Welcome to Delta Dental of Kansas, Inc.

This Description of Dental Care Coverage ("Benefits Booklet") is issued to the Policyholder by Delta Dental of Kansas, Inc. ("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 this dental coverage program and provides a summary of the benefits and other terms related to your dental coverage.

DDKS has designed a dental benefit policy to help protect your oral health available on the Health Insurance Marketplace ("Marketplace"). Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to your overall well-being. Certain restrictions may be applicable to the coverage. It is important to review the Exclusions and Limitations section of this document for these conditions.

You are free to go to any Dentist of your choosing; however, you will typically have lower out-of pocket expenses when you visit a Delta Dental PPO Dentist. Only services provided by a Delta Dental PPO Dentist are considered in-network when calculating the Maximum Out-of-Pocket under this Plan. It is to your advantage to choose a **Delta Dental PPO** Dentist.

If you have any questions about whether your Dentist participates in the Delta Dental PPO network, ask your Dentist when making an appointment or contact Customer Service at DDKS by calling [(316) 264-4511] or toll free [(800) 234-3375]. You may also access information through our website at www.deltadentalcoversme.com.

From our website, you can:

- Check your eligibility and policy information
- Print yourself an ID card
- Check claim status
- Locate a participating **Delta Dental PPO** Dentist

It is our pleasure to be of service to you.

SUMMARY OF DENTAL PLAN BENEFITS

Selected Network:
The Dental Network for this Plan is Delta Dental PPO.

Deductible Limitations for all Enrollees
All Covered Services are subject to a Deductible. After Enrollees have, in any Calendar Year, each paid either the individual Deductible of Seventy Dollars ($70.00) or have cumulatively paid charges for Covered Services in the amount of Two Hundred Ten Dollars ($210.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Calendar Year.

Maximum Benefit Per Adult Enrollees
The Maximum Benefit for all Covered Services for each Adult Enrollee in any one Calendar Year is One Thousand Dollars ($1,000.00).

Eligible Dependent Ages
Children are eligible for coverage to age twenty-six (26).

Pediatric Enrollee Age
A Pediatric Enrollee is eligible for the coverage outlined within the Summary of Pediatric Dental Benefits until the end of the month in which they reach the age of nineteen (19) unless otherwise specified by the Marketplace. Upon termination of coverage under the Summary of Pediatric Dental Benefits, an Enrollee will be provided coverage under the Summary of Adult Dental Benefits.

Maximum Out-of-Pocket for Pediatric Enrollees:
The Maximum Out-of-Pocket for all In-Network, Covered Services for Pediatric Enrollees in any one Calendar Year is Three Hundred Fifty Dollars ($350.00) for one (1) Pediatric Enrollee or Seven Hundred Dollars ($700.00) cumulatively paid charges for all Pediatric Enrollees. Once the Maximum Out-of-Pocket is reached, all In-Network, Covered Services for the remainder of the Calendar Year for Pediatric Enrollees are benefited at 100%.

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 listed in the Summary of Dental Plan Benefits, or (ii) the amount which is otherwise payable in accordance with other provisions of the Plan.

SUMMARY OF DENTAL PLAN BENEFITS

Summary of Pediatric Dental Benefits
Certified Coverage for Pediatric Enrollees - Basic

% paid by Plan PPO Network	% paid by Plan Out of Network (Non-PPO)	Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Subject to Deductible)		
100%	**80%**	**DIAGNOSTIC**: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral examinations – one (1) oral exam each six (6) months. Bitewing x-rays – are limited to once (1) each six (6) months. Full mouth or panoramic x-rays – once (1) each three (3) years.
100%	**80%**	**PREVENTIVE:** Provides for the following: Prophylaxis (Cleanings) - once (1) each six (6) months. Topical Fluoride – three (3) times per twelve (12) months. Sealants – once (1) per twelve (12) months per tooth when applied only to permanent molars and bicuspids with no caries (decay) or restorations on any surface and with the occlusal surface intact. Not covered when placed over restorations.
BASIC (Subject to Deductible)		
60%	**50%**	**ORAL SURGERY:** Provides for simple and surgical extractions as well as care of abscesses and treatment of fractures. Extraction of asymptomatic impacted teeth is not covered.
60%	**50%**	**REGULAR RESTORATIVE DENTISTRY**: Provides amalgam (silver) restorations and composite (white) resin restorations on all teeth once (1) per twelve (12) months. Also provides stainless steel crowns once (1) per twenty-four (24) months.
60%	**50%**	**ANESTHESIA:** In addition to nitrous oxide, includes general anesthesia and intravenous conscious sedation for extensive or complex oral surgical procedures. Anesthesia is not covered for diagnostic or preventive services.
60%	**50%**	**ENDODONTICS**: Includes root canal treatments and pulpotomies on baby teeth. Limited to once (1) per tooth per lifetime.
60%	**50%**	**PERIODONTICS:** Gum (periodontal) therapy, including surgical and non-surgical procedures is limited to once (1) per twelve (12) months.
MAJOR (Subject to Deductible)		
50%	**40%**	**SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns once (1) per five (5) years.
50%	**40%**	**PROSTHODONTICS**: Includes partial and complete dentures. Must replace one (1) or more anterior teeth, or replace two (2) or more posterior teeth unilaterally or three (3) or more posterior teeth bilaterally, excluding third molars. Limited to once (1) per five (5) years. Includes repairs and adjustments. Does not include bridges.
50%	**40%**	**HOSPITAL SERVICES**: Inpatient hospital services and emergency room services provided by a Dentist are covered.
ORTHODONTICS (Subject to Deductible)		
50%	**50%**	**ORTHODONTICS**: Prior authorization is required. Orthodontics are only covered for eligible children with documented medical necessity of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time, i.e. Medically Necessary. Includes retainers and harmful habit appliances.

Summary of Adult Dental Benefits
Basic

% paid by Plan PPO Network	% paid by Plan Out of Network (Non-PPO)	Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Subject to Deductible)		
100%	**80%**	**DIAGNOSTIC**: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral examinations – one (1) oral exam each six (6) months. Bitewing x-rays – are limited to once (1) each twelve (12) months. Full mouth or panoramic x-rays – once (1) each five (5) years.
100%	**80%**	**PREVENTIVE:** Provides for the following: Prophylaxis (Cleanings) - once (1) each six (6) months.
BASIC (Subject to Deductible)		
60%	**50%**	**ANCILLARY:** Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
60%	**50%**	**ORAL SURGERY:** Provides for extractions and other oral surgery including pre- and post-operative care.
60%	**50%**	**REGULAR RESTORATIVE DENTISTRY**: Provides amalgam (silver) restorations and composite (white) resin restorations on anterior (front) teeth.
60%	**50%**	**ENDODONTICS**: Includes procedures for root canal treatments and root canal fillings.
60%	**50%**	**PERIODONTICS:** Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluations, is counted towards the limitation for prophylaxis.
60%	**50%**	Surgical periodontal procedures.
MAJOR (Subject to Deductible)		
50%	**40%**	**SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	**40%**	**PROSTHODONTICS**: Includes bridges, partial and complete dentures, including repairs and adjustments.
ORTHODONTICS (Subject to Deductible)		
0%	**0%**	**ORTHODONTICS**: Orthodontic appliances and treatment - None.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

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

EXCLUSIONS AND LIMITATIONS

1. **Unless the "Summary of Dental Benefits" 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 or any other services for which coverage is available under your hospital medical/surgical or major medical plan,

   f. Charges for failure to keep a scheduled visit or for completion of forms.

