FARM CREDIT FOUNDATIONS
DENTAL PLAN

WRAP AROUND PLAN DOCUMENT
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HIPAA CERTIFICATION
FARM CREDIT FOUNDATIONS
DENTAL PLAN

PREAMBLE

This Farm Credit Foundations Dental Plan (the “Dental Plan”) is sponsored and maintained by those Farm Credit System employers that are parties to the Farm Credit Foundations Administrative Agreement Regarding Employee Benefit Plans (the “Administrative Agreement”).

Each of the Participating Employers in this Dental Plan is a member of the federal Farm Credit System as well as a party to the Administrative Agreement. These Farm Credit institutions include Farm Credit Banks, Federal Land Bank Associations, Production Credit Associations, Banks for Cooperatives, and other institutions that are chartered by and subject to regulation by the Farm Credit Administration. (12 U.S.C. § 2002(a)). The Farm Credit Banks, Production Credit Associations, and Federal Land Bank Associations are statutorily defined to be “federally chartered instrumentalities of the United States,” (12 U.S.C. §§ 2011(a), 2071(a), and 2091(a)), and the Agricultural Credit Associations, Federal Land Credit Associations, and Service Corporations are similarly defined 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”). 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 in this Dental Plan. 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.
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, 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 has been 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 or in any formal amendment adopted by the Plan Sponsor Committee.

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 “Administrative Agreement” means the Farm Credit Foundations Administrative Agreement Regarding Employee Benefit Plans, as amended from time to time.

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” (also known as “Contract Year”) means the period of twelve (12) consecutive months from January 1 through December 31.

Section 2.04 “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 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 “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 2.08 “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 2.09 “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 2.10 “Dental Plan” or “Plan” means the Farm Credit Foundations Dental Plan. The Dental Plan consists of this Wrap Around Plan Document and the Benefit Schedule.
Section 2.11  “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 Child through the end of the month in which the Child turns age 26;

(D) An Employee’s or Disabled Person’s Child if such Child:

   (1) Is over age 26; and

   (2) Is unmarried; and

   (3) Is 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) Is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap.

(E) A Domestic Partner’s Child if the Domestic Partner is enrolled in the Plan and such Child:

   (1) Would satisfy the requirements of (C) or (D) above if he/she was the Child of the Employee or Disabled Person; 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), or (E) of this Section 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 cease to be a Dependent as of the fifteenth day or the last day of the month coincident with or next following the date on which the loss of eligibility occurs.

A Covered Employee’s or covered Disabled Person’s or covered Domestic Partner’s foster child with respect to whom a welfare agency assumes dental care costs is expressly excluded from the definition of Dependent under this Dental Plan.

If a Covered Employee or covered Disabled Person or covered Domestic Partner claims a Child as a Dependent under this Section, 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), or (E) of this Section is satisfied.
If a Covered Employee or covered Disabled Person claims a Child as a Dependent under Subsection (D) of this Section (or, similarly, if a covered Domestic Partner claims a Child as a Dependent under (E)), 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 (D) or (E) of this Section. 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 (D) or (E) of this Section 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 2.12  “Disability Date” means the date an Employee qualifies as a Disabled Person under this Dental Plan.

Section 2.13  “Disabled Person” means an Employee who meets both of the following conditions:

(A) The Employee is 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

(B) The Employee is entitled to and is receiving benefits under the Farm Credit Foundations Long Term Disability Plan or the Employer’s policy of workers’ compensation.

Evidence of continued disability status under the Long Term Disability Plan or the Employer’s workers’ compensation policy 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 2.14  “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);

(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;
(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;

(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;

(E) **No Other Marriage or Domestic Partnership.** Neither the purported domestic partner nor the Employee or the Disabled Person is married to each other or to any other person, any prior marriages involving the person and/or the Employee or Disabled Person have been legally dissolved, the relationship between the person and the Employee or 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 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 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, 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 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 2.15 “Eligible Disabled Person”** means a Disabled Person who was enrolled in the Dental Plan on his/her Disability Date.

**Section 2.16 “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 2.17** “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. Such individuals are not intended to be permanent employees. They are typically (although not always) scheduled to work less than nineteen (19) hours per week and/or less than 1,000 hours during a calendar year;

(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);

(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; and

(D) **Interns.** An Intern is an employee who is assigned to a position in conjunction with a learning program. The length of the assignment is typically less than six (6) months.

**Section 2.18** “Employer” means AgriBank, FCB, the Former Ninth and Eleventh District Employers, Northwest Farm Credit Services, and each employer within the federal Farm Credit System which, with the permission of the 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 2.19** “FMLA” means the Family and Medical Leave Act of 1993, as amended from time to time.

**Section 2.20** “Former Ninth and Eleventh District Employer” means an Employer listed on Schedule C of the Administrative Agreement.

**Section 2.21** “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

**Section 2.22** “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 2.23 "Plan Administrator" means the Trust Committee. The 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 2.24 "Plan Sponsor Committee" means the Farm Credit Foundations Plan Sponsor Committee, which is established by the Administrative Agreement.

Section 2.25 "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 2.26 "Regular Full-Time Employee" means an Employee who is regularly scheduled to work at least thirty (30) 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 2.27 "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 (30) 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 2.28 "Spouse" means a person of the same or opposite sex to whom an Employee or Disabled Person is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. An individual will not be considered a Spouse for purposes of this Dental Plan if (i) his/her marriage to the Employee or Disabled Person has been terminated by a court having jurisdiction over one or both parties to the marriage or (ii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

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 2.29 "Trust Committee" means the Farm Credit Foundations Trust Committee, which is established by the Administrative Agreement.

Section 2.30 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Section 2.31 "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.

Section 2.32 "Wrap Around Plan Document" means this plan document, but not the Benefit Schedule which this Wrap Around Plan Document incorporates by reference.
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.

(B) Employees of Affiliating Employers. In the case of any Employee of a Farm Credit System Employer that affiliates with AgriBank or a Former Ninth and Eleventh District Employer and becomes an Employer under this Dental Plan in accordance with Section 2.18 of this Dental Plan, such Employee will become a Participant as provided in the affiliation agreement entered into between AgriBank or the Former Ninth and Eleventh District Employer 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 2.17(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.

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.

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 two Spouses or two Domestic Partners are both Eligible Employees and/or Eligible Disabled Persons, they may elect one of the following coverage options:

(A) The Spouses or Domestic Partners (as applicable) may each enroll in the single coverage;

(B) One of the Spouses or Domestic Partners (as applicable) may enroll in employee plus spouse coverage and cover the other Spouse or Domestic Partner as a Dependent; or

(C) One of the Spouses or Domestic Partners (as applicable) 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. 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 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”, 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.
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 with 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 valid revocation of the Employee’s election or the cessation of the Employee’s election to participate; or

(F) 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

(G) The date on which the Employee becomes covered as a Dependent hereunder; or

(H) 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.

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 date the Disabled Person no longer satisfies the Dental Plan’s eligibility requirements for Disabled Persons; or

(C) The end of the period for which a required Disabled Person’s contribution was last paid; or
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 fifteenth day or the last day of the month coincident with or next following (i) the valid revocation of the participation election of the Employee or Disabled Person through whom the Dependent is covered or (ii) the cessation of the participation election of the Employee or Disabled Person through whom the Dependent is covered; or

(F) The date upon which the Dependent becomes covered hereunder as an Employee or Disabled Person.
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 prepared for the Employer. The provisions of the Benefit Schedules, as 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 Schedules; provided, however, that should there be any contradictions between the Benefit Schedules 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 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, 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, 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.
“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.

