Description
of
Dental Care
Coverage
911377 Barton County Community College

INTRODUCTION

This document is a description of the Barton County Community College's dental plan (the Plan). All benefits described in the Schedule of Benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: dental care and treatment is necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right through a procedure described in the Plan Administration section to terminate, suspend, discontinue, or amend the Plan at any time upon advance notice to all participants.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, lack of timely filing of claims, or lack of coverage. These provisions are explained in summary fashion in this document. Additional information is available from the Plan Administrator at no extra cost.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges Incurred before termination, Amendment or elimination.

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, treatment, test or any other aspect of plan benefits or requirements.

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This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of the Plan's dental benefits or requirements.

Eligible Classes of Employees:
Full-Time Employees as defined below.

Eligibility Requirements For Employee Coverage.
A person is eligible for Employee coverage the first day of the month following the date he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least fourty (40) hours per week and is on the regular payroll of the Employer.
(2) is in a class eligible for coverage.
(3) completes the employment Waiting Period of:
First of the month following, or coincident with thirty (30) days of continuous Full-Time employment.

A person is **excluded** from coverage under this plan if they fall into one off the following employment classes:
(1) Part-time/variable hour workers, meaning those persons regularly scheduled to work less than 30 hours per week.
(2) Employees covered under a collective bargaining agreement.
(3) Seasonal Employees, meaning employees who are employed on a seasonal basis into a position for which the period of customary annual employment is six (6) months or less.
(4) Leased workers, as that term in used in Code § 414(n) of the Internal Revenue Code.

Eligible Classes of Dependents.

(1) Spouse. The term "Spouse" shall mean a person of the same or opposite sex to whom an Eligible Employee is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a Spouse for purposes of this Plan if (a) his/her marriage to the Eligible Employee has been terminated by a court having jurisdiction over one or both parties to the marriage or (b) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

(2) Child(ren). Children from birth to the limiting age of 26 years. The term "Children" shall include:
- Children under the age of twenty-six (26) who are either the birth Children of the Insured or the Insured's spouse or legally adopted by or placed for adoption with the Insured;
- Children under the age of twenty-six (26) in which the Insured is required to provide health care coverage pursuant to the Qualified Medical Child Support order (QMCSO).
- Children under the age of twenty-six (26) in which the Insured is the court-appointed legal guardian.

The term "Children" shall include natural Children, adopted Children or Children placed with the covered Employee in anticipation of adoption or a Child who has been placed under the legal guardianship of the Participant. (Step-Children who reside in the Employee's household may also be included).

If a Dependent is acquired other than at the time of their birth, due to a court order or decree, that Dependent will be considered an eligible Dependent from the date of such court order or decree, provided that this new Dependent is properly enrolled as a Dependent of the Covered Employee within thirty (30) days of the court order or decree.

A Child ceases to be eligible for this Plan when his or her employment situation is such that they are eligible for dental care coverage through their own Employer. Coverage under this plan will cease on the corresponding date for which they are eligible for coverage with their own Employer, regardless of whether or not this Child elected such coverage. This Plan reserves the right to conduct inquiries to assist in the administration of this provision.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any Child of a Plan Participant who is an alternate recipient under a QMCSO shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied. A participant of the Plan may obtain, without charge, a copy of the procedures QMCSO determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Coverage may be continued if a covered Dependent Child is incapable of self-sustaining employment by reason of intellectual disability or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Disability and dependency.
After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; foster Child; a Spouse or Child who is eligible to be covered as an employee; any person who is on active duty in any military service of any country; any person who resides outside the United States.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If you are an eligible Employee under the Plan, you cannot be covered as a Dependent.

If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

Eligible Classes of Retirees:

Retiree as defined below.

"Retiree(s)" means an individual who, in the event Plan Sponsor has elected to provide coverage to Retirees under this Plan, satisfies the conditions required to be considered a Retiree, as specified below.

The term "retirement" means that the Participant has terminated employment and is receiving a retirement or disability benefit for service with the Employer.

To the extent Plan Sponsor has elected to provide coverage to Retirees under the Plan, a Retiree shall be an individual who satisfies each of the following conditions:

(1) Term of Service. The Plan Participant has at least ten (10) years of service with the Employer at the time of his/her retirement from the Employer.

(2) Waiver of COBRA. The Plan Participant waives his/her right to elect COBRA continuation coverage pursuant to Section COBRA Continuation Options of the Plan Document.