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

   h. 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 (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer;; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

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

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

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

   l. Bridges, including repairs and adjustments.

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

   n. Orthodontic services that are not Medically Necessary and procedures related to such orthodontic services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments. Includes retainer and harmful habit appliances that are not Medically Necessary. The repair or replacement of an orthodontic appliance is not a Covered Service.

   o. 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.

   p. Treatment for inlays and onlays.

   q. 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.

   r. Dental benefits and services which are not completed.

   s. Treatment rendered outside of the United States or Canada.

   t. Procedures for dental implants and associated services.

   u. Diagnosis or treatment of temporomandibular joint dysfunction.

   v. Services performed for the purpose of full mouth reconstruction are not Covered Services. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.

   w. Benefits or services for control of harmful habits.

   x. Treatment to correct developmental malformations.

2. **Dental Benefits and Services are Limited as Follows unless, the "Summary of Dental Benefits" 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. 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 Benefits".

   c. Restoration of surfaces on teeth are limited to only once (1) within a twelve (12) 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.

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

   e. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.

   f. Individual crowns are subject to the following limitations:

      (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 Agreement 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 will apply.

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

   g. Prosthetic appliances are subject to the following limitations:

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

      (2) A removable prosthetic or fixed prosthetic device, including bridges or full upper or full lower dentures, may not be provided under the Agreement for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the last date of service the removable prosthetic or fixed prosthetic device, including bridges, full upper or full lower dentures was last supplied to the Enrollee whether or not the Agreement was then effective.

      (3) Denture reline and rebase is limited to only once (1) in any two (2) year 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 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 three (3) years.

h. Periodontic procedures are limited to only once (1) in any twelve (12) 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.

i. 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.

j. Endodontic services for root canal therapy is limited to only once (1) in any twenty-four (24) month period unless stated otherwise within the Summary of Dental Benefits.

l. k. Composite (white) fillings are covered on anterior (front) teeth. The Plan will provide benefits in an amount up to the Maximum Plan Allowance (MPA) for an equal surface amalgam (silver) filling on posterior (back) teeth.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.

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

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 Benefits Booklet, the following definitions shall apply:

1. "Adult Enrollee" means an Enrollee who is age nineteen (19) or older.

2. "Agreement" means the Subscription Agreement to Provide Basic Dental Benefits between DDKS and Policyholder, including any application, the attached appendices, endorsements and riders, thereto, if any. The Agreement constitutes the entire agreement between the parties.

3. "Application" means the formal, written request for coverage by the Policyholder. The Application includes the requested Plan coverage, Eligible Dependent information, and any other information which is required to be provided by the Marketplace.

4. "Benefit Booklet" means this written summary of certain features of the Plan.

5. "Calendar Year" means the twelve (12) month period commencing on the first day of January and terminating at 11:59 P.M. on the last day of December.

6. "Child" means, in addition to the Policyholder's own or lawfully adopted child or children, any step-child of the Policyholder. The term "Child" also includes any person placed with the Policyholder for adoption if such child was placed in the Policyholder's home by a child placement agency as defined by Kansas law, and any child of the Policyholder who is recognized as an alternate recipient under a qualified medical child support order. A Child is eligible for coverage if the child meets the Eligible Dependent Ages.

   In addition, a Child includes a disabled Child who is: i) unmarried, ii) incapable of earning his or her own living because of mental or physical disability, and iii) principally dependent upon the Policyholder for support at the time the Child would otherwise cease to be eligible for coverage by the Plan because of age. A disabled Child shall continue to be an Eligible Dependent for the duration of the disability, provided: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to DDKS within thirty (30) days after Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by DDKS.

7. "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.

8. "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 Agreement.

9. "DDKS" means Delta Dental of Kansas, Inc.

10. "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 makes payment.

11. "Dental Network" means the Delta Dental PPO Network. 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 as shown in the Summary of Dental Benefits, while Delta Dental Premier Dentists and non-Participating Dentists are paid at the out-of-network co-insurance percentages as shown in the Summary of Dental Benefits.
12. "Dentist" means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.
13. "Effective Date" means the first day of the initial term of the Agreement as identified on the enrollment materials.
14. "Eligible Dependent" means an individual who is a resident of the State of Kansas and either: i) the spouse, as determined under applicable state law at the time and location that the marriage was entered into, of a Policyholder; or ii) a Child of a Policyholder who satisfies the requirements set above in the definition of "Child".
15. "Enrollee" means a person, whether a Policyholder or Eligible Dependent, who is (i) validly enrolled for coverage under the Plan as required by the Marketplace, and (ii) for whom the appropriate premium is timely received by DDKS.
16. "Maximum Benefit" means the maximum benefit provided for Covered Services for Adult Enrollees which is set forth in the "Summary of Adult Dental Benefits" Section.
17. "Maximum Out-of-Pocket" means the annual limitation on all cost-sharing for which Policyholder is responsible as to Pediatric Enrollees as identified in Summary of Pediatric Dental Benefits. This limit does not apply to premiums, charges from Dentists who are not a Delta Dental PPO Dentist, services that are not Covered Services, or services provided for Adult Enrollees.
18. "Maximum Plan Allowance" means the lesser of the following:
    a. In the case of a Delta Dental PPO Dentist, In-Network 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.
    b. In the case of a Delta Dental Premier Dentist:
        i) the fee submitted by the Participating Dentist for the Covered Service, or
        ii) the Delta Dental Participating Dentist Maximum Plan Allowance for the Covered Service
    c. In the case of a non-Participating Dentist:
        i) the fee submitted by the Non-participating Dentist for the Covered Service, or
        ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance.
19. "Medically Necessary" as related to orthodontics means orthodontic services to help correct severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time. Orthodontic services include retainers and harmful habit appliances.
20. "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.
21. **"**Pediatric Enrollee" means an Enrollee who is under the age of nineteen (19).
22. "Plan" means the dental benefits arrangement which is offered and administered pursuant to the terms of the Agreement.
23. "Policyholder" means an individual who is: i) a resident of the State of Kansas; ii) over the age of eighteen (18); iii) legally competent to enter into the Agreement; and iv) has provided the information for enrollment and executed the Agreement. A Policyholder may or may not be an Enrollee, i.e. if a parent purchases coverage for their child only, then the parent is the Policyholder but is not an Enrollee.
24. "Renewal Date" means the date upon which the Agreement will renew for an additional one year term. This date is the annual anniversary date of the Effective Date or the applicable date set by the Marketplace.