“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.

“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.

“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.


“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.

“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 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;

(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.
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 Trust Committee and all Employees of Farm Credit Foundations; (b) members of the Trust Committee; and (c) the Internal Counsel of the 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 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 and the Benefit Schedule.
Section 9.03  **Claims and Claims Appeals.** Claims made for dental benefits, and any appeals from the denial of such claims, under the Dental Plan, shall be processed in accordance with the claims procedures set forth in the Benefit Schedule.

Section 9.04  **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. Failure to exhaust the administrative remedies provided for in this Article 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.

(A) The Employer may amend or terminate this Dental Plan at any time in accordance with the procedures established by the 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.

(B) The Plan Sponsor Committee delegates authority to Farm Credit Foundations to adopt certain ministerial amendments to the Dental Plan without the need for further approval from the Plan Sponsor Committee. Such ministerial amendments shall include the following:

(1) The correction of typographical errors;

(2) A change in insurance policy / contract number; and

(3) Changes to the benefit schedule.

Any ministerial amendments adopted by Farm Credit Foundations pursuant to this Subsection (B) shall be memorialized in writing and included with the records of the Dental Plan, along with the amendments adopted by the Plan Sponsor Committee. Farm Credit Foundations shall brief the Plan Sponsor Committee, as appropriate, on the details of such amendments.
 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 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
BASIC PLAN
Welcome to Delta Dental of Kansas, Inc.

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

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

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

From our website, you can

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

It is our pleasure to be of service to you.
Summary of Dental Plan Benefits
FCF CONSOLIDATED BASIC PLAN
Group #50500-000-00002-00000

% paid by Plan

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<th>PPO Network</th>
<th>Premier Network</th>
<th>Non Network</th>
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<tbody>
<tr>
<td>Diagnostic &amp; Preventive (Not subject to Deductible)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>I. Diagnostic: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral evaluations – two (2) times per Contract year. Diagnostic x-rays – bitewings two (2) times per Contract year. Full mouth x-rays or panoramic x-rays – once each three (3) years.</td>
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<td>II. Preventive: Provides for the following: Prophylaxis (Cleanings) – two (2) times per Contract year. Periodontal Prophylaxis (Cleanings) – if diagnosed with periodontal disease, then eligible for two (2) additional periodontal cleanings per Contract year. Topical Fluoride – two (2) times per Contract year for dependent Children under age nineteen (19). Space Maintainers for dependent Children under age nineteen (19) and only for premature loss of primary molars. Sealants – once (1) per lifetime for dependent Children under age nineteen (19) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.</td>
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<tr>
<th>BASIC (Subject to Deductible)</th>
<th>80%</th>
<th>80%</th>
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<td>III. Ancillary: Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.</td>
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<td>IV. Oral Surgery: Provides for extractions and other oral surgery including pre and post-operative care.</td>
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<td>V. Regular Restorative Dentistry: Provides amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12)</td>
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<td>VI. Endodontics: Includes procedures for root canal treatments and root canal fillings.</td>
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<td>VII. Periodontics:</td>
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<tr>
<td>a. Includes procedures for the treatment of diseases of the tissues supporting the teeth.</td>
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<td>b. Surgical periodontal procedures.</td>
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<td>VIII. Occlusal Guards: Includes coverage for procedures outlined in Exclusions &amp; Limitations section of this booklet.</td>
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<td>MAJOR (Subject to Deductible)</td>
<td>IX. SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.</td>
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<td>None</td>
<td>XI. PROSTHODONTICS: Includes bridges, partial and complete dentures, including repairs and adjustments.</td>
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<tr>
<td>Orthodontics (Subject to Deductible)</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

A Covered Service is deemed to be benefited by DDKS if it is reimbursable, in whole or in part, under the terms of the Plan or would otherwise be reimbursable, in whole or in part, except for the application of a deductible, co-insurance payment, waiting period, frequency limitation, annual or lifetime benefit maximum, or other limitation contained in the Plan. For a Covered Service benefited by DDKS through payment, DDKS will pay the lesser of i) the percentage of the fee actually charged for a Covered Service which is indicated in the Summary of Dental Plan Benefits, or ii) in the amount which is otherwise paid in accordance with other provisions of the Plan.

This is a Summary of Benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Plan which is binding on all of the parties and supersedes all other written or oral communications.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION
Selected Network

The Dental Network is Delta Dental PASSIVE PPO.

Maximum Benefit Per Person

The Maximum Benefit for all Covered Services, including Occlusal Guards, for each Enrollee in any one Contract Year is Seven Hundred Fifty Dollars ($750.00).

Deductible Limitations

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

After Covered Employee and his/her Covered Dependents who are Enrollees have, in any Contract Year, each paid either the individual Deductible of Fifty Dollars ($50.00), have cumulatively paid charges for Covered Services in the amount of One Hundred Fifty Dollars ($150.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Contract Year.

Payment of Claims

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

Covered Dependent Ages

Dependents are eligible for coverage to age 19 or to age 25 if a full-time student.

DESCRIPTION OF DENTAL CARE COVERAGE

This Description of Dental Care Coverage is issued to the Covered Employee by Delta Dental of Kansas, Inc., hereinafter referred to as “DDKS”, a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental coverage program and constitutes your summary of the Plan and contains the provisions of your dental coverage. Only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth are benefits under the Plan and then only if identified as a covered dental benefit in the Summary of Dental Plan Benefits. Certain restrictions may be applicable to your coverage. It is important to review the Exclusions and Limitations section of this document for these conditions.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this Benefit Schedule, appropriate modifications will be made in the benefits provided under the Plan.

HOW TO USE YOUR PLAN

Make an appointment with your Dentist. Tell the Dentist that you are covered by Delta Dental of Kansas, Inc.
If the planned treatment involves prosthetic or orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics or oral surgery, except for simple extraction of a single tooth, the Dentist should submit a treatment plan to DDKS to determine how much of the bill will be paid by DDKS and what your share of the cost will be. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of DDKS’s consultant, the treatment is not necessary or a lesser procedure could have restored the tooth to contour and function. Even if the Dentist does predetermine benefits, however, it does not obligate DDKS if you as an Employee or Dependent are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist or a new treatment plan should be obtained and resubmitted to DDKS.

PAYMENTS FOR COVERED SERVICES

Following treatment, the Dentist should forward the attending Dentist’s statement to DDKS. If the Dentist is a Participating Dentist, DDKS will make direct payment to the Dentist for each Covered Service. If the Dentist is not a Participating Dentist, DDKS will pay the Employee on each Covered Service. The amount of payment will be calculated using the percentage amount indicated in the Summary of Dental Plan Benefits Section in this Benefit Schedule. If more than one percentage column is shown in the Summary of Dental Plan Benefits, the percentage used will be the one that corresponds to the network status of the Dentist at the time the Covered Services are rendered. DDKS will pay for each Covered Service, subject to the Coordination of Benefits (COB) stipulations in the “Non-Duplication of Benefits” Section of this Benefit Schedule, based on the lesser of i) the fee submitted by the Dentist for the Covered Service, or ii) the Maximum Plan Allowance (MPA). For more information on MPA, see the definition of MPA in the “Definitions” Section of this Benefit Schedule.

