, a “qualified beneficiary” means the Participant,, and the Participant’s dependents (including a Spouse or Domestic Partner), but only if such persons were covered under this Dental Plan on the day before the “qualifying event”. The term “qualified beneficiary” shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage.

- (B) **Qualifying Event.** For purposes of this Section, a “qualifying event” means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Dental Plan as a result of such an event:
 - (1) Termination of the Participant’s employment (other than for “gross misconduct”) or a reduction in the number of hours the Participant normally works.
 - (2) Death of the Participant.
 - (3) Divorce or legal separation of the Participant and the Participant’s covered Spouse.
 - (4) The Participant’s entitlement to Medicare.
 - (5) A covered Dependent no longer satisfies the conditions for being covered as a Dependent of the Participant.

- (C) **Election to Continue Coverage.** Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the Plan Administrator and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.

- (D) **Premium for Continuation Coverage.** A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.

- (E) **Maximum Coverage Period.** The maximum period of time for which continuation coverage will be provided shall be as follows:
- (1) Termination of Employment or Reduction in Hours. Eighteen (18) months if coverage is lost as a result of termination of the Participant's employment or a reduction in the Participant's hours.
 - (2) Disability Extension. Twenty-nine (29) months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of continuation coverage and the qualified beneficiary notifies the Plan Administrator of such determination while continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.
 - (3) Second Qualifying Event. Thirty-six (36) months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.
 - (4) Any Other Qualifying Event. Thirty-six (36) months for any qualifying event for which a shorter maximum coverage period is not set forth in this Subsection (E).
- (F) **Termination of Continuation Coverage.** Continuation coverage may be terminated prior to the expiration of the maximum coverage period if a qualified beneficiary becomes covered under another group health plan, if a required premium is not paid within the applicable deadline (including any applicable grace period), or if the Employer terminates this Dental Plan and no longer offers coverage under a group health plan to any of its Employees.
- (G) **Coverage Provided During Continuation Period.** The coverage provided during the continuation period shall be identical to the coverage provided to similarly situated persons covered under the Dental Plan with respect to whom a qualifying event has not occurred. If coverage under the Dental Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage.
- (H) **Calculation of Continuation Coverage Deadlines.** The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Dental Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

Section 6.02 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. If, however, a Participant exercised his/her right to continue coverage under USERRA before December 10, 2004, the Participant's right to continue coverage is limited to a maximum period of eighteen (18) months if such coverage would otherwise be lost as a result of such military service. The Participant's right to continue coverage is subject to the following:

- (A) **Payment of Premium.** The Participant must pay the applicable premium for any USERRA continuation coverage.
- (B) **Failure to Apply for Reemployment.** Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA. 43 U.S.C. § 4312(c).
- (C) **Reasonable Procedures.** The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this Section.
- (D) **Construction and Application.** This Section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute.

**ARTICLE VII
HIPAA MEDICAL PRIVACY AND SECURITY**

PART I - PREAMBLE

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy and Security Article is adopted in response to the provisions of the Medical Privacy and Security Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Section 7.02 Application of Amendment. This Article shall supersede the provisions of the Dental Plan to the extent those provisions are inconsistent with the provisions of this Article.

Section 7.03 Relationship to Other Group Health Plans. The Dental Plan is part of an “organized health care arrangement” (“OHCA”) with the following plans maintained by the Employer:

- (A) The Farm Credit Foundations Medical Plan;
- (B) The Farm Credit Foundations Retiree Medical Plan; and
- (C) The Health Flexible Spending Account that is a component of the Farm Credit Foundations Flexible Benefits Plan.

The plans that are part of the OHCA as set forth above may be collectively referred to in this Article VII as the “Group Health Plan.”

PART II – DISCLOSURE OF PHI TO THE EMPLOYER

Section 7.04 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by Part II of this Article VII, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose Protected Health Information or electronic Protected Health Information to the Employer.

Section 7.05 Definitions. For purposes of this Article VII, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in 45 C.F.R. Parts 160 and 164.

- (A) “**Breach**” means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a “breach.”