HOW TO USE YOUR BENEFITS

Make an appointment with your Dentist. Tell the Dentist that you are covered by DDKS.

If the planned treatment involves prosthodontic services, individual crowns (except stainless steel), 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' consultant, the treatment is not necessary or a lesser procedure could have restored the tooth or dental arch to contour and function. Even if the Dentist does predetermine benefits, however, it does not obligate DDKS if an Enrollee is no longer eligible for benefits at the time the services are actually performed or the 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 Policyholder on each Covered Service. The amount of payment will be calculated using the percentage amount indicated in the "Summary of Dental Benefits" Section in this booklet. If more than one percentage column is shown in the "Summary of Dental 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, based on the lesser of i) the fee submitted by the Dentist for the Covered Service, or ii) the Maximum Plan Allowance (MPA).

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.

PAYMENT OF CLAIMS

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

EMERGENCY TREATMENT

DDKS's dental coverage includes services for emergency treatment. Each individual dental office has its own emergency treatment procedure and Enrollees 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 unless performed by a licensed Dentist.

NO PRE-EXAMINATION

There are no pre-examination requirements for individuals and dependents to be eligible for dental benefits.

COVERAGE

1. **Commencement Of Coverage:**

   Coverage of an Enrollee will commence upon the Effective Date as identified on the enrollment materials and as allowed by the Marketplace. Unless otherwise instructed by the Marketplace, enrollment information must be submitted on or before the 15th day of the month and premium payments must be received by the 26th day of the month in order for coverage to be effective the first day of the concurrent month. If these time frames are not met, coverage will not commence until the first day of the following next month.

2. **Changes to Add Enrollees:**

   A change may be made to add an Enrollee if enrollment information and the required premium fees for the additional coverage are provided consistent with the requirements of the Marketplace. Changes may be made if notice is provided to the Marketplace within sixty (60) days, or within any other applicable time frame established by the Marketplace, following the occurrence of one of these triggering events:

   (a) the birth or the filing of a petition for adoption or certificate of placement of a Child;
   (b) the Policyholder's marriage;
   (c) Enrollee permanently moves to the state of Kansas;
   (d) Policyholder or Eligible Dependent's loss of minimum essential coverage as defined by the ACA;
   (e) Policyholder or Eligible Dependent's loss of employer sponsored coverage;
   (f) Any other change in circumstance as recognized by the Marketplace.

   Coverage will commence the first day of the following month subject to the receipt of enrollment information and payment consistent with the dates specified above for Commencement of Coverage unless otherwise specified by the Marketplace.

No other changes may be made to add or remove Enrollees after the Effective Date unless allowed by the Marketplace.

3. Changes to Coverage:

No changes may be made to the coverage selected after the Effective Date except upon renewal unless otherwise allowed by the Marketplace or during an applicable open enrollment period through the Marketplace.

4. Marketplace Termination of Coverage for the Enrollee:

If, at any time, an Enrollee fails to satisfy all of the requirements of the Agreement as set forth herein, coverage under the Agreement shall terminate for such Enrollee at the end of the month in which the Enrollee fails to meet any applicable requirement(s) unless otherwise specified within the Agreement or by the Marketplace.

Unless otherwise specified by the Marketplace, upon occurrence of one of the following events, coverage shall terminate for an Enrollee in the following manner:

a) If, at any time, an Enrollee ceases to be a resident of the State of Kansas, coverage under the Agreement shall terminate at the end of the policy year in which the Enrollee fails to qualify as a Kansas resident. An Enrollee will not lose coverage solely based upon a second residence outside of Kansas, status as a full-time student attending college in another state, or traveling outside of the state of Kansas.

b) If, at any time, an Enrollee who is not the Policyholder ceases to qualify as an Eligible Dependent, coverage under the Agreement shall terminate at the end of the month in which the Enrollee fails to qualify as an Eligible Dependent unless otherwise specified by the Marketplace.

Unless otherwise specified by the Marketplace, at termination of coverage under the Agreement, operative procedures which are then in progress and i) which are completed within thirty (30) days of the termination of coverage, and ii) submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; partial and complete, dentures; and bridges. Operative procedures are considered in progress only if all procedures for commencement of lab work have been completed.

Policyholder must notify the Marketplace and/or DDKS when an Enrollee is no longer eligible for coverage and Policyholder shall be liable for any claim payments made by DDKS during the period of time the Enrollee was not eligible for coverage.

5. Voluntary Termination of Coverage by Enrollee:

If, at any time, an Enrollee obtains other minimum essential coverage, the enrollee may, with appropriate notice to the Marketplace and DDKS, terminate his or her coverage with DDKS. Reasonable notice is defined as at least fourteen (14) days before the requested effective date of termination. The last day of coverage for an enrollee voluntarily terminating coverage of his/her marketplace plan is:

a. The termination date specified by the enrollee, if the enrollee provides reasonable notice;

b. Fourteen (14) days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

c. A date on or after the date on which the termination is requested by the enrollee, subject to the determination of DDKS, if DDKS agrees to effectuate termination in fewer than fourteen days, and the enrollee requests an earlier termination effective date.

d. If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of DDKS coverage is the day before the individual is determined eligible for Medicaid, CHIP or the BHP.

In the case of a termination due to death, the last day of coverage is the date of death.

6. Termination of the Agreement:

The Agreement shall remain in full force and effect for the term specified unless one of the provisions set forth below applies:

a. If Policyholder fails to timely pay premiums as due, the Marketplace has the right to terminate the Agreement following the applicable grace period as outlined below:

(i) If Policyholder has purchased coverage through the Marketplace, has paid at least one month of premium, and is entitled to advance payment of the premium tax credit, then a ninety (90) day grace period will apply. If full payment of all premiums due is made during this grace period, any claims incurred during the grace period will be benefited consistent with the coverage provided herein and the Agreement will remain in force.

(ii) For all other Policyholders, a thirty (30) day grace period will apply.

If the Marketplace subsequently accepts any late premiums, the payments shall reinstate the Agreement, but such reinstatement shall provide coverage under the Plan only with respect to Covered Services which are first provided more than ten (10) days after the date of such reinstatement if allowed by the Marketplace.

If Policyholder defaults in the making of premium payments during the applicable grace period, termination of the Agreement shall become effective on the date of the expiration of the period for which the last monthly premium was paid. In no event will DDKS be required by the Agreement to provide any benefits for any period for which the Policyholder has not made the premium payments in advance of the incurrence of the benefits.

b. If Policyholder engages in fraudulent conduct, furnishes DDKS with fraudulent information, makes an intentional misrepresentation of material fact, or otherwise fails to perform Policyholder's responsibilities under the terms of the Agreement (excluding failure to pay premiums), then DDKS may terminate coverage following a thirty (30) day notice to Policyholder if allowed by the Marketplace.

c. Upon the death of the Policyholder, the Agreement shall terminate and DDKS will prorate the applicable premiums for the month in which the charge occurred.