(3) Timely Election to Continue Coverage. The Plan Participant affirmatively elects, using the procedures prescribed by the Plan Administrator, to continue coverage under the Plan no later than thirty (30) days after his/her retirement from employment with the Employer.

Eligibility Requirements For Retiree Coverage.

If Plan Sponsor has elected to cover Retirees under the Plan, the eligibility conditions for a Retiree are as set forth Eligible Classes of Retirees. Individuals receiving COBRA continuation coverage shall not be eligible for Retiree coverage under this Plan. An individual whose coverage as a Retiree under this Plan is subsequently terminated for any reason shall thereafter not be eligible again for coverage as a Retiree under this Plan.

Effective Date of Coverage for Retirees.

If Plan Sponsor has elected to cover Retirees under the Plan, an individual who meets the Plan's eligibility conditions for Retirees and who timely submits to the Plan Administrator a properly completed application for Retiree coverage shall begin coverage as a Retiree on the first day of the month coincident with or next following the date on which the individual terminated employment with the Employer at a time that he/she satisfied the Plan's conditions for Retiree coverage. The deadline for submitting an application for Retiree coverage shall be the same deadline that is applicable to all other new enrollees (other than Special Enrollees) in the Plan, as elected by Plan Sponsor in the Plan Document. An individual who fails to submit a timely application for Retiree coverage shall thereafter be prohibited from enrolling in the Plan as a Retiree.

Eligible Classes of Dependents of Retirees.
As defined in the Eligible Classes of Employees Dependents.

The Dependents of a Retiree who is eligible to, and does, continue his/her coverage under the Plan shall be eligible to continue their participation in the Plan if, and only if, they were covered under the Plan at the time of the Retiree's termination of employment with Plan Sponsor.

FUNDING

Cost of the Plan

Eligible Participants will be advised of any required contributions at the time they apply for enrollment in the Plan. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required contribution amount.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee wishing to include Dependent coverage is REQUIRED to enroll those dependents, including coverage for Newborn Children.

Enrollment Requirements for Newborn Children. It is important to remember that a Newborn Dependent is NOT automatically enrolled in the Plan. Newborn children of a Covered Employee will be covered from the moment of birth, if the Child is not enrolled within thirty (30) days of birth, the enrollment will be considered a Late Enrollment.

SPECIAL ENROLLMENT

If an eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative dental coverage) but subsequently loses coverage under the other dental plan and makes application for coverage hereunder within thirty (30) days of the loss, such individual shall be a Special Enrollee provided such person:

(a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including, as a result of:

- legal separation
- divorce
- death
- termination of employment
- reduction in the number of hours of employment or Employer contributions toward such coverage were terminated

Individuals who lose other coverage due to nonpayment of premium or for cause (i.e., filing fraudulent claims) shall not be Special Enrollees hereunder. An eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within thirty (30) days of the acquisition of the new Dependent.

Coverage for a Special Enrollee (other than a Newborn, newly adopted Child or newly acquired Dependent through marriage) shall begin as of the first day of the calendar month following the enrollment request. Coverage for a newly adopted, Newborn or acquired Dependent through marriage Special Enrollee shall begin as of the date of the adoption, placement for adoption, birth or date of marriage.

Special Enrollment and Children's Health Insurance Program (CHIP)

If an eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because they were unable to afford the premiums) and later approved for premium assistance under the Medicaid or CHIP, as long as you and your dependents are eligible, but not enrolled, and make application for coverage hereunder within sixty (60) days of being determined eligible for premium assistance this will be considered a Special Enrollment. For more information, please contact the Plan Administrator or www.insurekidsnow.gov

TIMELY AND LATE ENROLLMENTS

An enrollment is either "timely" or "late":

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty (30) days after the person becomes eligible for the coverage.

If two Employees (husband and wife) are covered under the Plan and one of the Employees terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or considered a special enrollment and coverage shall not become effective until the end of the next Open Enrollment Period. The Open Enrollment Period will be an annual Open Enrollment Period during the month of August, at which time an Employee may change to single or elect family coverage under the plan as a Late Enrollee to be effective on November 1st.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following, or coincident with the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement
(2) The Actively at Work Requirement

Actively at Work Requirement.
Active Employees - An Employee must be Actively at Work for a benefit or a benefit increase to take effect. An Employee will be considered Actively at Work if the Employee is performing the regular duties of employment on that day either at the Employer's place of business or at some location to which the Employee is required to travel for the Employer's business.
An Employee is considered to be Actively at Work on each day of a regular paid vacation or personal paid time off, or while the individual is under their annual employment contract and through the duration of the applicable contract period when considered Employed, and on each regular non-workday on which the Employee is unable to perform the essential functions of his or her job, if the Employee was Actively at Work on the last preceding regular workday
If an Employee is absent from work due to the inability to perform the essential functions of his or her job on the date this Plan would otherwise have been effective, the effective date will be deferred until the date on which the Employee returns as an Active Employee.