- (1) Any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of the Group Health Plan or Business Associate (as defined in 45 C.F.R. § 160.103) if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such employee or individual, respectively, with the Group Health Plan or the Business Associate, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the Privacy or Security Rules;
 - (2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan or Business Associate to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the Privacy or Security Rules; and
 - (3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.
- (B) **“De-identified Health Information”** means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed. Information that must be removed, pursuant to this Section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.
- (C) **“Electronic Media”** means
- (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or
 - (2) Transmission media used to exchange information already in electronic storage media. Transmission media includes, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- (D) **“Electronic Protected Health Information” (“e-PHI”)** is PHI that is transmitted or maintained in electronic media.

- (E) **“Individually Identifiable Health Information”** means information for which each of the following conditions is met:
- (1) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;
 - (2) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
 - (3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.
- (F) **“Plan Administration Functions”** means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan that is not part of the same OHCA as the Dental Plan.
- (G) **“Protected Health Information” (“PHI”)** means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.
- (H) **“Security Incident”** (as defined in 45 C.F.R. § 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (I) **“Security Rule”** means the Security Standards and Implementation Specifications in 45 C.F.R. Parts 160 and 164, subpart C.
- (J) **“Summary Health Information”** means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed, except that geographical locations may be described using a five digit ZIP code.
- (K) **“Unsecured Protected Health Information” (“Unsecured PHI”)** means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 7.06 Enrollment/Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section 7.07 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

- (A) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any Business Associates of the Group Health Plan;
- (B) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any appeals that are filed with respect to claims that are denied in whole or in part;
- (C) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;
- (D) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits;
- (E) Detecting fraud or abuse;
- (F) Determining whether charges for services are appropriate or justified;
- (G) Requesting underwriting or premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance;
- (H) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess-loss insurance in the event the Group Health Plan is self-insured in whole or in part;
- (I) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;
- (J) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;
- (K) Reporting corporate finances with respect to current and projected healthcare costs;

- (L) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (M) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.07 is subject to the provisions of Section 7.08.

Section 7.08 Conditions for Disclosure for Plan Administration Functions.

With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 7.07, the Employer agrees to do the following:

- (A) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law;
- (B) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;
- (C) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;
- (D) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. This includes reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s) and the Department of Health and Human Services (the "HHS") may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;
- (E) Restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out of pocket in full;
- (F) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in 45 C.F.R. § 164.524;

- (G) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by 45 C.F.R. § 164.526;
- (H) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by 45 C.F.R. § 164.528;
- (I) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;
- (J) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- (K) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:
 - (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;
 - (2) Ensure that any agents (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and
 - (3) Report to the Group Health Plan any Security Incident of which it becomes aware.
- (L) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III of this Article VII;
- (M) Provide a certification to the Group Health Plan as required by Section 7.09.

Section 7.09 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any Protected Health Information to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 7.08 of Part II of this Article VII.

PART III - ADMINISTRATIVE SAFEGUARDS

Section 7.10 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III of Article VII. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III of Article VII does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 7.11 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to participants: (a) those Employees of the Employer who have the responsibility for administering the benefit programs of the Employer, including, but not limited to, all Employees who serve on or are appointed by the Farm Credit Foundations Trust Committee and all Employees in the benefits section of the AgriBank Benefits Department; (b) members of the Farm Credit Foundations Trust Committee; and (c) the Internal Counsel of the Farm Credit Foundations Trust Committee and his/her support staff in the legal department, but only for the limited purposes of ensuring investigation of and responding to complaints alleging violations of the policies and procedures established by the Employer.