7. Coordination of this Contract's Benefits with other Benefits:

A. General.

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

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

B. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Order of Benefit Determination Rules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C.3.b.2.d.1.The plan covering the custodial parent;

C.3.b.2.d.2.The plan covering the spouse of the custodial parent;

C.3.b.2.d.3.The plan covering the non-custodial parent; and then

C.3.b.2.d.4.The plan covering the spouse of the non-custodial parent.

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

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

(d) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by stat4e or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. The rule does not apply if the rule labeled C(3) above can determine the order of benefits.

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

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

D. Effect of the Benefits of this Plan.

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

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

E. Right to Receive and Release Needed Information.

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

F. Facility of Payment.

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, DDKS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. DDKS will not have to pay that amount again. The term "payment

made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery.

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

DENTIST CONDUCT:

DDKS may refuse to pay for any Covered Services which are provided in a manner that is inconsistent with the generally accepted applicable standards of dentistry.

WRITTEN NOTICE OF CLAIMS

Written notice of claims must be submitted to DDKS at its office within six (6) months of the date the Covered Service was provided. Notice given by or on behalf of the Enrollee should be sent to Delta Dental of Kansas, [1619 N. Waterfront Parkway, Wichita, KS 67206], or to any authorized agent of DDKS, with information sufficient to identify the Enrollee. But, failure to submit a claim within six (6) months of the date that the Covered Service was 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.

CLAIM FORMS

DDKS, upon receipt of a notice of claim, will furnish to the Enrollee 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 Enrollee 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.

INQUIRIES/APPEALS

Enrollees 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].

If a claim for benefits is denied in whole or in part, written notification called an "Explanation of Benefits" will be provided within thirty (30) days after a claim is received, unless special circumstances require an extension of time for processing. If additional time is necessary, DDKS will notify the Enrollee and/or the treating Dentist of the reason for the additional time, including a description of additional information that is necessary to process the claim if information is missing. If additional information is necessary, the Enrollee will have forty-five (45) days to provide the additional information or else the claim will be decided based upon the information then available to DDKS.

Enrollees have the right to appeal a claim determination if the requested dental benefits were not paid in full. In order to appeal a benefit determination, Enrollees or their authorized representative must write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769 within one hundred eighty (180) days of the date of the Explanation of Benefits for the claim. Written appeals should be submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Enrollee's identification number.
2. Policyholder's name and birth date. If the Enrollee is not the Policyholder, the Enrollee's name and birth date must also be included.
3. Dentist name and, if known, license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question, including the basis for appeal.
7. Any additional information that the Enrollee believes supports his/her position.

A full and fair evaluation of the appeal will be made by DDKS and, in some cases the Enrollee may be examined clinically. If necessary, additional information or documents may be requested. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, Enrollees 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 Enrollee will be advised. Generally, a written answer or decision will be sent to the Enrollee within thirty (30) days thereafter, however, DDKS must provide a written answer or decision within sixty (60) days receipt of the appeal.

If DDKS denies any part of the claim on appeal, DDKS will provide the Enrollee written notice of the basis for the denial and additional information. The Enrollee may request, free of charge, a copy of any applicable rules, exclusions, or limitations relied upon in the benefit determination. In addition, DDKS will provide the Enrollee with a copy of the documents relevant to the benefit determination free of charge upon request.

REEVALUATION AND REVIEW

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

DDKS LIABILITY

DDKS shall have no liability for any 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 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 the Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under the Agreement constitutes the Enrollee's (and the related Policyholder'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 Policyholder shall be deemed a warranty or shall be used in defense of a claim or in any other dispute under the Agreement, unless it is contained in a written instrument, a copy of which has been agreed to in writing by Policyholder and DDKS.

LEGAL ACTIONS

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

GOVERNING LAW

The laws of the State of Kansas shall govern the validity of the Agreement, the construction of its terms and the interpretation of the rights and duties of the parties. Any action brought to enforce, construe, or interpret the Agreement (including but not

limited to any mediation or arbitration but only if arbitration is voluntarily agreed to by the parties at the time a dispute arises) shall be commenced and maintained in a location mutually agreeable by the parties to the dispute. Any provision of the Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

DELTA DENTAL OF KANSAS, INC.
A NON-PROFIT DENTAL SERVICE CORPORATION

SUBSCRIPTION AGREEMENT TO PROVIDE BASIC DENTAL BENEFITS

SECTION I - DECLARATIONS

This Subscription Agreement to Provide Basic Dental Benefits ("Agreement") is made and entered into by and between an individual, who is over the age of eighteen (18), a resident of the State of Kansas, and legally competent to enter into this Agreement hereinafter referred to as "Policyholder," and DELTA DENTAL OF KANSAS, INC. hereinafter referred to as "DDKS". This Agreement is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communications regarding the insurance arrangement between the Policyholder and DDKS.

1.1 INITIAL TERM AND RENEWAL:

The initial term of this Agreement shall commence upon the Effective Date. If your coverage was purchased through the Health Insurance Marketplace ("Marketplace"), your Plan will renew effective January 1st of each year and will renew automatically for subsequent one-year terms unless otherwise specified by the Marketplace. At any point, this Agreement may be terminated consistent with the Termination provisions of Section VIII.

1.2 MONTHLY PREMIUM RATES:

Enrollees under age 21		**Enrollees over age 20**
1 Enrollee	$ 29.86	$18.33 per Enrollee
2 Enrollees	$ 59.72	
3 or more Enrollees	$ 89.58	

The monthly premium rate will be the cumulative rate for all Enrollees.

The above rates will remain in effect through the Renewal Date. Policyholder will receive notice of any rate change at least sixty (60) days prior to the Renewal Date. DDKS reserves the right to change rates as allowed by the Kansas Insurance Department and/or the Marketplace.

1.3 DDKS NETWORK:

The Dental Network for this Plan is **Delta Dental PPO**. Only services provided by a Delta Dental PPO Dentist are in-network services for purposes of calculating the Maximum Out-Of-Pocket for Pediatric Enrollees. You will typically have lower out-of-pocket expenses when you visit a Delta Dental PPO Dentist, although you may seek services from a Dentist who is not a Delta Dental PPO provider and still receive benefits.

1.4 SELECTED BENEFITS, MAXIMUMS, DEDUCTIBLES AND CO-INSURANCE PERCENTAGE PAID BY DDKS:

A Covered Service is deemed to be benefited by DDKS if it is reimbursable, in whole or in part, under the terms of this Agreement 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 this Agreement. 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 below, or ii) the amount which is otherwise payable in accordance with the terms of this Agreement.

Deductible Limitations for all Enrollees

All Covered Services are subject to the Calendar Year Deductible. After Enrollees have, in any Calendar Year, each paid either the individual Deductible of Seventy Dollars ($70.00) or have cumulatively paid charges for Covered Services in the amount of Two Hundred Ten Dollars ($210.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of the Calendar Year.