Effective Date of Dependent Coverage. Subject to the Deferral Rule, a Dependent's coverage will take effect on the day that the Eligibility Requirement is met, the Employee is covered under the Plan and all Enrollment Requirements are met. For marriage, birth or adoption (or placement for adoption), provided the Employee enrolls within thirty (30) days, coverage will become effective the date of marriage or the date of birth or adoption (or placement for adoption).

TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.
(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)

(3) The date the Employee ceases to be in a classification shown in the Schedule of Benefits or eligibility section.
(4) The end of the period for which any required contribution has been paid if the charge for the next period is not paid when due.
(5) The date the Employee enters full-time military service of any Country.
(6) The date that any Plan Benefit Maximum (as set forth in the Schedule of Benefits) has been exceeded.
(7) The end of the month following a temporary layoff, leave of absence or disability.

Continuation During Family and Medical Leave. All provisions of the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Company, group dental benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements and obligations of the Employer and Employee concerning conditions of leave, the notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An Employee with questions concerning any rights and/or obligations should contact the Plan Administrator to obtain further information free-of-charge.

Uniformed Services Employment and Reemployment Rights Act. An Employee or Dependent who is an armed forces veteran, member of the National Guard or a military reservist and who is covered under the Plan immediately prior to being called into active duty uniformed service or active service with the National Guard or Public Health Service has rights under the Plan through the Uniformed Services Employment and Reemployment Rights Act. The rights apply both prior to going into and upon returning from active duty or service, and include, but are not limited to, extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee. As a result of this law, you can maintain the coverage You have under the Plan for Your Dependents while You fulfill the period of active duty or service and when You return to employment You can be covered with no Pre-Existing Condition exclusion. If the active duty or service is less than thirty-one (31) days, you are not required to pay more that You would have been required to pay if You had not been away from the Employer in active duty or service.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all of the Plan's eligibility and Waiting Period requirements. If a Participant terminates employment, is rehired less than twenty-six (26) weeks from the date of termination of employment, and is an Eligible Employee upon rehire, then the former Participant will again become a Participant in the Plan on the first payroll period following his/her date of rehire.

However, an Employee returning to work directly from coverage under the Plan's COBRA continuation option will not have to satisfy the Waiting Period.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of:
(1) The date the Plan is terminated
(2) The last day of the calendar month in which the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
(3) The date Dependent coverage is terminated under the Plan
(4) On the first day that he or she ceases to be a Dependent as defined by the Plan (See the COBRA Continuation Option.)
(5) The date the Plan is changed to end coverage for a class to which the Dependent belongs
(6) The date the Employee fails to make any required contribution for Dependent coverage within thirty (30) days of the premium due date
(7) The date that any Plan Benefit Maximum (as set forth in the Schedule of Benefits) has been exceeded.

When Retiree Coverage Terminates. Retiree coverage will terminate on the earliest of these events:
(1) The Participant attains age sixty-five (65);

(2) The Participant becomes covered, or becomes eligible to be covered, under another employer's group health plan;
Note: The reference to "another employer's group health plan" only refers to an employer of the Participant himself/herself.

(3) The Participant fails to make a required premium payment on a timely basis; or

(4) The Employer terminates the Plan.

When Retiree Dependent Coverage Terminates. The coverage of the Spouse and/or Dependent(s) shall terminate upon the earliest occurrence of the following events:

(1) The Participant's coverage under the Plan terminates;

(2) The Spouse/Dependent attains age sixty-five (65);

(3) The Participant fails to make a required premium payment on a timely basis;

(4) The Spouse/Dependent becomes covered, or becomes eligible to be covered, under another employer's group health plan; or

(5) The Employer terminates the Plan.

Construction and Application. This section shall be construed and applied in a manner consistent with the requirements of Kansas Statutes Annotated 12-5040.

SCHEDULE OF BENEFITS

Eligibility Verification. Call 620-792-9151 or 866-792-9151 to verify eligibility for benefits **before** the charge is Incurred.