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the information technology department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Group Health Plan’s policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.12 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.13 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III of Article VII, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

**ARTICLE VIII
ADMINISTRATION OF THE DENTAL PLAN**

Section 8.01 Plan Administrator. The Plan Administrator is the Farm Credit Foundations Trust Committee. The Plan Administrator is responsible for the administration of the Dental Plan. The Plan Administrator has the full discretionary authority to administer the Dental Plan. Except as otherwise provided by law or otherwise delegated in this Dental Plan, all decisions of the Plan Administrator are final and binding on all parties. For this purpose, the Plan Administrator, in addition to such other powers as the law may provide, has the following powers to:

- (A) Establish rules and procedures for the purpose of the administration of this Dental Plan;
- (B) Require each Participant to supply such information and sign such documents as may be necessary to administer this Dental Plan;
- (C) Interpret, construe and carry out the provisions of the Dental Plan and render decisions on the administration of the Dental Plan, including factual and legal determinations as to whether any individual is entitled to receive any benefit under the terms of this Dental Plan; and
- (D) Appoint such agents, attorneys, accountants and consultants and any other person required for proper administration of the Dental Plan.

The Plan Administrator shall keep all books, accounts, records and other data as may be necessary for the proper administration of the Dental Plan.

Section 8.02 Plan Must Be Nondiscriminatory. The Plan Administrator will administer this Dental Plan in a nondiscriminatory manner so that all persons similarly situated will receive substantially similar treatment.

ARTICLE IX CLAIMS PROCEDURES

Section 9.01 Claims Administration. Delta Dental of Kansas, Inc. has been delegated to act as Claims Fiduciary through an administrative services agreement. In such agreement, fiduciary responsibility for claims administration is delegated to the Claims Administrator as provided in Section 405(c) of ERISA just as though the Dental Plan were not a “governmental plan,” but a plan fully subject to Title I of ERISA as to the duties and responsibilities of the Claims Administrator. The Claims Fiduciary has the ultimate responsibility for the final determination of all claims made under the Dental Plan except to the extent, and only to the extent, that a claim requires a determination to be made as to whether a given individual was eligible to be, and in fact was, covered under the Dental Plan at the time the claim was incurred. The Claims Fiduciary shall have the sole and exclusive discretion and power to grant and/or deny all claims for benefits. No finding, decision, and/or determination made by the Claims Fiduciary shall be disturbed unless the Claims Fiduciary has acted in an arbitrary or capricious manner.

Section 9.02 Duties of the Claims Administrator.

The Claims Administrator shall have the discretionary power and authority to perform the following duties and responsibilities:

- (A) Receive claims for benefits and render decisions with respect to such claims under the Dental Plan;
- (B) Compute the amounts payable for any Participant or other person in accordance with the provisions of the Dental Plan, determine the manner and time of payment, and determine and authorize the person or persons to whom such payments will be paid;
- (C) Make discretionary interpretations regarding the terms relating to administration of claims under the Dental Plan, its interpretations to be final and conclusive on all persons claiming benefits under the Dental Plan;
- (D) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of claims under the Dental Plan;
- (E) Adopt such rules and procedures relating to the administration of claims as it deems necessary or desirable;
- (F) Be responsible for all claims administration reporting and disclosure requirements for the Dental Plan under the law;
- (G) Receive from the Employer, Employees, Participants and other persons such information as shall be necessary for the proper administration of claims under the Dental Plan; and
- (H) Maintain all claims administration records of the Dental Plan.

The Claims Administrator shall also handle appeals for benefits in accordance with this Article IX and the Benefit Schedule.

Section 9.03 How to File a Claim. In order to obtain benefits under this Dental Plan, it is necessary for a Claim to be filed with the Claims Administrator. Generally, to file a Claim, the Participant shall show his/her ID card to the Provider who is providing the service. The Provider will file the Claim on behalf of the Participant. It is, however, the Participant's responsibility to ensure that the necessary Claim information has been provided to the Claims Administrator.

Once the Claims Administrator receives the Claim, it will be processed and, if approved, the benefit payment will usually be sent directly to the Provider. The Participant shall receive a statement informing him/her of the amount of the Claim paid on his/her behalf. In some cases, the Claims Administrator will send the payment directly to the Participant or, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claims Administrator's records.