Payment of Claims

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

See the Summary of Dental Plan Benefits on the next page for additional coverage information regarding coverage.

SUMMARY OF DENTAL PLAN BENEFITS

Summary of Pediatric Dental Benefits

Certified Coverage for Pediatric Enrollees - Basic

Maximum Out-of-Pocket for Pediatric Enrollees for In-Network, Covered Services per Calendar Year:

1 Pediatric Enrollee $ 350
2 or more Pediatric Enrollees $ 700

Once the Maximum Out-of-Pocket is reached for Pediatric Enrollees, all In-Network, Covered Services for the remainder of the Calendar Year for Pediatric Enrollees are benefited at 100%.

Pediatric Enrollee Age
A Pediatric Enrollee is eligible for the coverage outlined within this Summary of Pediatric Dental Benefits until the end of the month in which they reach the age of nineteen (19) unless otherwise specified by the Marketplace. Upon termination of coverage under the Summary of Pediatric Dental Benefits, an Enrollee will be provided coverage under the Summary of Adult Dental Benefits.

% paid by DDKS PPO Network	% paid by DDKS Out of Network (Non-PPO)	Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Subject to Deductible)		
100%	**80%**	**Diagnostic:** Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral examinations – one (1) oral exam each six (6) months. Bitewing x-rays – are limited to once (1) each six (6) months. Full mouth or panoramic x-rays – once (1) each three (3) years.
100%	**80%**	**Preventive:** Provides for the following: Prophylaxis (Cleanings) - once (1) each six (6) months. Topical Fluoride – three (3) times per twelve (12) months. Sealants – once (1) per twelve (12) months per tooth when applied only to permanent molars and bicuspids with no caries (decay) or restorations on any surface and with the occlusal surface intact. Not covered when placed over restorations.
BASIC (Subject to Deductible)		
60%	**50%**	**Oral Surgery:** Provides for simple and surgical extractions as well as care of abscesses and treatment of fractures. Extraction of asymptomatic impacted teeth is not covered.
60%	**50%**	**Regular Restorative Dentistry:** Provides amalgam (silver) restorations and composite (white) resin restorations on all teeth once per twelve (12) months. Also provides stainless steel crowns once (1) per twenty-four (24) months.
60%	**50%**	**Anesthesia:** In addition to nitrous oxide, includes general anesthesia and intravenous conscious sedation for extensive or complex oral surgical procedures. Anesthesia is not covered for diagnostic or preventive services.
60%	**50%**	**Endodontics:** Includes root canal treatments and pulpotomies on baby teeth. Limited to once (1) per tooth per lifetime.
60%	**50%**	**Periodontics:** Gum (periodontal) therapy, including surgical and non-surgical procedures is limited to once (1) per twelve (12) months.

Summary of Pediatric Dental Benefits
(Continued)

% paid by DDKS PPO Network	% paid by DDKS Out of Network (Non-PPO)	Examples of Covered Services
MAJOR (Subject to Deductible)		
50%	**40%**	**Special Restorative Dentistry:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns once (1) per five (5) years.
50%	**40%**	**Prosthodontics:** Includes partial and complete dentures. Must replace one (1) or more anterior teeth, or replaces two (2) or more posterior teeth unilaterally or three (3) or more posterior teeth bilaterally, excluding third molars. Limited to once (1) per five (5) years. Includes repairs and adjustments. Does not include bridges.
50%	**40%**	**Hospital Services:** Inpatient hospital services and emergency room services provided by a Dentist are covered.
ORTHODONTICS (Subject to Deductible)		
50%	**50%**	**Orthodontics:** Prior authorization is required and orthodontics are only covered for eligible children when Medically Necessary, i.e. with documented medical necessity of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time. Includes retainers and harmful habit appliances.

Summary of Adult Dental Benefits

Basic

Maximum Benefit Per Adult Enrollees
The Maximum Benefit for all Covered Services for each Adult Enrollee in any Calendar Year is One Thousand Dollars ($1,000.00).

Eligible Dependent Ages
Dependents are eligible for coverage to age twenty-six (26).

% paid by DDKS PPO Network	% paid by DDKS Out-of-Network (Non-PPO)	Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Subject to Deductible)		
100%	**80%**	**Diagnostic:** Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral examinations – one (1) oral exam each six (6) months. Bitewing x-rays – are limited to once (1) each twelve (12) months. Full mouth or panoramic x-rays – once (1) each five (5) years.
100%	**80%**	**Preventive:** Provides for the following: Prophylaxis (Cleanings) - once (1) each six (6) months.
BASIC (Subject to Deductible)		
60%	**50%**	**Ancillary:** Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
60%	**50%**	**Oral Surgery:** Provides for extractions and other oral surgery including pre and post-operative care.
60%	**50%**	**Regular Restorative Dentistry:** Provides amalgam (silver) restorations and composite (white) resin restorations on anterior (front) teeth.
60%	**50%**	**Endodontics:** Includes procedures for root canal treatments and root canal fillings.
60%	**50%**	**Periodontics:** a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis.
60%	**50%**	b. Surgical periodontal procedures.
MAJOR (Subject to Deductible)		
50%	**40%**	**Special Restorative Dentistry:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	**40%**	**Prosthodontics:** Includes bridges, partial and complete dentures, including repairs and adjustments.
ORTHODONTICS (Subject to Deductible)		
0%	**0%**	**Orthodontics:** Orthodontic appliances and treatment - None.

SECTION II - EXCLUSIONS AND LIMITATIONS

2.1 Unless the "Summary of Dental Plan Benefits" 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; or preventive control programs , or any other services for which coverage is available under your hospital medical/surgical or major medical plan.

f. Charges for failure to keep a scheduled visit or for completion of forms.

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

h. 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 (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

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

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

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

l. Bridges, including repairs and adjustments.

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

n. Orthodontic services that are not Medically Necessary and procedures related to such orthodontic services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments. Includes retainer and harmful habit appliances that are not Medically Necessary. The repair or replacement of an orthodontic appliance is not a Covered Service.

o. 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.

p. Treatment for inlays and onlays.

q. 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.

r. Dental benefits and services which are not completed.

s. Treatment rendered outside of the United States or Canada.

t. Procedures for dental implants and associated services.

u. Diagnosis or treatment of temporomandibular joint dysfunction.

v. Services performed for the purpose of full mouth reconstruction are not Covered Services. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.

w. Benefits or services for control of harmful habits.

x. Treatment to correct developmental malformations.

2.2 Dental Benefits and Services are Limited as Follows unless, the "Summary of Dental Benefits" 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. 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 Benefits" section.

c. Restoration of surfaces on teeth are limited to only once (1) within a twelve (12) 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.

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

e. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.

f. Individual crowns are subject to the following limitations:

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 this Agreement 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 will apply.