This benefit applies when dental Covered Charges are Incurred by a person while covered under this Plan. All benefits described in this Dental Benefits Section are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's or delegated party's determination that: care and treatment is Medically Necessary; charges are the Allowed Amount; services, supplies, and care are not Experimental and/or Investigational.

Benefit Payment
Each Plan Year benefits will be paid to a Covered Person for dental charges. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits.

Maximum Benefit Amount
The Maximum amount payable for Dental Benefits is shown in the Schedule of Benefits.

Dental Charges
Dental charges are the Allowed Amount charged by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

In order for benefits to be payable, the person must be covered on the date the dental treatment is received. Most dental treatment is considered to have been received on the date the work is done. However, there are some kinds of treatment that take more time to complete. In these cases, treatment is considered to have been received on the dates shown below.

- **(a)** As to fixed bridgework, crowns, inlays, onlays and gold restorations, the date the tooth or teeth are first prepared.
- **(b)** As to full or partial removable dentures, the date the impression is taken.
- **(c)** As to root canal work, the date the pulp chamber is opened.
- **(d)** As to an appliance or modification of an appliance, the date the impression is taken.

A dental charge is Incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro-rata charge will be considered to be Incurred as each visit or treatment is completed. Charges are limited to Usual, Customary and Reasonable Fees.

Order of Claims
If a service is covered by both the Medical and Dental Benefits, the Medical benefits are considered first. The Allowed Amount for Dental Benefits is considered after the Medical Benefits.

Percentage payable by the Plan Participant, per Plan Year

Preventive Services	100%
Basic Services	80%
Major Services	50%
Plan Year Maximum	$1,500
Orthodontia Services	None

Deductible payable by the Plan Participant, per Plan Year:

Individual	$50
Family	$100

Dental Deductible per covered Person applies to Basic and Major Dental Procedures. Preventive Dental Procedures are NOT subject to the Deductible.

Preventive Dental Procedures –

The limits on Preventive Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams and prophylaxis. This includes the cleaning, scaling and polishing of teeth. Limit of two exams per Covered Person each Plan Year. Cutterage and scaling performed in conjunction with and on the same day as a routine exam will be considered part of the routine exam procedure.

(2) Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue, and cavity detection, including those provided in association with a covered dental implant limited as follows:

- **(a)** Bitewing x-ray series limited to two (2) times per Plan year,
- **(b)** One full-mouth or panoramic x-ray as part of a routine oral exam two (2) times per Plan year.
- **(c)** All other dental imaging services as Dentally Necessary.
- **(d)** If full-mouth/panoramic and bitewing x-rays are performed in conjunction with each other, the total amount payable will be based on the Usual and Reasonable Charge for a full-mouth/panoramic x-ray.

(3) Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children, under the age of nineteen (19) once every three (3) years.

(4) Topical application of fluoride for Dependent Children under age nineteen (19), two (2) times per Plan Year.

(5) Problem focused exams.

Basic Dental Procedures –

(1) Extractions. This includes local anesthesia and routine post-operative care.

(2) Silver (amalgam), silicate, acrylic, synthetic, resin, porcelain and composite filling to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.

(3) Space maintainers for covered Dependent children to replace primary teeth. No payment will be made for duplicate space maintainers.

(4) Periodontics (gum treatments).

(5) Endodontics (root canals).

(6) General and local anesthetics, upon demonstration of Medical Necessity.

(7) Diagnostic casts, laboratory tests and other diagnostic exams.

(8) Biopsy and examination of oral tissue.

(9) Antibiotic drugs administered in an office setting.

(10) Emergency palliative treatment for pain.

(11) Re-cementing bridges, crowns or inlays

(12) Oral surgery, limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.

Major Dental Procedures–

(1) Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Dental Implants

(3) Repair of crowns, bridgework and removable dentures.

(4) Installation of crowns, inlays and abutments.

(5) Installing precision attachments for removable dentures.

(6) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during a six-month period following the installation.
(7) Addition of clasp or rest to existing partial removable dentures.
(8) Initial installation of fixed bridgework to replace one or more natural teeth.
(9) Rebasing or relining of removable dentures over six (6) months old once every thirty-six (36) months. If the benefits pay for new dentures, it will not pay to rebase or reline the old dentures..
(10) Replacing an existing full or partial removable denture, new bridgework, or the addition of teeth to an existing full or partial removable denture or bridgework. However, only replacement and additions that meet the "Prosthesis Replacement Rule" below will be covered.