Section 9.04 Claims Procedures. Claims made for benefits under the Dental Plan shall be processed in accordance with the following:

- (A) **Claims.** Written proof describing the occurrence, character or extent of a loss or expense for which a Claim is made must be given to the Claims Administrator within twelve (12) months of its occurrence. Claims may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.
- (B) **Form of Claims.** Claims for benefits must be made by the Claimant in such form as the Claims Administrator may prescribe and shall include the following information:
 - (1) The amount, date and nature of each expense;
 - (2) The name of the person, organization or entity to which the expense was/is to be paid;
 - (3) The Group Number identifying the Dental Plan;
 - (4) The name of the Participant for whom the expense was incurred and, if such person is not the Employee or Disabled Person requesting the benefit, the relationship of such Participant to the Employee or Disabled Person; and
 - (5) The amount recovered or expected to be recovered, under any insurance arrangement or other plan (including Medicare, as reflected on the Explanation of Medicare Benefits), with respect to the expense.
- (C) **Delayed Submission of Claims.** If the required proof of expense or loss is not given by the time it is due, it will not affect the Claim if:
 - (1) It was not possible to give the required proof within the required time; and

(2) The required proof is given as soon as possible.

- (D) **Payment of Claims.** The Dental Plan shall pay benefits with respect to Covered Expenses, as determined by the Claims Administrator, typically within thirty (30) days of the receipt of all the necessary information on the claim for benefits. Covered Persons may elect to have benefits paid directly to themselves, or may assign benefits so that payment is made directly to the Hospital or person providing the covered service. By virtue of any such payment, the Employer and Dental Plan will be released from further liability for any amount so paid.
- (E) **Payment of Benefits for a Deceased, Minor or Incompetent Person.** Any incurred benefits unpaid and unassigned at death will be paid to the estate of the deceased person. If benefits are payable to a person who is either a minor or incompetent to give a valid release, the Dental Plan may pay up to \$2,500 to any relative who is entitled to it, in the discretion of the Claims Administrator. Any such payment made will fulfill the obligations of the Dental Plan, the Employer, and the Claims Administrator in the amount paid.
- (F) **Denial of Claims.** If a Claim for benefits is denied in whole or part, the Claims Administrator shall, within a reasonable period of time, but no later than thirty (30) days after receipt of the Claim and all necessary information related thereto, notify the Claimant of the denial of the Claim. This period, however, may be extended by fifteen (15) days, provided that the Claims Administrator determines that such an extension is necessary and notifies the Claimant of the extension before the end of the initial 30-day period. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall have at least forty-five (45) days from receipt of the notice to provide the specified information.

Such notice of denial:

- (1) Shall be in writing;
- (2) Shall be written in a manner calculated to be understood by the Claimant; and
- (3) Shall contain --
- (a) The specific reason(s) for denial of the Claim;
 - (b) A specific reference to the pertinent Dental Plan provisions upon which the denial is based;
 - (c) A description of any additional material or information necessary for the Claimant to perfect the Claim, along with an explanation why such material or information is necessary; and
 - (d) An explanation of the Dental Plan's claim review procedure.

(G) **Appeal of Claim Denial to Claims Administrator.** Upon denial of a Claim in whole or in part, the Claimant or his/her duly authorized representative shall have 180 days within which to file with the Claims Administrator a written request for a review of such denial, whereupon:

- (1) The Claims Administrator shall act as promptly as is practicable, ordinarily within sixty (60) days; and
- (2) The Claimant or his/her duly authorized representative shall, pending said review, be permitted at all reasonable hours to review the pertinent documents and also be entitled to submit issues and comments in writing.

A copy of the claim form, x-rays, and clinical comments must be submitted to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas, 67278.

(H) **Peer Review and Reevaluation.** Reevaluation will be made by the consultant staff and, in some cases, the Claimant may be examined clinically by a regional dental consultant. The Employer or Covered Person may also request such an examination.

If a case cannot be resolved in this manner, the Employer or Claimant may request an evaluation by the applicable state dental association peer review system.

(I) **Decision on Review by Claims Administrator.** If the Claims Administrator determines that an additional amount is due, it shall pay any such amount. If the Claims Administrator determines that the claim is not meritorious, in whole or in part, the Claims Administrator shall notify the Claimant accordingly within sixty (60) days after it receives the request for review.