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

g. Prosthetic appliances are subject to the following limitations:

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

2. A removable prosthetic or fixed prosthetic device, including bridges or full upper or full lower dentures, may not be provided under this Agreement for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the last date of service the removable prosthetic or fixed prosthetic device including bridges, full upper or lower dentures was last supplied to the Enrollee whether or not this Agreement was then effective.

3. Denture reline and rebase is limited to only once (1) in any two (2) year 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 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 three (3) years.

h. Periodontic procedures are limited to only once (1) in any twelve (12) 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.

i. 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.

j. Endodontic services for root canal therapy is limited to only once (1) in any twenty-four (24) month period unless stated otherwise within the "Summary of Dental Benefits" section.

k. Composite (white) fillings are covered on anterior (front) teeth. The Plan will provide benefits in an amount up to the Maximum Plan Allowance (MPA) for an equal surface amalgam (silver) filling on posterior (back) teeth.

l. 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.

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

2.3 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.

SECTION III – DEFINITIONS

For the purpose of this Agreement, the following definitions shall apply:

3.1 "Adult Enrollee" means an Enrollee who is age nineteen (19) or older.

3.2 "Agreement" means this Subscription Agreement to Provide Basic Dental Benefits between DDKS and Policyholder, including any application, the attached appendices, endorsements and riders, thereto, if any. This Agreement constitutes the entire agreement between the parties.

3.3 "Application" means the formal, written request for coverage by the Policyholder. The Application includes the requested Plan coverage, Eligible Dependent information, and any other information which is required to be provided by the Marketplace.

3.4 "Benefit Booklet" means the written summary of certain features of the Plan.

3.5 "Calendar Year" means the twelve (12) month period commencing on the first day of January and terminating at 11:59 P.M. on the last day of December.

3.6 "Child" means, in addition to the Policyholder's own or lawfully adopted child or children, any step-child of the Policyholder. The term "Child" also includes any person placed with the Policyholder for adoption if such child was placed in the Policyholder's home by a child placement agency as defined by Kansas law, and any child of the

Policyholder who is recognized as an alternate recipient under a qualified medical child support order. A Child is eligible for coverage if the child meets the Eligible Dependent Ages.

In addition, a Child includes a disabled Child who is: i) unmarried, ii) incapable of earning his or her own living because of mental or physical disability, and iii) principally dependent upon the Policyholder for support at the time the Child would otherwise cease to be eligible for coverage by the Plan because of age. A disabled Child shall continue to be an Eligible Dependent for the duration of the disability, provided: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to DDKS within thirty (30) days after Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by DDKS.

3.7 "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.

3.8 "Covered Services" means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of this Agreement.

3.9 "DDKS" means Delta Dental of Kansas, Inc.

3.10 "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 makes payment.

3.11 "Dental Network" means the Delta Dental PPO Network. 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 as shown in the "Summary of Dental Benefits" section, while Delta Dental Premier Dentists and non-Participating Dentists are paid at the out-of-network co-insurance percentages as shown in the "Summary of Dental Benefits" section.

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

3.13 "Effective Date" means the first day of the initial term of this Agreement as identified on the enrollment materials.

3.14 "Eligible Dependent" means an individual who is a resident of the State of Kansas and either: i) the spouse, as determined under applicable state law at the time and location that the marriage was entered into, of a Policyholder; or ii) a Child of a Policyholder who satisfies the requirements set above in the definition of "Child".

3.15 "Enrollee" means a person, whether a Policyholder or Eligible Dependent, who is (i) validly enrolled for coverage under the Plan as required by the Marketplace, and (ii) for whom the appropriate premium is timely received by DDKS.

3.16 "Maximum Benefit" means the maximum benefit provided for Covered Services for Adult Enrollees which is set forth in the "Summary of Adult Dental Benefits" section.

3.17 "Maximum Out-of-Pocket" means the annual limitation on all cost-sharing for which Policyholder is responsible as to Pediatric Enrollees as identified in the "Summary of Pediatric Dental Benefits" section. This limit does not apply to premiums, charges from Dentists who are not a Delta Dental PPO Dentist, services that are not Covered Services, or services provided for Adult Enrollees.

3.18 "Maximum Plan Allowance" means the lesser of the following:

a. In the case of a Delta Dental PPO Dentist, In-Network 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.

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

c. In the case of a non-Participating Dentist:
   i) the fee submitted by the Non-participating Dentist for the Covered Service, or

ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance.

3.19 "Medically Necessary" as related to orthodontics means orthodontic services to help correct severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time. Orthodontic services include retainers and harmful habit appliances.

3.20 "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.

3.21 **"**Pediatric Enrollee" means an Enrollee who is under the age of nineteen (19).

3.22 "Plan" means the dental benefits arrangement which is offered and administered pursuant to the terms of this Agreement.

3.23 "Policyholder" means an individual who is: i) a resident of the State of Kansas; ii) over the age of eighteen (18) iii) legally competent to enter into this Agreement; and iv) has provided the information for enrollment and executed this Agreement. A Policyholder may or may not be an Enrollee, i.e. if a parent purchases coverage for their child only, then the parent is the Policyholder but is not an Enrollee.

3.24 "Renewal Date" means the date upon which this Agreement will renew for an additional one year term. This date is the annual anniversary date of the Effective Date or the applicable date set by the Marketplace.

SECTION IV – COVERAGE AND TERMINATION

4.1 COMMENCEMENT OF COVERAGE:

Coverage of an Enrollee will commence upon the Effective Date as identified on the enrollment materials and as allowed by the Marketplace. Unless otherwise instructed by the Marketplace, enrollment information must be submitted on or before the 15th day of the month and premium payments must be received by the 26th day of the month in order for coverage to be effective the first day of the concurrent month. If these time frames are not met, coverage will not commence until the first day of the following next month.

4.2 CHANGES TO ADD ENROLLEES:

A change may be made to add an Enrollee if enrollment information and the required premium fees for the additional coverage are provided consistent with the requirements of the Marketplace. Changes may be made if notice is provided to the Marketplace within sixty (60) days, or within any other applicable time frame established by the Marketplace, following the occurrence of one of these triggering events:

(a) the birth or the filing of a petition for adoption or certificate of placement of a Child;
(b) the Policyholder's marriage;
(c) Enrollee permanently moves to the state of Kansas;
(d) Policyholder or Eligible Dependent's loss of minimum essential coverage as defined by the ACA;
(e) Policyholder or Eligible Dependent's loss of employer sponsored coverage; or
(f) Any other change in circumstance as recognized by the Marketplace.

Coverage will commence the first day of the following month subject to the receipt of enrollment information and payment consistent with the dates specified above for Commencement of Coverage unless otherwise specified by the Marketplace.

No other changes may be made to add or remove Enrollees after the Effective Date unless allowed by the Marketplace.

4.3 CHANGES TO COVERAGE:

No changes may be made to the coverage selected after the Effective Date except upon renewal unless otherwise allowed by the Marketplace or during an applicable open enrollment period through the Marketplace.