You will receive notice of the Plan’s payment and the amount, if any, that you owe the Dentist. The amount you owe should be paid in accordance with the Dentist’s usual billing procedure.

NO PRE-EXAMINATION

There are no pre-examination requirements for Employees and Dependents to be eligible for dental benefits.

EMERGENCY TREATMENT

DDKS’s group dental coverage includes services for emergency treatment. Each individual dental office has its own emergency treatment procedure and patients should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist’s normal business hours. Hospital or medical service emergency room expenses are not covered benefits.

INQUIRIES/APPEALS

Dentists and patients are encouraged to contact DDKS when they have a question concerning a particular claim. Such inquiry should be directed to the DDKS Customer Service Department. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511 or from outside of the Wichita area, 1-800-234-3375.
Patients who have inquiries or an appeal regarding the Plan are encouraged to write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769. Written inquiries are best submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.
2. Patient’s name and birth date. If the patient is not the Covered Employee, the patient’s name and birth date must also be included.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question.

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

Normally, patients will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of DDKS’ receipt. However, if the matter is referred to a review committee, or other unusual circumstances arise, the patient will be advised. Generally, a written answer or decision will be sent to the patient within thirty (30) days thereafter.

**REEREVALUATION AND REVIEW**

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

**NOTICE OF CLAIM**

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

**CLAIM FORMS**

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

Written proofs of loss/claims must be submitted to the insurer at its office within six (6) months of the date that the Covered Service was provided. But, failure to submit a claim within six (6) months of the date that the Covered Service provided will not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time, provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

TIME OF PAYMENT OF CLAIMS

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

DDKS LIABILITY

DDKS shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any such person including but not limited to employees, Enrollees, Dentists, dental assistants, dental hygienists, hospitals, or the agents or employees of any of such foregoing persons, whether receiving or providing services. Further, DDKS shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee.

RIGHT TO INFORMATION

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

MISREPRESENTATIONS

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

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of the Plan. Further, and in all events, any action of any kind by any person who is subject to the Plan must be commenced within five (5) years from the date on which the right, claim, demand, or cause of action shall first accrue.
GOVERNING STATUTES

Any provision of the Plan which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

EXCLUSIONS AND LIMITATIONS

1. Unless the “Summary of Dental Benefits” Section Specifically Provides For Coverage, The Following Dental Benefits And Services Are Excluded:

   a. Coverage for any patient who has been, but no longer is, an Enrollee.

   b. Benefits or services for injuries or conditions compensable under Worker’s Compensation or Employer’s Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.

   c. Benefits or services which are determined by DDKS to be for Cosmetic purposes.

   d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the person became an Enrollee.

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

   f. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for Cosmetic purposes; for splinting or equilibration.

   g. Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

   h. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.

   i. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of the Plan.

   j. Crowns and endodontic treatment in conjunction with an overdenture.

   k. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

   l. Replacement of lost or stolen dentures or charges for duplicate dentures.

   m. Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

   n. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.
o. Any benefit, procedure or service, a motivating purpose for which is to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

p. Dental benefits and services which are not completed.

q. Emergency treatment rendered outside of the United States or Canada (unless the following documentation is provided to process the claim(s)):

1. A copy of proof of licensing for the provider must be attached to the claim form with a receipt of services from the rendering office.

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

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

r. Benefits or services for control of harmful habits.

s. Treatment to correct developmental malformations.

t. Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in the “Summary of Dental Plan Benefits” Section. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.

u. Individual crowns unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

v. Procedures for dental implants and associated services, unless these are specified as Covered Services in the “Summary of Dental Plan Benefits” Section.

w. Diagnosis or treatment of temporomandibular joint dysfunction, unless these are specified as Covered Services in the “Summary of Dental Plan Benefits” Section.

x. 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.

2. Dental Benefits and Services are Limited as Follows, unless the “Summary of Dental Plan Benefits” Section specifies other limitations. Typically, when dental benefits and services are limited under the Plan, any amounts not benefited by DDKS due to the limitation are the responsibility of the Enrollee, up to the amount of the Maximum Plan Allowance (MPA).

a. If a more expensive Covered Service is provided than DDKS determines to be the least costly professionally accepted treatment, DDKS will pay the applicable benefit for the Covered Service which is needed to achieve reasonable functionality.
b. Some Covered Services may be subject to specific age and frequency limitations. These limitations are generally identified in the “Summary of Dental Plan Benefits” Section.

c. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are benefited by DDKS under the Plan and then only if specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

d. Prophylaxis, periodontal maintenance and oral evaluations may be subject to specific time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section. Bitewing x-rays may be subject to specific age, time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section.

e. Full mouth and panoramic x-rays may be subject to specific time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.

f. A seven (7) vertical bitewing series is limited to once (1) every two (2) years.

g. Restoration of surfaces on teeth are limited to only once (1) or twice (2) within a twenty-four (24) month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within twenty-four (24) months after a crown is seated are subject to frequency limitations.

h. Recementation of space maintainers are limited to once (1) per arch or quadrant per lifetime.

i. Claims not submitted to DDKS within twelve (12) months of the date that the Covered Service was provided will not qualify as a Covered Service unless it was not reasonably possible to submit the claim within such time and provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

j. Sealants are limited to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact. Coverage for sealants is limited to one (1) per lifetime per permanent molar unless the “Summary of Dental Plan Benefits” Section allows for other frequency limitations.

k. Inlays will automatically receive benefits equal to the corresponding surface of a filling.

l. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section:

   (1) Individual crowns on the same tooth are limited to only once (1) in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the Enrollee whether or not the Plan was then effective. If a crown is placed on a tooth which has had a restoration in the previous twenty-four (24) month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

   (2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not benefited by DDKS for any person under twelve (12) years of age due to age limitation.

   (3) Recementation of a crown is limited to only once (1) in a lifetime.
(4) Repairs per crown are limited to two (2) in a twelve (12) month period.

(5) Stainless steel crowns are limited to once (1) in a twenty-four (24) month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection 2.2 (l) will apply.

(6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.

m. Prosthetic appliances are not a Covered Service unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. If a Covered Service, the following limitations apply unless the “Summary of Dental Plan Benefits” Section state different limitations:

(1) Not more than one (1) full upper and one (1) full lower denture shall be constructed under the Plan in any five (5) year period for any Enrollee. Said time period is to be measured from the date the denture was last supplied to the Enrollee whether or not the Plan was then effective.

(2) A removable prosthetic or fixed prosthetic may not be provided under the Plan for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the date the denture or bridge was last supplied to the Enrollee whether or not the Plan was then effective.

(3) Denture reline and rebase is limited to only once (1) in any thirty-six (36) month period for Enrollee.

(4) Denture adjustments are limited to only two (2) times in any twelve (12) month period for an Enrollee.

(5) Crowns when used for abutment purposes are benefited at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.

(6) Recementation of a bridge is limited to only once (1) in a lifetime.

(7) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial toward the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.

(8) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.

(9) Tissue conditioning is limited to no more than two (2) per arch each thirty-six (36) months.

n. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period.
Periodontic procedures are not Covered Service unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. When covered, payment is limited to only once (1) in any twenty-four (24) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is limited to once (1) in any six (6) month period; and crown lengthening which carries no frequency limitation.

Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services and is limited to a maximum of ninety (90) minutes, per episode.

Coverage for Occlusal Guards which are removable dental appliances designed to minimize the effects of bruxism (grinding) and other occlusal factors are allowed once (1) every year.

Orthodontic Services are not Covered Services unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

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

DEFINITIONS

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

1. “Benefit Schedule” means this written summary of certain features of the Plan.

2. “Cosmetic” means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory. The determination of whether services are “Cosmetic” shall be made by DDKS in its discretion. Cosmetic services are not Covered Services under the Plan unless a Cosmetic service is specified as a Covered Service in the “Summary of Dental Plan Benefits” Section.

3. “Covered Services” means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of the Plan.

4. “DDKS” means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Association member company which has agreed to provide to Enrollees the benefits described in this Plan, or both, as applicable.

5. “Deductible” means the amount specified in the “Summary of Dental Plan Benefits” Section which must be paid with respect to Covered Services provided to an Enrollee before the Plan provides benefits.

6. “Dental Network” means one of the following networks as identified in the “Summary of Dental Plan Benefits” Section:

a.1. “Delta Dental Premier”: The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that DDKS offers. All Delta Dental Premier providers are considered Participating Dentists and are paid according to DDKS’ Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-participating Dentists are not considered Delta Dental Premier Providers, and are paid according to DDKS’ Non-Participating Dentist Maximum Plan Allowance.
2. If Delta Dental Premier is the Exclusive Network, then Enrollees must exclusively use Dentists in the Delta Dental Premier network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who does not participate in the Delta Dental Premier network, the Enrollee is responsible for all treatment costs incurred.

b.1. **“Delta Dental PPO”**: The Delta Dental PPO network is a subset of DDKS Participating Dentists who agree contractually to participate in the Delta Dental PPO network as part of a discounted fee-for-service plan. Delta Dental PPO providers sign a supplemental agreement and are paid according to a Maximum Plan Allowance for PPO Dentists as defined below. Delta Dental PPO Dentists are paid at the in-network co-insurance percentages in the “Summary of Dental Plan Benefits” Section, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in the “Summary of Dental Plan Benefits” Section.

2. If Delta Dental PPO is the Exclusive Network, then Enrollees in the plan must exclusively use Dentists in the Delta Dental PPO network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all treatment costs incurred.

3. If Delta Dental PPO is a Passive Network, then co-insurance levels for Delta Dental PPO and Delta Dental Premier are the same and Enrollees can use any Participating Dentist, as shown in the “Summary of Dental Plan Benefits” Section.

7. **“Dentist”** means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.

8. **“Enrollee”** means a Covered Person, for whom the appropriate premium is timely received by DDKS. An Enrollee shall be deemed to have enrolled when such Enrollee’s name, enrollment information and the required premium are furnished to DDKS by Employer. However, in the case of an Enrollee in continuation coverage, such person shall be deemed to have enrolled when DDKS is timely furnished by the Enrollee with the applicable enrollment form and premium.

9. **“Maximum Benefit”** means the maximum benefit provided for Covered Services (and Orthodontic Services if specifically included as a Covered Service) which is set forth in the “Summary of Dental Plan Benefits” Section.

10. **“Maximum Plan Allowance”** means the lesser of the following:

    a. In the case of a Participating Delta Dental Premier Dentist:
       i) the fee submitted by the Participating Dentist for the Covered Service, or
       ii) the Delta Participating Dentist Maximum Plan Allowance for the Covered Service.

    b. In the case of a Delta Dental PPO Dentist:
       i) the fee submitted by the Delta Dental PPO Dentist for the Covered Service, or
       ii) the Delta Dental PPO Dentist Maximum Plan Allowance for the Covered Service.

    c. In the case of a Non-Participating Dentist:
       i) the fee submitted by the Dentist for the Covered Service,
       ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or
       iii) if the Plan utilizes an Exclusive Network, no benefits are provided.
12. “Orthodontic Services” means appliances and treatments, interceptive and corrective, whose purpose is to correct abnormally aligned or positioned teeth. X-rays, extractions and other dental services provided as part of the treatment of abnormally aligned or positioned teeth are considered “Orthodontic Services.”

13. “Participating Dentist” means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentists agree to render services in accordance with the terms and conditions established by DDKS and have satisfied DDKS that they are in compliance with such terms and conditions.

NON-DUPLICATION OF BENEFITS

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has dental care coverage under more than one plan. The term “plan” is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed one hundred percent (100%) of the total allowable expense.

B. DEFINITIONS.

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

(a) The term “plan” includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident type coverage; and Medicare or other governmental benefits, as permitted by law.

(b) The term “plan” does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; medical benefits under group or individual automobile contracts; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

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

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

When the plan is primary, its benefits are determined before those of any other plan and without considering any other plan’s benefits. When the plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan’s benefits.
“Allowable expense” means a dental care service or expense, including deductibles and co-payments, or co-insurance that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(a) If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

(b) The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are second opinions, precertification requirements, and preferred provider arrangements.

“Claim determination period” means a Contract Year. However, it does not include any part of a year during which a person has no coverage under the plan, or before the date the COB provision or a similar provision takes effect.

“Closed panel plan” is a plan that provides dental benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

“Custodial parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES.

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

(1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

(2) A plan that does not contain a coordination of benefits, maintenance of benefits, or non-duplication of benefits provision that is consistent with this Section is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

(4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
(a) The plan that covers the person other than as a dependent, for example as an employee, member, Covered Employee or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, Covered Employee or retiree is secondary and the other plan is primary.

(b) The order of benefits when a child is covered by more than one plan is:

1. The primary plan is the plan of the parent whose birthday is earlier in the year if:
   a. The parents are married;
   b. The parents are not separated (whether or not they ever have been married); or
   c. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
   d. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
   a. The plan of the custodial parent;
   b. The plan of the Spouse of the custodial parent;
   c. The plan of the noncustodial parent; and then
   d. The plan of the Spouse of the noncustodial parent.

(c) The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working Spouse will be determined under the order described in “C. Order of Benefit Determination Rules 4(a).”

(d) If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, Covered Employee or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
(e) The plan that covered the person as an employee, member, Covered Employee or retiree longer is primary.

(f) If a health plan includes coverage for dental procedures under the major medical provisions of the plan, that plan is primary.

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

D. EFFECT ON THE BENEFITS OF THIS PLAN.

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

(a) Determine its obligation to pay or provide benefits under its contract;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid allowable expenses during that claims determination period.

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

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

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

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

G. RIGHT OF RECOVERY.

If the amount of the payments made by DDKS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.
DELTA DENTAL OF KANSAS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:

Privacy Officer
Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769
(316) 264-1099 or (800) 733-5823

Delta Dental of Kansas, Inc. (the “Plan”) is required by law to maintain the privacy of your health
information and to provide you with this notice of our legal duties and privacy practices with respect
to your health information and we are committed to protecting the privacy and confidentiality of your
health and personal information.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

The Plan may use and disclose your health information about you for payment or health care operations
without any consent or authorization beyond your enrollment in the Plan.