Section 9.05 Right to Information. The acceptance by any Claimant of any benefit of coverage under this Dental Plan constitutes the automatic and irrevocable consent by that Claimant for the release to the Dental Plan of any and all of the information and records related to the coverage that was provided and constitutes a full waiver by that Claimant of any such information and records that is otherwise privileged.

Further, when an attending or examining Provider provides any benefits covered under this Dental Plan to a Claimant, the provision of such services constitutes consent by that Provider to provide such information and records to the Dental Plan, upon request. If such services were provided in a hospital, the provision of such services constitutes consent by such hospital to provide such information and records to the Dental Plan upon request.

Finally, the Dental Plan, at its own expense, shall have the right and opportunity to cause any Claimant to be examined when and so often as it reasonably requires during the pending of a Claim under this Dental Plan and the right and opportunity to make an autopsy if it is not prohibited by law.

Section 9.06 **Litigation of Claim.** Prior to initiating legal action concerning a Claim in any court, state or federal, against the Dental Plan, any trust used in conjunction with this Dental Plan, the Employer, and/or the Plan Administrator, a Claimant must first exhaust the administrative remedies provided in this Article IX. Failure to exhaust the administrative remedies provided for in this Article IX shall be a bar to any civil action concerning a Claim for benefits under the Dental Plan. If the Claims Administrator pursuant to the Dental Plan's written claims procedures makes a final written determination denying a Claim, the Claimant, to preserve the Claim, must file an action with respect to the denied claim not later than one hundred eighty (180) days following the date of the Plan Administrator's final determination.

ARTICLE X
SUBROGATION AND REIMBURSEMENT OF THE DENTAL PLAN

Section 10.01 Subrogation/Reimbursement Rights of the Dental Plan.

- (A) **Dental Plan's Right to Subrogation.** The Dental Plan shall be subrogated to all rights that a Participant, Covered Dependent, or his/her assignee has against any person, firm, corporation, insurer (including, but not limited to, worker's compensation or any other occupational disease act or law, uninsured motorist coverage, and business/homeowners dental liability insurance coverage or payments) or other entity with respect to *any and all benefits* previously paid by the Dental Plan, or on behalf of the Dental Plan, to such individual for any injuries, expenses, or loss which may be caused by the negligence or wrongful act of a third party.
- (B) **Dental Plan's Right to Reimbursement.** A Participant, Covered Dependent, or assignee agrees to include the amounts of any and all benefits paid by the Dental Plan (or any amount considered to be for future dental expenses) in any claim such individual brings against any person, firm, corporation, insurer, or other entity. Upon any recovery made by a Participant, Covered Dependent, or assignee from any source of compensation, whether by judgment, settlement, compromise, or otherwise, the Dental Plan shall have first lien upon such recovery and be entitled to immediate reimbursement to the extent of any and all benefits paid by the Dental Plan.

Section 10.02 Amount of Recovery. The Dental Plan has the right to recovery, whether by subrogation or reimbursement, for any and all benefits paid by the Dental Plan. The amount due shall not be reduced due to attorney's fees and/or costs incurred in pursuing a claim or reimbursement. In addition, these rights take priority over the Participant's, Covered Dependent's, or assignee's right to be made whole.

Section 10.03 Condition of Payment. By accepting benefits from the Dental Plan, a Participant, Covered Dependent, or his/her assignee agrees to the following:

- (A) The Dental Plan may require a Participant, Covered Dependent, assignee, or someone legally qualified and authorized to act for such person, to agree to the provisions in this Dental Plan, Sections 10.01 and 10.03 in writing, and execute any and all other instruments reasonably necessary for the Dental Plan to assert its rights under these Sections;
- (B) Any amounts recovered by such individual or by the Dental Plan by judgment, settlement, or otherwise will be applied first to reimburse the Dental Plan;
- (C) The Dental Plan shall be subrogated to all claims, demands, actions, and rights of recovery against a third party to the extent of any and all payments made by the Dental Plan; and

- (D) At the Dental Plan's request, a Participant, Covered Dependent, or assignee must take any action, give information, and/or execute instruments required by the Dental Plan, in its discretion, in order to aid the Dental Plan in its enforcement of its rights of recovery, reimbursement, and subrogation. If such individual fails to comply with such requests, the Dental Plan may withhold benefits, services, payments, or credits due under the Dental Plan.