PROSTHESIS REPLACEMENT RULE

This rule requires that satisfactory evidence be furnished to show that one of the following criteria applies:

(a) The replacement or addition of teeth is required to replace teeth that were extracted after the existing denture was installed and while the individual was covered under the plan.
(b) The existing denture cannot be made serviceable and was installed at least five (5) years prior to its replacement; or
(c) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, then benefit payment will be based on the cost of the treatment, which provides professionally satisfactory results at the most cost-effective level.
For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

Exclusions and Limitations:

(1) Administrative costs of completing claim forms or reports or for providing dental records.
(2) Bone grafts for alveolar ridge augmentation.
(3) Charges for broken or missed dental appointments.
(4) Chemotherapeutic agent(s) inserted into a periodontal pocket.
(5) Cosmetic dentistry. Facings on crowns or pontics beyond the second bicuspid are considered cosmetic, except for Injuries or Medically Necessary care and treatment of cleft lip and palate.
(6) Charges incurred for treatment, services or supplies which constitute personal comfort, beautification or cosmetic procedures.
(7) Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
(8) Excluded under Medical. Services that are listed as excluded under Medical Benefits section of the Plan.
(9) Dentist charges for travel expenses, mileage, traveling time, telephone calls, or for services provided over the telephone.
(10) The charges for services of anyone who is not a licensed Dentist or Dental Hygienist.
(11) Home Sealant Kits.
(12) Instructions for plaque control, oral hygiene, or diet.
(13) Services related to: Bite registration, equilibration, or occlusal analysis.
(14) Treatment or service to alter or maintain vertical dimension or restore occlusion.

(15) Treatment or service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance.
(16) Treatment, service, or material that does not meet professionally recognized standards of quality.
(17) Treatment or service for provisional or permanent splinting. Crowns, fillings or appliances that are used to connect (splint)teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
(18) Orthodontic treatment, service, appliance or bands not specified in the Schedule of Benefits.
(19) Hospital, healthcare facility or medical emergency room charges.
(20) Orthognathic surgery. Surgery to correct malposition in the bones of the jaw.
(21) Treatment or service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three (3) years.
(22) Patient education services.
(23) Personalization of dentures.
(24) Charges that are payable under the Major Medical Expense Benefit of the Plan.
(25) Recall visits for checking sealant application.
(26) Services which are not included in the list of covered dental services.
(27) Charges for the treatment of Temporal Mandibular Joint dysfunction (TMJ).

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized. Any terms not listed shall be understood by its normal meaning within the context in which it is used.

Active Employee Performing on a regular, full-time basis all normal employment duties for at least thirty (30) hours per week. Duties may be at the employer's business or another location if you are required to travel on the job. You will be Actively at Work on each day of paid vacation if you were actively at work on your last regular working day. You will be actively at work on each non-working holiday if you were actively at work on your last regular working day.

Alternate Care means dental treatment or care that is provided in lieu of the benefits specified in this Plan, because it may be provided in a less comprehensive setting or because it is less expensive. Alternate Care must be recommended by the case manager for a Covered Person whose condition would otherwise require hospital care, Medically Necessary and approved by the Plan Administrator.

Amendment is a formal document that changes the provisions of the Plan Document.

Calendar Year means January 1st through December 31st.

Case Manager is an individual or entity that reviews the cost effectiveness or prescribed courses of treatment for the Covered Person and evaluates and recommends more cost effective alternative courses of treatment under the terms or an agreement with the Employer.

Claims Administrator is the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the administration, consideration, investigation and settlement of claims, maintain records, COBRA Administration, submit reports and other such administrative functions as may be set forth in a written administration agreement. Both the ultimate responsibility for the administration of this Plan and the authority to interpret the Plan shall remain with the Plan Administrator.

Close Relative means the Spouse, parent, brother, sister, Child or Spouse's parent of the Covered Person.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Congenital Birth Defect is a medical condition that existed at birth and is diagnosed within the first five (5) years of life.

Cosmetic Surgery, Cosmetic Reasons means medically unnecessary treatment and surgical procedures, usually, but not limited to, plastic surgery, directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Expenses are expenses Incurred by a Covered Person for any Medically Necessary treatments, services, or supplies that are not specifically excluded from the coverage elsewhere in this Plan.

Covered Person (s) is an Employee or Dependent who is covered under this Plan.