Payment means activities related to the Plan’s payment to pay you or your health care provider for
covered expenses. Activities associated with payment include, but are not limited to, enrollment
activities; collection of contributions from you and your employer; payment for covered expenses,
including coordination of benefits; review of payment decisions upon appeal; activities related to pre-
authorization of benefits and utilization review; and disclosure of contribution payment history to a
consumer reporting agency.

Health Care Operations means activities undertaken to administer your program including, but not
limited to, activities necessary to reduce overall health care costs; contacting you or your health care
provider about alternative treatments; evaluating practitioner and provider performance; training of
non-health care professionals; activities related to obtaining an insurance contract, such as census rating
for premiums; conducting or arranging for claims review, legal services, and auditing functions; fraud
and abuse detection and compliance-related activities; analysis related to managing and operating the Plan;
development or change of payment methods or coverage policies; and educational activities.

Under applicable federal law, there are other uses and disclosures the Plan may make without your specific
authorization some are included below:

Disclosures of Protected Health Information to the Plan Sponsor. The Plan will disclose protected
information only to the minimal extent it helps your employer administer the program, such as
providing billing information, and confirmation of enrollment. The employer must limit its use of that
information to obtaining quotes or modifying, amending, or terminating the Plan.
Creation of de-identified health information. The Plan may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. Once information is de-identified it is no longer protected.

Furnishing data to Business Associates. The Plan’s Business Associates (e.g., printers, mailing services, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

Uses and disclosures required by law. The Plan will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

Disclosures for public health activities. We may disclose your protected health information for the following public health activities in circumstances that would help prevent or control disease, report child abuse, and domestic violence. Such disclosure will be made only to extent required by law or with your agreement.

Disclosures for health oversight activities. The Plan may disclose your protected health information to a health oversight agency for oversight activities to complete applicable audits, investigations or inspections.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed during any judicial or administrative proceeding as required by appropriate administrative or judicial court proceedings.

Disclosures for law enforcement purposes. We may disclose your protected health information to a law enforcement official as required by law or to comply with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer.

Disclosures regarding victims of a crime or to avert a serious threat to health or safety. In response to a law enforcement official’s request, the Plan may disclose information about you with your approval or in an emergency situation and you are incapacitated, or if it appears you were the victim of a crime. We may also disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. The Plan may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

Other Uses and Disclosures Requiring Your Authorization. All other uses and disclosures of your health information, including family members or any other individual not already authorized to receive protected health information, will be made by the Plan only with your express written authorization.

Furthermore, while the Plan does not typically use or disclose your protected health information for marketing purposes; sell your protected health information for direct or indirect financial benefit or non-financial benefit (i.e. in-kind item or service); or retain, use or disclose psychotherapy notes, if the Plan does intend to engage in such activity, your authorization will be obtained as required by law prior to engaging in said activity.
If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice. You may request that your health information be provided in an electronic form and we can work together to agree on an appropriate electronic format. You may be charged a fee to cover expenses associated with your request. We can refuse access under certain circumstances. If the Plan refuses access, you will be notified in writing and may be entitled to have a neutral person review the refusal.

Right To Amend Incorrect or Incomplete Information. You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To request this list or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

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

Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, http://www.deltadentalks.com.

Right to Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

COMPLAINTS

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

The effective date of this Notice is September 23, 2013. The Plan reserve the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.
Welcome to Delta Dental of Kansas, Inc.

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

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

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

From our website, you can

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

It is our pleasure to be of service to you.
## Summary of Dental Plan Benefits

**FCF CONSOLIDATED COMP PLAN**  
Group #50500-000-00001-00000

<table>
<thead>
<tr>
<th>% paid by Plan</th>
<th>Examples of Covered Services</th>
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<tbody>
<tr>
<td><strong>DIAGNOSTIC &amp; PREVENTIVE</strong></td>
<td>(Not subject to Deductible)</td>
</tr>
<tr>
<td><strong>PPO Network</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Premier Network</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Non Network</strong></td>
<td>100%</td>
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</tbody>
</table>
| **I. DIAGNOSTIC:** Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:  
Oral evaluations – two (2) times per Contract year.  
Diagnostic x-rays – bitewings two (2) times per Contract year.  
Full mouth x-rays or panoramic x-rays – once each three (3) years. |
| **II. PREVENTIVE:** Provides for the following:  
Prophylaxis (Cleanings) – two (2) times per Contract year.  
Periodontal Prophylaxis (Cleanings) – if diagnosed with periodontal disease, then eligible for two (2) additional periodontal cleanings per Contract year.  
Topical Fluoride – two (2) times per Contract year for dependent Children under age nineteen (19).  
Space Maintainers for dependent Children under age nineteen (19) and only for premature loss of primary molars.  
Sealants – once (1) per lifetime for dependent Children under age nineteen (19) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact. |
| **BASIC (Subject to Deductible)** | 80% | 80% | 80% |
| **III. ANCILLARY:** Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain. |
| **IV. ORAL SURGERY:** Provides for extractions and other oral surgery including pre and post-operative care. |
V. REGULAR RESTORATIVE DENTISTRY:
Provides amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).

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

VII. PERIODONTICS:
a. Includes procedures for the treatment of diseases of the tissues supporting the teeth.
b. Surgical periodontal procedures.

VIII. OCCLUSAL GUARDS: Includes coverage for procedures outlined in Exclusions & Limitations section of this booklet.

<table>
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<tr>
<th>MAJOR (Subject to Deductible)</th>
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<td>50%  50%  50%</td>
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<td>50%  50%  50%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ORTHODONTICS (Subject to Deductible)</th>
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<tbody>
<tr>
<td>50%  50%  50%</td>
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</table>
A Covered Service is deemed to be benefited by DDKS if it is reimbursable, in whole or in part, under the terms of the Plan or would otherwise be reimbursable, in whole or in part, except for the application of a deductible, co-insurance payment, waiting period, frequency limitation, annual or lifetime benefit maximum, or other limitation contained in the Plan. For a Covered Service benefited by DDKS through payment, DDKS will pay the lesser of i) the percentage of the fee actually charged for a Covered Service which is indicated in the Summary of Dental Plan Benefits, or ii) in the amount which is otherwise paid in accordance with other provisions of the Plan.

This is a Summary of Benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Plan which is binding on all of the parties and supersedes all other written or oral communications.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION
Selected Network
The Dental Network is Delta Dental PASSIVE PPO.

Maximum Benefit Per Person
The Maximum Benefit for all Covered Services, including Implant Services and Occlusal Guards, for each Enrollee in any one Contract Year is One Thousand Five Hundred Dollars ($1500.00).

The Maximum Benefit for Orthodontic Services, including Harmful Habit Appliances, for each Enrollee is Two Thousand Dollars ($2000.00) during such person's lifetime.

Payment for Orthodontic Services shall not be included in determining the Maximum Benefit for each contract year.

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

After Covered Employee and his/her Covered Dependents who are Enrollees have, in any Contract Year, each paid either the individual Deductible of One Hundred Dollars ($100.00), have cumulatively paid charges for Covered Services in the amount of Three Hundred Dollars ($300.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Contract Year.

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

Covered Dependent Ages
Dependents are eligible for coverage to age 19 or to age 25 if a full-time student.