**ARTICLE XI
TERMINATION AND AMENDMENT OF THE DENTAL PLAN**

Section 11.01 Termination and Amendment. The Employer may amend or terminate this Dental Plan at any time in accordance with the procedures established by the Farm Credit Foundations Plan Sponsor Committee, which procedures are hereby incorporated by reference. Any approved change to the Dental Plan shall be made through a written instrument. Upon termination of this Dental Plan, the Employer shall give notice of the termination to all Participants, all individuals then receiving benefits under this Dental Plan and any other affected person.

ARTICLE XII MISCELLANEOUS

Section 12.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 12.02 Employment Not Guaranteed. Nothing contained in this Dental Plan or any modification or amendment to this Dental Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Dental Plan.

Section 12.03 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any individual employed by an Employer who is carrying out his/her responsibilities within the scope of his/her job duties and to whom fiduciary responsibility with respect to this Dental Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Dental Plan or under his/her job duties related to this Dental Plan. This indemnification does not cover such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person, provided this paragraph shall not limit any indemnification of the Employee pursuant to any indemnification provisions of the bylaws of the Employer of the Employee or pursuant to any indemnification insurance held by such employer.

Section 12.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Dental Plan.

Section 12.05 Legal Service. Process can be served on the Dental Plan by directing such legal service to the Claims Administrator and/or the Plan Administrator.

Section 12.06 Limitation of Rights. Neither the establishment of this Dental Plan, nor any amendment, nor the payment of any benefit gives any Participant or any other person a legal or equitable right against the Employer or the Plan Administrator, nor any rights of continued employment.

Section 12.07 Limitation on Liability. A Dental Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Dental Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission to act of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 12.08 Named Fiduciary. The named fiduciary of this Dental Plan shall be the Farm Credit Foundations Trust Committee ("Trust Committee"). The Trust Committee shall have complete authority to control and manage the operation and administration of this Dental Plan. If so designated in a contract between the Trust Committee and a Claims Administrator, the Claims Administrator shall also be a named fiduciary of this Dental Plan to the extent designated in such contract.

Section 12.09 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Dental Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Dental Plan is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

Section 12.10 Nonalienation of Benefits. Benefits payable under this Dental Plan are not subject in any manner to transfer or assignment, unless such benefits are transferred or assigned (a) for the purpose of providing payment for services provided under the terms of this Dental Plan, and/or (b) as expressly permitted under the terms of this Dental Plan; any attempt to transfer, assign, or otherwise dispose of any right to benefits payable under this Dental Plan, is void. The Employer is not in any manner liable for, nor subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under this Dental Plan.

Section 12.11 Prohibition Against Retroactive Entry into the Dental Plan. In the event that a person was determined to be ineligible to participate in the Dental Plan due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Dental Plan on a prospective basis only. Except as may be required in connection with the Dental Plan's voluntary compliance with HIPAA special enrollment rights, no person shall be allowed to enter the Dental Plan on a retroactive basis.

Section 12.12 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Dental Plan, and then only to the extent of the benefits payable under the Dental Plan to such Participant or beneficiary. The Employer will make all payments of benefits this Dental Plan provides solely from the assets of the Employer, and the Plan Administrator is not liable for payment of benefits in any manner.

Section 12.13 Source of Funds. The Dental Plan shall be funded by direct payments from the Farm Credit Foundations Welfare Benefit Trust. The trust shall be funded by the Employer and voluntary Employee compensation reductions subject to all of the provisions of this Dental Plan.

Section 12.14 State Law. The laws of the state of Delaware will determine all questions arising with respect to the provisions of this Dental Plan except to the extent superseded by Federal law.