Creditable Coverage. Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a Significant Break in Coverage. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

Deductible is a specified dollar amount of Covered Expenses not payable under the Plan which must be Incurred before Covered Expenses in excess of such amount can be considered for payment at the co-insurance level.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Employee means a person who is Actively at Work, a regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Barton County Community College.

Enrollment Date means the first day of coverage under this Plan, or if earlier, the beginning of any applicable Waiting Period hereunder.

Experimental and/or Investigational means treatment which is experimental in nature or which is not accepted as effective therapy by:

1. The state medical association;
2. The appropriate specialty board;
3. The American Medical Association;
4. The surgeon General; or
5. The Food and Drug Administration.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Full-Time an Employee is considered to be employed on a Full-Time basis if he is regularly scheduled to work for at least thirty (30) hours per week. The work may occur either at the usual place of business of the company or at a location to which the business or the Company requires the Participant to travel.

Incurred expenses will be deemed Incurred on the date the Covered Person receives the treatment, service, or supply that gives rise to the expense.

Injury(ies) means an accidental physical Injury to the body caused by unexpected external means.

Late Enrollee the term "Late Enrollee" means an individual who did not enroll for coverage during the initial eligibility date described in "When Coverage Starts". A Late Enrollee will not be eligible for coverage under the plan, except as provided under "Special Enrollment" provision.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Medically Necessary care and treatment is recommended or approved by a Physician (or Dentist, with regard to dental care); is consistent with the patient's condition or accepted standards of good medical (and dental practice) care; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.
All of these criteria must be met. Merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Open Enrollment Period is, unless otherwise specified in the Schedule of Benefits, the one-month period prior to the beginning of each Plan Year.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language

Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan Administrator is Barton County Community College. Such Company shall be responsible for the day-to-day functions and management of the Plan. The Plan Administrator has appointed Freedom Claims Management, Inc. as the Claims Administrator to the Plan to perform Plan related services.

Plan Participant is any Employee or Dependent who meets the eligibility requirements and who is properly enrolled in the Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Significant Break in Coverage means a period of sixty-three (63) (or more) days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

Sickness (Sick) is a person's Illness, disease or Pregnancy (including complications).

Special Enrollee means an Employee or Dependent who is entitled to and who requests Special Enrollment within thirty (30) days of losing other dental coverage, or for a newly acquired Dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption.

Temporomandibular /Craniomandibular Joint Dysfunction (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular/Craniomandibular Joint.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

You or Your is the Employee who is Actively At Work for the Employer.

Waiting Period means the period that must pass under this Plan (or for purposes of determining Creditable Coverage the Waiting Period under any other health and/or dental plan) before an Employee or Dependent is eligible to enroll in the Plan.

HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment that person must:

(1) Make certain a current enrollment form/claim form is provided to the Claims Administrator each Plan Year.

(2) ALL QUESTIONS ON THE ENROLLMENT FORM/CLAIM FORM MUST BE ANSWERED.

(3) For Plan reimbursements, submit bills for services rendered. ALL BILLS MUST SHOW:

- **(a)** Name of Plan
- **(b)** Group number of Plan
- **(c)** Employee's name
- **(d)** Name of patient
- **(e)** Name, address, telephone number of the provider of care
- **(f)** Diagnosis
- **(g)** Type of service rendered, with diagnosis and/or procedure codes
- **(h)** Date of service
- **(i)** Charges

(4) Send the above to the Claims Administrator at this address:

FREEDOM CLAIMS MANAGEMENT, INC.
P.O. BOX 1365
GREAT BEND, KS 67530
(866) 792-9151 or (620) 792-9151

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator at the time services are Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when a treatment or care is given or a procedure performed. Claims filed later than that date may be declined or reduced **unless**:

(1) It is not reasonably possible to submit the claim in that time; and
(2) upon termination of self-funded plan.

The Claims Administrator will determine if enough information has been submitted to determine the type of claim and enable proper consideration of the claim. If not, more information may be requested.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

APPEALS

When a claimant receives an Adverse Benefit Determination, the claimant has one-hundred-eight (180) days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- was relied upon in making the benefit determination.
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination.
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants, or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a dental judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This dental care professional will have appropriate training and experience in the field of medicine involved in the dental judgment. Additionally, dental or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

COORDINATION OF BENEFITS

Coordination of the benefit plans. This provision will coordinate the dental benefits payable under this Plan with similar benefits payable under other plans so that the total amount payable under each Plan combined does not exceed the Allowable Expense for the medical or dental care or treatment.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit plan. This provision will coordinate the dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Group practice and other group prepayment plans.