DESCRIPTION OF DENTAL CARE COVERAGE

This Description of Dental Care Coverage is issued to the Covered Employee by Delta Dental of Kansas, Inc., hereinafter referred to as “DDKS”, a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental coverage program and constitutes your summary of the Plan and contains the provisions of your dental coverage. Only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth are benefits under the Plan and then only if identified as a covered dental benefit in the Summary of Dental Plan Benefits. Certain restrictions may be applicable to your coverage. It is important to review the Exclusions and Limitations section of this document for these conditions.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this Benefit Schedule, appropriate modifications will be made in the benefits provided under the Plan.
HOW TO USE YOUR PLAN

Make an appointment with your Dentist. Tell the Dentist that you are covered by Delta Dental of Kansas, Inc.

If the planned treatment involves prosthetic or orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics or oral surgery, except for simple extraction of a single tooth, the Dentist should submit a treatment plan to DDKS to determine how much of the bill will be paid by DDKS and what your share of the cost will be. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of DDKS’s consultant, the treatment is not necessary or a lesser procedure could have restored the tooth to contour and function. Even if the Dentist does predetermine benefits, however, it does not obligate DDKS if you as an Employee or Dependent are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist or a new treatment plan should be obtained and resubmitted to DDKS.

PAYMENTS FOR COVERED SERVICES

Following treatment, the Dentist should forward the attending Dentist’s statement to DDKS. If the Dentist is a Participating Dentist, DDKS will make direct payment to the Dentist for each Covered Service. If the Dentist is not a Participating Dentist, DDKS will pay the Employee on each Covered Service. The amount of payment will be calculated using the percentage amount indicated in the Summary of Dental Plan Benefits Section in this Benefit Schedule. If more than one percentage column is shown in the Summary of Dental Plan Benefits, the percentage used will be the one that corresponds to the network status of the Dentist at the time the Covered Services are rendered. DDKS will pay for each Covered Service, subject to the Coordination of Benefits (COB) stipulations in the “Non-Duplication of Benefits” Section of this Benefit Schedule, based on the lesser of i) the fee submitted by the Dentist for the Covered Service, or ii) the Maximum Plan Allowance (MPA). For more information on MPA, see the definition of MPA in the “Definitions” Section of this Benefit Schedule.

You will receive notice of the Plan’s payment and the amount, if any, that you owe the Dentist. The amount you owe should be paid in accordance with the Dentist’s usual billing procedure.

NO PRE-EXAMINATION

There are no pre-examination requirements for Employees and Dependents to be eligible for dental benefits.

EMERGENCY TREATMENT

DDKS’s group dental coverage includes services for emergency treatment. Each individual dental office has its own emergency treatment procedure and patients should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist’s normal business hours. Hospital or medical service emergency room expenses are not covered benefits.

INQUIRIES/APPEALS

Dentists and patients are encouraged to contact DDKS when they have a question concerning a particular claim. Such inquiry should be directed to the DDKS Customer Service Department. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511 or from outside of the Wichita area, 1-800-234-3375.
Patients who have inquiries or an appeal regarding the Plan are encouraged to write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769. Written inquiries are best submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.
2. Patient’s name and birth date. If the patient is not the Covered Employee, the patient’s name and birth date must also be included.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question.

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

Normally, patients will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of DDKS’ receipt. However, if the matter is referred to a review committee, or other unusual circumstances arise, the patient will be advised. Generally, a written answer or decision will be sent to the patient within thirty (30) days thereafter.

RETEVALUATION AND REVIEW

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

NOTICE OF CLAIM

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

CLAIM FORMS

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

Written proofs of loss/claims must be submitted to the insurer at its office within six (6) months of the date that the Covered Service was provided. But, failure to submit a claim within six (6) months of the date that the Covered Service provided will not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time, provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

TIME OF PAYMENT OF CLAIMS

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

DDKS LIABILITY

DDKS shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any such person including but not limited to employees, Enrollees, Dentists, dental assistants, dental hygienists, hospitals, or the agents or employees of any of such foregoing persons, whether receiving or providing services. Further, DDKS shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee.

RIGHT TO INFORMATION

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

MISREPRESENTATIONS

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

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of the Plan. Further, and in all events, any action of any kind by any person who is subject to the Plan must be commenced within five (5) years from the date on which the right, claim, demand, or cause of action shall first accrue.
GOVERNING STATUTES

Any provision of the Plan which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

EXCLUSIONS AND LIMITATIONS

1. Unless the “Summary of Dental Benefits” Section Specifically Provides For Coverage, The Following Dental Benefits And Services Are Excluded:
   
a. Coverage for any patient who has been, but no longer is, an Enrollee.

b. Benefits or services for injuries or conditions compensable under Worker’s Compensation or Employer’s Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.

c. Benefits or services which are determined by DDKS to be for Cosmetic purposes.

d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the person became an Enrollee.

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

f. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for Cosmetic purposes; for splinting or equilibration.

g. Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

h. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.

i. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of the Plan.

j. Crowns and endodontic treatment in conjunction with an overdenture.

k. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

l. Replacement of lost or stolen dentures or charges for duplicate dentures.

m. Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

n. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.
o. Any benefit, procedure or service, a motivating purpose for which is to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

p. Dental benefits and services which are not completed.

q. Emergency treatment rendered outside of the United States or Canada (unless the following documentation is provided to process the claim(s)):

   (1) A copy of proof of licensing for the provider must be attached to the claim form with a receipt of services from the rendering office.

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

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

r. Benefits or services for control of harmful habits with a removal appliance.

s. Treatment to correct developmental malformations.

t. Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in the “Summary of Dental Plan Benefits” Section. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.

u. Individual crowns unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

v. Diagnosis or treatment of temporomandibular joint dysfunction, unless these are specified as Covered Services in the “Summary of Dental Plan Benefits” Section.

w. 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.

2. **Dental Benefits and Services are Limited as Follows**, unless the “Summary of Dental Plan Benefits” Section specifies other limitations. Typically, when dental benefits and services are limited under the Plan, any amounts not benefited by DDKS due to the limitation are the responsibility of the Enrollee, up to the amount of the Maximum Plan Allowance (MPA).

   a. If a more expensive Covered Service is provided than DDKS determines to be the least costly professionally accepted treatment, DDKS will pay the applicable benefit for the Covered Service which is needed to achieve reasonable functionality.

   b. Some Covered Services may be subject to specific age and frequency limitations. These limitations are generally identified in the “Summary of Dental Plan Benefits” Section.
c. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are benefited by DDKS under the Plan and then only if specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section.

d. Prophylaxis, periodontal maintenance and oral evaluations may be subject to specific time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section. Bitewing x-rays may be subject to specific age, time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section.

e. Full mouth and panoramic x-rays may be subject to specific time and frequency limitations. Such limitations are identified in the “Summary of Dental Plan Benefits” Section. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.

f. A seven (7) vertical bitewing series is limited to once (1) every two (2) years.

g. Restoration of surfaces on teeth are limited to only once (1) or twice (2) within a twenty-four (24) month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within twenty-four (24) months after a crown is seated are subject to frequency limitations.

h. Recementation of space maintainers are limited to once (1) per arch or quadrant per lifetime.

i. Claims not submitted to DDKS within twelve (12) months of the date that the Covered Service was provided will not qualify as a Covered Service unless it was not reasonably possible to submit the claim within such time and provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

j. Sealants are limited to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact. Coverage for sealants is limited to one (1) per lifetime per permanent molar unless the “Summary of Dental Plan Benefits” Section allows for other frequency limitations.

k. Inlays will automatically receive benefits equal to the corresponding surface of a filling.

l. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section:

(1) Individual crowns on the same tooth are limited to only once (1) in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the Enrollee whether or not the Plan was then effective. If a crown is placed on a tooth which has had a restoration in the previous twenty-four (24) month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

(2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not benefited by DDKS for any person under twelve (12) years of age due to age limitation.