**FARM CREDIT FOUNDATIONS
DENTAL PLAN BENEFIT SCHEDULE**

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HOW THE BENEFITS ARE PROVIDED

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

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

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

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

DDKS’S TOLL-FREE CUSTOMER SERVICE LINE

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

ARTICLE I DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**ARTICLE II
COVERED EXPENSES**

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

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

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

The Deductible does not apply to expenses incurred for Diagnostic and Preventive Dental Care Procedures. The individual Deductible is applied separately for each Covered Person up to a maximum of three Covered Persons annually.

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

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

Part I – Coverage Options

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

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

- (B) **Comprehensive Care Coverage Option.** The following Comprehensive Coverage Option is identical to the Basic Coverage Option except that it also provides coverage for the following:

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

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

Part II – Basic Coverage Option

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

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

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

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

Part III – Comprehensive Coverage Option

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

- (A) **SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns. The following limitations apply to individual crowns:
 - (1) Individual crowns on the same tooth are a covered benefit only once in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the Covered Person whether or not the Covered Person was covered under this Plan;
 - (2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not covered benefits for any person under twelve years of age;
 - (3) Recementation of a crown may be allowed for payment only once in a twelve (12) consecutive month period;

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

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

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

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

Part IV – Maximum Benefit Amounts

Section 2.11 Maximum Annual Benefit Limit.

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

Section 2.12 Maximum Lifetime Benefit for Orthodontic Procedures.

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

ARTICLE III LIMITATIONS AND EXCLUSIONS

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

- (A) Coverage for any patient who has been, but no longer is, a Covered Person.
- (B) Benefits or services for injuries or conditions compensable under worker's compensation or employer's liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.
- (C) Benefits or services which are determined by the Plan to be Cosmetic surgery or dentistry for Cosmetic reasons.
- (D) Prescription drugs, premedications and relative analgesia; hospital, healthcare facility or medical emergency room charges; laboratory charges; general anesthesia for restorative dentistry; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.
- (E) Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the patient became a Covered Person hereunder, except orthodontics, and then only if such orthodontic coverage was provided under the Employers' group dental program in effect immediately preceding the Effective Date and if orthodontic services are included as a covered dental benefit.
- (F) Benefits and services which are not necessary and customary as determined by the standards of generally accepted dental practice.
- (G) Appliances or restorations for altering vertical dimension, for restoring or maintaining occlusion, for replacing tooth structure lost by attrition or abrasion, for aesthetic purposes, splinting, or equilibration.
- (H) Dental care injuries or disease caused by riots or any form of civil disobedience if the Covered Person was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; injuries intentionally self-inflicted; and injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting therefrom.
- (I) Treatment to correct congenital or developmental malformations.
- (J) Services performed for the purpose of full mouth reconstruction. Extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the program.

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

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

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

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

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

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

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

ARTICLE IV
NON-DUPLICATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE V MISCELLANEOUS

Section 5.01 Emergency Treatment. Each individual dental office has its own emergency treatment procedure and patients should contact their dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours. Hospital or medical service emergency room expenses are not covered benefits.

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

- (A) In General. Any inquiries or complaints should be directed to the Customer Service Department in Wichita, Kansas, and should include all of the following information:
 - (1) Employee group number and identification number.
 - (2) Patient name and birth date.
 - (3) Dentist name and license number.
 - (4) Claim number.
 - (5) Date(s) of service.
- (B) Written Inquiries. Written inquiries are best submitted on the copy of the Explanation of Benefits form.
- (C) Telephone Inquiries. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511, outside of the Wichita area, 1-800-234-3375.
- (D) Written Complaints. Covered Persons who have complaints about the Plan or about services provided by a Dentist under the Plan are encouraged to write their complaint to Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas, 67278.
- (E) Complaints by Telephone. Covered Persons may also telephone the Customer Service Department using any of the numbers identified above.
- (F) In Person Inquiry or Complaint. Inquiries or complaints may also be presented in person at the business office of Delta Dental of Kansas, Inc., which is located at 1619 N. Waterfront Parkway, Wichita, Kansas, 67206.

If necessary, additional information or documents may be requested for a full and fair review. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.