(3) Federal government plans or programs. This includes Medicare.

(4) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(5) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charges. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations. When dental payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan Deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits by these rules up to the allowable charge.

(a) The benefits of the plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

i. Secondary to the plan covering the person as a Dependent, and

ii. Primary to the plan covering the person as other than a Dependent (e.g. a retired Employee),

then the benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a Child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the Child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the Child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the Child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the Child. In this case, the benefit plan of that parent will be considered before other plans that cover the Child as a Dependent.

(iv) If the specific terms of the court decree state the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules outlined above when a Child is covered as a Dependent and the parents are not separated or divorced.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been

paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

Claims Determination Period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. Certain facts are needed to apply these Coordination of Benefits rules. The Claims Administrator has the right to give information or obtain the needed facts from any insurance company, organization or person regarding any Covered Persons. As a claimant under this Plan, the Covered Person must supply the Claims Administrator with information necessary to enforce this provision. Each person claiming benefits under this Plan must provide any facts needed to pay the claim.

Facility of Payment. When another Plan makes payment which should have been made under this Plan, the Claims Administrator reserves the right, exercisable alone and at its sole discretion, to decide:

1. Whether or not to reimburse the organization making the payment; and
2. The amount to be paid in order to satisfy the intent of this provision.

Right of Recovery. If the Claims Administrator makes any payment which is more than the amount needed to satisfy the intent of this provision, then the Claims Administrator will have the right to recover the amount of the excess from one or more of the following:

1. The person to or for whom such payments were made;
2. Any insurance company; or
3. Any other organization.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur dental charges due to Injuries which may be caused by the act or omission of a first or third party. In such circumstances, the Covered Person may have a claim against that first and/or third party, or insurer, for payment of the dental charges. Accepting benefits under this Plan for those Incurred dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any first and/or third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any first and/or third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the first and/or third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for dental expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any first and/or third party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the first and/or third party or insurer.

Amount subject to subrogation or refund. The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. Theses rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for dental charges, attorney fees, or other costs and expenses. Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate.

Defined terms: "Recovery" means monies paid to the Covered Person by way of judgment, settlement or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for dental charges against the other person.

"Refund" means repayment to the Plan for dental benefits that it has paid toward care and treatment of the Injury or Sickness.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Assignment of Rights. As a condition to the Plan making payments for any dental charges, the Covered Person must assign to the Plan his or her rights to any recovery arising out of, or related to, any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid. The scope of this assignment is consistent with the amount subject to subrogation or refund set forth above.

In the event that any recovery from a first and/or third party or insurer does not result in the Covered Person being “made whole”, this provision in the plan still applies.

COBRA CONTINUATION OPTIONS

Federal law gives certain persons the right to continue their health and/or dental care benefits beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of 45 days during initial premium/contribution and 30 days thereafter). This law is referred to as "COBRA", which stands for The Consolidated Omnibus Budget Reconciliation Act of 1985. Generally, COBRA applies to employers with 20 or more full and/or part-time Employees. Employees should check with their Employers to see if COBRA applies to them.

For the purpose of this COBRA Continuation Options provision, the following definitions apply:

(1) "COBRA" means The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
(2) "Code" means the Internal Revenue Code of 1986, as amended.
(3) "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.
(4) "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations there-under.
(5) "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations there-under.
(6) "Qualified Beneficiary" means:
  (a) A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan; and
  (b) A covered Spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below; and
(7) "Qualifying Event" means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:
  (a) Termination of a Covered Employee's employment (other than for gross misconduct) or reduction in hours of employment;
  (b) The death of a Covered Employee;
  (c) The divorce or legal separation of the Covered Employee from his Spouse;
  (d) The Covered Employee becoming entitled to Medicare coverage; or
  (e) A child ceasing to be eligible as a Dependent child under the terms of the Group Health Plan.
(8) "Totally Disabled" or "Total Disability" means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

RIGHT TO ELECT CONTINUATION COVERAGE
If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution. A Qualified Beneficiary must elect the coverage within the sixty (60) day period on the later of:
(1) The date of the Qualifying Event; or
(2) The date he was notified of his right to continue coverage.
(3) The date he begins to receive benefits under the Trade Act of 2002

NOTIFICATION OF QUALIFYING EVENT
If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company of the Qualifying Event within sixty (60) days of the event in order for coverage to continue. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the Section below entitled "Total Disability" in order for coverage to continue. Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

LENGTH OF CONTINUATION COVERAGE

(1) A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Group Health Plan for up to eighteen (18) months from the date of the Qualifying Event.