4.4 MARKETPLACE TERMINATION OF COVERAGE FOR ENROLLEE:

If, at any time, an Enrollee fails to satisfy all of the requirements of this Agreement as set forth herein, coverage under this Agreement shall terminate for such Enrollee at the end of the month in which the Enrollee fails to meet any applicable requirement(s) unless otherwise specified within this Agreement or by the Marketplace.

Unless otherwise specified by the Marketplace, upon occurrence of one of the following events, coverage shall terminate for an Enrollee in the following manner:

a. If, at any time, an Enrollee ceases to be a resident of the State of Kansas, coverage under this Agreement shall terminate at the end of the Calendar Year in which the Enrollee fails to qualify as a Kansas resident. An Enrollee will not lose coverage solely based upon a second residence outside of Kansas, status as a full-time student attending college in another state, or traveling outside of the state of Kansas.

b. If, at any time, an Enrollee who is not the Policyholder ceases to qualify as an Eligible Dependent, coverage under this Agreement shall terminate at the end of the month in which the Enrollee fails to qualify as an Eligible Dependent unless otherwise specified by the Marketplace.

Unless otherwise specified by the Marketplace, at termination of coverage under this Agreement, operative procedures which are then in progress and i) which are completed within thirty (30) days of the termination of coverage, and ii) submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; partial and complete, dentures; and bridges. Operative procedures are considered in progress only if all procedures for commencement of lab work have been completed.

Policyholder must notify DDKS and/or the Marketplace when an Enrollee is no longer eligible for coverage and Policyholder shall be liable for any claim payments made by DDKS during the period of time the Enrollee was not eligible for coverage.

4.5 VOLUNTARY TERMINATION OF COVERAGE BY ENROLLEE:

If, at any time, an Enrollee obtains other minimum essential coverage, the enrollee may, with appropriate notice to the Marketplace and DDKS, terminate his or her coverage with DDKS. Reasonable notice is defined as at least fourteen (14) days before the requested effective date of termination. The last day of coverage for an enrollee voluntarily terminating coverage of his/her marketplace plan is:

a. The termination date specified by the enrollee, if the enrollee provides reasonable notice;

b. Fourteen (14) days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

c. A date on or after the date on which the termination is requested by the enrollee, subject to the determination of DDKS, if DDKS agrees to effectuate termination in fewer than fourteen days, and the enrollee requests an earlier termination effective date.

d. If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of DDKS coverage is the day before the individual is determined eligible for Medicaid, CHIP or the BHP.

In the case of a termination due to death, the last day of coverage is the date of death.

SECTION V – CLAIMS

5.1 DENTIST CONDUCT:

DDKS may refuse to pay for any Covered Services which are provided in a manner that is inconsistent with the generally accepted applicable standards of dentistry.

5.2 WRITTEN NOTICE OF CLAIMS:

Written notice of claims must be submitted to DDKS at its office within six (6) months of the date that the Covered Service was provided. Notice given by or on behalf of the Enrollee should be sent to Delta Dental of Kansas, 1619 N.

Waterfront Parkway, Wichita, KS 67206, or to any authorized agent of DDKS, with information sufficient to identify the Enrollee. But, failure to submit a claim within six (6) months of the date that the Covered Service was 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.

5.3 CLAIM FORMS:

DDKS, upon receipt of a notice of claim, will furnish to the Enrollee 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 Enrollee 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.

5.4 PREDETERMINATION OF BENEFITS:

Treatment plans that involve Covered Services which include prosthodontic services, individual crowns (except stainless steel), surgical periodontics, endodontics, and oral surgery except for simple extraction of a single tooth, should be submitted to DDKS for predetermination of benefits. Failure to do so may result in a loss of benefits if, in the professional judgment of DDKS, such treatment is not necessary or a lesser procedure could have restored the tooth or dental arch to a reasonable degree of functionality. A predetermination of benefits does not obligate DDKS to provide any benefits associated therewith if the Enrollee is no longer eligible to receive such benefits at the time the Covered Services are performed. A predetermination of benefits is only effective with respect to Covered Services which commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist. Otherwise a new predetermination of benefits must be sought.

5.5 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 Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under this Agreement constitutes the Enrollee's (and the related Policyholder'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.

5.6 EMERGENCY TREATMENT:

Each individual dental office has its own emergency treatment protocol and Enrollees 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 Services under this Agreement unless performed by a licensed dentist.

5.7 INQUIRIES/APPEALS:

Enrollees 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.

If a claim for benefits is denied in whole or in part, written notification called an "Explanation of Benefits" will be provided within thirty (30) days after a claim is received, unless special circumstances require an extension of time for processing. If additional time is necessary, DDKS will notify the Enrollee and/or the treating Dentist of the reason for the additional time, including a description of additional information that is necessary to process the claim if information is missing. If additional information is necessary, the Enrollee will have forty-five (45) days to provide the additional information or else the claim will be decided based upon the information then available to DDKS.

Enrollees have the right to appeal a claim determination if the requested dental benefits were not paid in full. In order to appeal a benefit determination, Enrollees or their authorized representative must write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769 within one hundred eighty (180) days of the date of the Explanation of Benefits for the claim. Written appeals should be submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Enrollee's identification number.
2. Policyholder's name and birth date. If the Enrollee is not the Policyholder, the Enrollee's name and birth date must also be included.

3. Dentist name and, if known, license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question, including the basis for appeal.
7. Any additional information that the Enrollee believes supports his/her position.

A full and fair evaluation of the appeal will be made by DDKS and, in some cases the Enrollee may be examined clinically. If necessary, additional information or documents may be requested. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, Enrollees 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 Enrollee will be advised. Generally, a written answer or decision will be sent to the Enrollee within thirty (30) days thereafter, however, DDKS must provide a written answer or decision within sixty (60) days receipt of the appeal.

If DDKS denies any part of the claim on appeal, DDKS will provide the Enrollee written notice of the basis for the denial and additional information. The Enrollee may request, free of charge, a copy of any applicable rules, exclusions, or limitations relied upon in the benefit determination. In addition, DDKS will provide the Enrollee with a copy of the documents relevant to the benefit determination free of charge upon request.

5.8 REGIONAL CONSULTANTS:

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.

SECTION VI – AGREEMENTS

6.1 POLICYHOLDER AGREES:

Throughout the term of this Agreement, Policyholder agrees as follows:

a. At the time of the execution of this Agreement, to furnish DDKS through the Marketplace with accurate initial enrollment information regarding all Enrollees, including Eligible Dependents, if any.

b. To timely remit to the Marketplace all applicable premiums in a timely manner.

c. To inform Enrollees to notify their Dentist at the time of their first appointment that they are covered by this Agreement.

d. To provide DDKS with such other information as it shall request in connection with this Agreement.

e. At all times while this Agreement is in effect, Policyholder represents and warrants that all Enrollees covered by this Agreement meet the definition of a Policyholder or Eligible Dependent as set forth by the terms of this Agreement. Policyholder agrees that DDKS has discretion to determine if such requirements are met and will produce information requested by DDKS to substantiate compliance with this requirement. Policyholder acknowledges no benefits will be provided under this Agreement if such persons do not meet said requirements.