(3) Recementation of a crown is limited to only once (1) in a lifetime.

(4) Repairs per crown are limited to two (2) in a twelve (12) month period.
(5) Stainless steel crowns are limited to once (1) in a twenty-four (24) month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection 2.2 (l) will apply.

(6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.

m. Prosthetic appliances are not a Covered Service unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. If a Covered Service, the following limitations apply unless the “Summary of Dental Plan Benefits” Section state different limitations:

1. Not more than one (1) full upper and one (1) full lower denture shall be constructed under the Plan in any five (5) year period for any Enrollee. Said time period is to be measured from the date the denture was last supplied to the Enrollee whether or not the Plan was then effective.

2. A removable prosthetic or fixed prosthetic may not be provided under the Plan for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the date the denture or bridge was last supplied to the Enrollee whether or not the Plan was then effective.

3. Denture reline and rebase is limited to only once (1) in any thirty-six (36) month period for Enrollee.

4. Denture adjustments are limited to only two (2) times in any twelve (12) month period for an Enrollee.

5. Crowns when used for abutment purposes are benefited at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.

6. Recementation of a bridge is limited to only once (1) in a lifetime.

7. If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial toward the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.

8. Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.

9. Tissue conditioning is limited to no more than two (2) per arch each thirty-six (36) months.

n. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period.

o. Periodontic procedures are not Covered Service unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. When covered, payment is limited to only once (1) in any twenty-four (24) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is limited to once (1) in any six (6) month period; and crown lengthening which carries no frequency limitation.
p. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services and is limited to a maximum of ninety (90) minutes, per episode.

q. Procedures for dental implants and associated services will be a Covered Service but only as follows:

   (1) Coverage should be predetermined and is limited to those Enrollees, age sixteen (16) and over. Enrollees do not need to be totally edentulous, meaning there may still be natural teeth in the arch for which the dental implants are being contemplated.

   (2) The Dentist should submit to DDKS a written report of recommended treatment setting forth the type and number of implants to be used, radiographs to support the dental necessity of the implant procedures as required by DDKS, and the proposed fees for the entire procedure.

   (3) As determined by DDKS, the Covered Services may include benefits such as, but not limited to, consultations and surgical placement of implant devices (including the associated device and/or prosthesis) provided in conjunction with the dental implant procedures.

   (4) Benefits are limited to the amount of the annual maximum as stated above

r. Coverage for Occlusal Guards which are removable dental appliances designed to minimize the effects of bruxism (grinding) and other occlusal factors are allowed once (1) every year.

s. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in the “Summary of Dental Plan Benefits” Section. If a Covered Service:

   (1) Plan benefits will cease on the date of termination if the treatment plan is terminated for any reason, or the Enrollee is no longer eligible for benefits before completion of the case. Treatment may be terminated by the Dentist, by written notification to DDKS and to the Enrollee, for lack of Enrollee interest and cooperation.

   (2) Related services, such as but not limited to, x-rays, extractions, and study models, shall be payable at the orthodontic co-insurance percentage as specified in the “Summary of Dental Plan Benefits” Section.

   (3) The repair or replacement of an orthodontic appliance is not a Covered Service.

t. Maximum Benefit For Orthodontic Services:

   (1) Anything contained in the Agreement or any appendix to the contrary notwithstanding, the maximum benefit for Orthodontic Services payable in any one (1) contract Year, as applicable, or any portion thereof, shall be the amount indicated in the “Summary of Dental Plan Benefits” Section.

   (2) If Orthodontic Services are a Covered Service, payment for Orthodontic Services shall be limited to the Maximum Benefit per Enrollee which is specified in the “Summary of Dental Plan Benefits” Section. Payment for Orthodontic Services 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 the treatment.

   (3) If a Deductible applies, DDKS shall not be obligated to pay for, or otherwise discharge, in whole or in part, any fee, up to the Deductible.
(4) The Maximum Benefit for Orthodontic Services will be reduced by all amounts previously paid as orthodontics benefits by DDKS or by any other dental plan or arrangement.

(5) Rebonding, recementing and/or repair of fixed retainers must be included in the Orthodontics case fee. A separate fee submitted by the Orthodontics provider is not allowed. In cases of excessive or continuous repairs/recements/rebonds, individual consideration may be given to allow the service as a Covered Service.

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

DEFINITIONS

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

1. “Benefit Schedule” means this written summary of certain features of the Plan.

2. “Cosmetic” means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory. The determination of whether services are “Cosmetic” shall be made by DDKS in its discretion. Cosmetic services are not Covered Services under the Plan unless a Cosmetic service is specified as a Covered Service in the “Summary of Dental Plan Benefits” Section.

3. “Covered Services” means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of the Plan.

4. “DDKS” means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Association member company which has agreed to provide to Enrollees the benefits described in this Plan, or both, as applicable.

5. “Deductible” means the amount specified in the “Summary of Dental Plan Benefits” Section which must be paid with respect to Covered Services provided to an Enrollee before the Plan provides benefits.

6. “Dental Network” means one of the following networks as identified in the “Summary of Dental Plan Benefits” Section:

   a1. “Delta Dental Premier”: The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that DDKS offers. All Delta Dental Premier providers are considered Participating Dentists and are paid according to DDKS’ Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-participating Dentists are not considered Delta Dental Premier Providers, and are paid according to DDKS’ Non-Participating Dentist Maximum Plan Allowance.

   2. If Delta Dental Premier is the Exclusive Network, then Enrollees must exclusively use Dentists in the Delta Dental Premier network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who does not participate in the Delta Dental Premier network, the Enrollee is responsible for all treatment costs incurred.
b.1. **“Delta Dental PPO”:** The Delta Dental PPO network is a subset of DDKS Participating Dentists who agree contractually to participate in the Delta Dental PPO network as part of a discounted fee-for-service plan. Delta Dental PPO providers sign a supplemental agreement and are paid according to a Maximum Plan Allowance for PPO Dentists as defined below. Delta Dental PPO Dentists are paid at the in-network co-insurance percentages in the “Summary of Dental Plan Benefits” Section, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in the “Summary of Dental Plan Benefits” Section.

2. If Delta Dental PPO is the Exclusive Network, then Enrollees in the plan must exclusively use Dentists in the Delta Dental PPO network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all treatment costs incurred.

3. If Delta Dental PPO is a Passive Network, then co-insurance levels for Delta Dental PPO and Delta Dental Premier are the same and Enrollees can use any Participating Dentist, as shown in the “Summary of Dental Plan Benefits” Section.

7. “Dentist” means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.

8. “Enrollee” means a Covered Person, for whom the appropriate premium is timely received by DDKS. An Enrollee shall be deemed to have enrolled when such Enrollee’s name, enrollment information and the required premium are furnished to DDKS by Employer. However, in the case of an Enrollee in continuation coverage, such person shall be deemed to have enrolled when DDKS is timely furnished by the Enrollee with the applicable enrollment form and premium.

9. “Maximum Benefit” means the maximum benefit provided for Covered Services (and Orthodontic Services if specifically included as a Covered Service) which is set forth in the “Summary of Dental Plan Benefits” Section.

10. “Maximum Plan Allowance” means the lesser of the following:

   a. In the case of a Participating Delta Dental Premier Dentist:
      i) the fee submitted by the Participating Dentist for the Covered Service, or
      ii) the Delta Participating Dentist Maximum Plan Allowance for the Covered Service.

   b. In the case of a Delta Dental PPO Dentist:
      i) the fee submitted by the Delta Dental PPO Dentist for the Covered Service, or
      ii) the Delta Dental PPO Dentist Maximum Plan Allowance for the Covered Service.

   c. In the case of a Non-Participating Dentist:
      i) the fee submitted by the Dentist for the Covered Service,
      ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or
      iii) if the Plan utilizes an Exclusive Network, no benefits are provided.

11. “Orthodontic Services” means appliances and treatments, interceptive and corrective, whose purpose is to correct abnormally aligned or positioned teeth. X-rays, extractions and other dental services provided as part of the treatment of abnormally aligned or positioned teeth are considered “Orthodontic Services.”
12. “Participating Dentist” means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentists agree to render services in accordance with the terms and conditions established by DDKS and have satisfied DDKS that they are in compliance with such terms and conditions.

NON-DUPLICATION OF BENEFITS

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has dental care coverage under more than one plan. The term “plan” is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed one hundred percent (100%) of the total allowable expense.

B. DEFINITIONS.

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

(a) The term “plan” includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident type coverage; and Medicare or other governmental benefits, as permitted by law.

(b) The term “plan” does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; medical benefits under group or individual automobile contracts; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

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

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

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

(3) “Allowable expense” means a dental care service or expense, including deductibles and co-payments, or co-insurance that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
(a) If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

(b) The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are second opinions, precertification requirements, and preferred provider arrangements.

(4) “Claim determination period” means a Contract Year. However, it does not include any part of a year during which a person has no coverage under the plan, or before the date the COB provision or a similar provision takes effect.

(5) “Closed panel plan” is a plan that provides dental benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) “Custodial parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES.

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

(1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

(2) A plan that does not contain a coordination of benefits, maintenance of benefits, or non-duplication of benefits provision that is consistent with this Section is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

(4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(a) The plan that covers the person other than as a dependent, for example as an employee, member, Covered Employee or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, Covered Employee or retiree is secondary and the other plan is primary.
(b) The order of benefits when a child is covered by more than one plan is:

1. The primary plan is the plan of the parent whose birthday is earlier in the year if:
   a. The parents are married;
   b. The parents are not separated (whether or not they ever have been married); or
   c. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
   d. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
   a. The plan of the custodial parent;
   b. The plan of the Spouse of the custodial parent;
   c. The plan of the noncustodial parent; and then
   d. The plan of the Spouse of the noncustodial parent.

(c) The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working Spouse will be determined under the order described in “C. Order of Benefit Determination Rules 4(a).”

(d) If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, Covered Employee or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(e) The plan that covered the person as an employee, member, Covered Employee or retiree longer is primary.

(f) If a health plan includes coverage for dental procedures under the major medical provisions of the plan, that plan is primary.

(g) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.
D. EFFECT ON THE BENEFITS OF THIS PLAN.

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

(a) Determine its obligation to pay or provide benefits under its contract;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid allowable expenses during that claims determination period.

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

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

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

F. FACILITY OF PAYMENT.

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

G. RIGHT OF RECOVERY.

If the amount of the payments made by DDKS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.
DELTA DENTAL OF KANSAS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:
Privacy Officer
Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769
(316) 264-1099 or (800) 733-5823

Delta Dental of Kansas, Inc. (the “Plan”) is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information and we are committed to protecting the privacy and confidentiality of your health and personal information.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

The Plan may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your enrollment in the Plan.

Payment means activities related to the Plan’s payment to pay you or your health care provider for covered expenses. Activities associated with payment include, but are not limited to, enrollment activities; collection of contributions from you and your employer; payment for covered expenses, including coordination of benefits; review of payment decisions upon appeal; activities related to pre-authorization of benefits and utilization review; and disclosure of contribution payment history to a consumer reporting agency.

Health Care Operations means activities undertaken to administer your program including, but not limited to, activities necessary to reduce overall health care costs; contacting you or your health care provider about alternative treatments; evaluating practitioner and provider performance; training of non-health care professionals; activities related to obtaining an insurance contract, such as census rating for premiums; conducting or arranging for claims review, legal services, and auditing functions; fraud and abuse detection and compliance-related activities; analysis related to managing and operating the Plan; development or change of payment methods or coverage policies; and educational activities. Under applicable federal law, there are other uses and disclosures the Plan may make without your specific authorization some are included below:

Disclosures of Protected Health Information to the Plan Sponsor. The Plan will disclose protected information only to the minimal extent it helps your employer administer the program, such as providing billing information, and confirmation of enrollment. The employer must limit its use of that information to obtaining quotes or modifying, amending, or terminating the Plan.

Creation of de-identified health information. The Plan may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. Once information is de-identified it is no longer protected.
Furnishing data to Business Associates. The Plan’s Business Associates (e.g., printers, mailing services, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

Uses and disclosures required by law. The Plan will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

Disclosures for public health activities. We may disclose your protected health information for the following public health activities in circumstances that would help prevent or control disease, report child abuse, and domestic violence. Such disclosure will be made only to extent required by law or with your agreement.

Disclosures for health oversight activities. The Plan may disclose your protected health information to a health oversight agency for oversight activities to complete applicable audits, investigations or inspections.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed during any judicial or administrative proceeding as required by appropriate administrative or judicial court proceedings.

Disclosures for law enforcement purposes. We may disclose your protected health information to a law enforcement official as required by law or to comply with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer.

Disclosures regarding victims of a crime or to avert a serious threat to health or safety. In response to a law enforcement official’s request, the Plan may disclose information about you with your approval or in an emergency situation and you are incapacitated, or if it appears you were the victim of a crime. We may also disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. The Plan may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

Other Uses and Disclosures Requiring Your Authorization. All other uses and disclosures of your health information, including family members or any other individual not already authorized to receive protected health information, will be made by the Plan only with your express written authorization.

Furthermore, while the Plan does not typically use or disclose your protected health information for marketing purposes; sell your protected health information for direct or indirect financial benefit or non-financial benefit (i.e. in-kind item or service); or retain, use or disclose psychotherapy notes, if the Plan does intend to engage in such activity, your authorization will be obtained as required by law prior to engaging in said activity.

If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure.
YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

**Right To Inspect and Copy.** You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice. You may request that your health information be provided in an electronic form and we can work together to agree on an appropriate electronic format. You may be charged a fee to cover expenses associated with your request. We can refuse access under certain circumstances. If the Plan refuses access, you will be notified in writing and may be entitled to have a neutral person review the refusal.

**Right To Amend Incorrect or Incomplete Information.** You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

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

**Right to Request Alternative Methods of Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, [http://www.deltadentalks.com](http://www.deltadentalks.com).

**Right to Breach Notification.** You have the right to be notified if we determine that there has been a breach of your protected health information.

**COMPLAINTS**

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

The effective date of this Notice is September 23, 2013. The Plan reserve the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.