6.2 DDKS AGREES:

Throughout the term of this Agreement, DDKS agrees as follows:

a. Prior to making payment for Covered Services, to require the Dentist or Policyholder, as the case may be, to timely submit a claim which satisfies the claims procedures of DDKS.

b. To make payment to a Participating Dentist, Non-Participating Dentist, or Policyholder, as the case may be, for each Covered Service based upon the applicable terms of this Agreement.

SECTION VII - GENERAL PROVISIONS

7.1 COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS:

A. GENERAL.

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

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

B. DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

C. ORDER OF BENEFIT DETERMINATION RULES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C.3.b.2.d.1. The plan covering the custodial parent;

C.3.b.2.d.2. The plan covering the spouse of the custodial parent;

C.3.b.2.d.3. The plan covering the non-custodial parent; and then

C.3.b.2.d.4. The plan covering the spouse of the non-custodial parent.

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

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

(d) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by stat4e or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. The rule does not apply if the rule labeled C(3) above can determine the order of benefits.

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

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

D. EFFECT ON THE BENEFITS OF THIS PLAN.

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

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

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

F. FACILITY OF PAYMENT.

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

G. RIGHT OF RECOVERY.

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

7.2 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 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.

7.3 MISREPRESENTATIONS:

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

7.4 CHANGES TO AGREEMENT:

No agent or representative has authority to change this Agreement or waive any of its provisions. No change in this Agreement shall be valid unless approved by an executive officer of DDKS and evidenced by endorsement hereon.

7.5 LEGAL ACTIONS:

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

7.6 GOVERNING LAW:

The laws of the State of Kansas shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties. Any action brought to enforce, construe, or interpret this Agreement may include mediation or arbitration but only if arbitration is voluntarily agreed to by the parties at the time a dispute arises. Any provision of this Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

7.7 SEVERABILITY:

If any part of this Agreement is determined to be invalid, unenforceable, or contrary to law or professional ethics, that part shall be reformed, if possible to conform to applicable law and ethics. If reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

7.8 ASSIGNMENT:

Policyholder may not assign its interest in this Agreement without the prior written consent of DDKS.

7.9 NOTICE:

Any notice required or desired to be given under this Agreement shall be deemed to have been given if delivered personally to the Policyholder or hereinafter named designee of DDKS, or sent by first-class United States Postal mail. Any such notice shall be effective upon receipt of said notice unless an alternate date is specified. Policyholder shall have the right to designate a different address or agent for the receipt of notice by providing written notice of such designation to DDKS. Otherwise, notices shall be sent in writing to the address of the Policyholder as listed in the Application. Notices to DDKS shall be in writing and sent to:

Compliance Officer
Delta Dental of Kansas, Inc.
PO Box 789769
Wichita, KS 67278-9769

7.10 BENEFITS BOOKLET:

DDKS shall prepare a Benefits Booklet which shall be approved by the Commissioner of Insurance for the State of Kansas. The Benefits Booklet shall summarize certain features of the Plan's coverage, rules, and claims payments.

7.11 MISCELLANEOUS:

a. Waiver of Breach. The waiver of any breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach.
b. Captions. The paragraph headings are for convenience only, and shall be disregarded in interpreting this Agreement.
c. Authorized to Enter into Agreement. Both Policyholder and DDKS represent and warrant they are authorized to enter into this Agreement.

SECTION VIII – TERMINATION OF AGREEMENT

This Agreement shall remain in full force and effect for the term specified in Section I unless one of the provisions set forth below applies:

8.1 If Policyholder fails to timely pay premiums as due, the Marketplace has the right to terminate this Agreement following the applicable grace period as outlined below:

(i) If Policyholder has purchased coverage through the Marketplace, has paid at least one month of premium, and is entitled to advance payment of the premium tax credit, then a ninety (90) day grace period will apply. If full

payment of all premiums due is made during this grace period, any claims incurred during the grace period will be benefited consistent with the coverage provided herein and this Agreement will remain in force.

(ii) For all other Policyholders, a thirty (30) day grace period will apply.

If the Marketplace subsequently accepts any late premiums, the payments shall reinstate this Agreement, but such reinstatement shall provide coverage under the Plan only with respect to Covered Services which are first provided more than ten (10) days after the date of such reinstatement as allowed by the Marketplace.

If Policyholder defaults in the making of premium payments during the applicable grace period, termination of this Agreement shall become effective on the date of the expiration of the period for which the last monthly premium was paid. In no event will DDKS be required by this Agreement to provide any benefits for any period for which the Policyholder has not made the premium payments in advance of the incurrence of the benefits.

8.2 If Policyholder engages in fraudulent conduct, furnishes DDKS with fraudulent information, makes an intentional misrepresentation of material fact, or otherwise fails to perform Policyholder's responsibilities under the terms of this Agreement (excluding failure to pay premiums), then DDKS may terminate coverage following a thirty (30) day notice to Policyholder if allowed by the Marketplace.

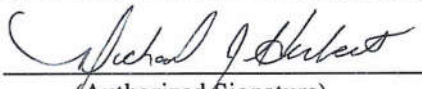
8.3 Upon the death of Policyholder, this Agreement shall terminate and DDKS will prorate the applicable premiums for the month in which the charge occurred.

ACKNOWLEDGMENT OF SIGNATURE

POLICYHOLDER HEREBY ACKNOWLEDGES THAT BY COMPLETING THE APPLICATION AND/OR ENROLLMENT PROCESS FOR DENTAL COVERAGE OFFERED BY DELTA DENTAL OF KANSAS, INC., POLICYHOLDER AGREES TO THE TERMS AND CONDITIONS SET FORTH IN THIS SUBSCRIPTION AGREEMENT TO PROVIDE BASIC DENTAL BENEFITS AS IS FULLY SET FORTH WITHIN THE APPLICATION.

In witness whereof, Delta Dental of Kansas, Inc. has caused this Agreement to be signed by its authorized representative:

DELTA DENTAL OF KANSAS, INC.

By: 
(Authorized Signature)

President & CEO
(Title)

Date: [May 1, 2016]

Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Jennifer Morrison, Compliance Manager, 2801 Hoover Road, Stevens Point, WI 54481, Phone: 715-344-6087, TTY: 877-287-9039, Fax: 715-344-9058, *jmorrison@deltadentalwi.com*.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jennifer Morrison, Compliance Manager, 2801 Hoover Road, Stevens Point, WI 54481, Phone: 715-344-6087, TTY: 877-287-9039, Fax: 715-344-9058, *jmorrison@deltadentalwi.com*. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jennifer Morrison, Compliance Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.