(2) A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, legal separation or entitlement to Medicare, and Dependent children who have become ineligible for coverage may continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event.

TOTAL DISABILITY

(1) In case a Qualified Beneficiary who is determined under Title II or XVI of Social Security Act (hereinafter the "Act") to have been Totally Disabled prior to or within sixty (60) days of the COBRA effective date, that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer.

(a) Prior to the end of eighteen (18) months of Continuation Coverage that he was disabled as of the date of the Qualifying Event; and

(b) Within sixty (60) days of the determination of Total Disability under the Act.

(2) The Employer will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond eighteen (18) months pursuant to this Section.

(3) If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

(a) The Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and

(b) Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

TERMINATION OF CONTINUATION COVERAGE

Continuation Coverage will automatically end earlier than the applicable 18, 29, or 36-month period for a Qualified Beneficiary if:

(1) The required monthly contribution for coverage is not received by the Company within thirty (30) days following the date it is due;

(2) The Qualified Beneficiary is or becomes covered under any other Group Health Plan as an Employee or otherwise. If the other Group Health Plan contains an exclusion or limitation relating to a Pre-Existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the Pre-Existing Condition applies to the Qualified Beneficiary (or, if sooner, until the expiration of the applicable 18, 29, or 36-month COBRA period).

(3) For Totally Disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such Beneficiary is no longer Totally Disabled; or

(4) The Company ceases to offer any Group Health Plans.

MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is 18 or 29 months, and a second Qualifying Event occurs during the 18 or 29-month period, the Qualified Beneficiary may elect, in accordance with the Section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to 36 months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was a Covered Employee becomes entitled to benefits under Medicare (whether or not this is a Qualifying Event), a Qualified Beneficiary (other than the Covered Employee) may elect to continue coverage for a maximum of 36 months from the date of the initial Qualifying Event, to the extent another period of Continuation Coverage is not required by law under COBRA.

CONTINUATION COVERAGE
The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Covered Employees and their Dependents. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add Dependents for continuation Coverage, such Dependents must meet the definition of Dependent under the Group Health Plan.

CARRYOVER OF DEDUCTIBLES AND PLAN MAXIMUMS
If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and coinsurance features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

PAYMENT OF PREMIUM

(1) The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.
  (a) The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.
  (b) For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for continuation coverage months 19-29.

(2) Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments
  (a) If continuation Coverage is elected, the monthly contribution for coverage for those months, up to and including the month in which the election is made, must be made within 45 days of the date of election.

(3) Without further notice from the Employer, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within 30 days of the payment's due date, Continuation Coverage will terminate in accordance with the Section entitled "Termination of Continuation Coverage," Subsection 1. This 30-day grace period does not apply to the first contribution required under 2 above. If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A 'reasonable period of time' is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

(4) No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

If needed, further information on COBRA can be obtained through the Plan Administrator free of charge.

For further information contact:
Freedom Claims Management, Inc.
P. O. Box 1365
Great Bend, KS 67530
620-792-9151

FUNDING THE PLAN AND PAYMENT OF BENEFITS

PLAN ADMINISTRATOR. The Plan is to be administered by the Plan Administrator. An individual may be appointed by Barton County Community College to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, a new Plan Administrator shall be appointed as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan, that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes, which may arise, relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. Theses are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
(3) In accordance with the Plan documents.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties in appointing the fiduciary establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or

(2) The named fiduciary breached its fiduciary responsibility.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

For Employee and Dependent Coverage: Funding is derived from the funds of the Employee for dental coverage. Eligible Participants will be advised of any required contributions at the time they apply for enrollment in the Plan. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required contribution amount. Participants in a Plan that do not require Participant contribution at the time they enrolled, will be notified by the Plan Administrator prior to the date a contribution requirement is made effective.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for, or of, employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records, or a delay in making any changes, will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of the overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CONFORMITY WITH LAW

If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group dental plan and the administration is provided through a third party Claims Administrator. The funding for benefits is derived from the Contributions made by covered Employees.

PLAN NAME: Barton County Community College Dental Plan

TAX ID NUMBER: 48-0720175

PLAN EFFECTIVE DATE: November 1, 2024

PLAN YEAR ENDS: October 31st

EMPLOYER INFORMATION

Barton County Community College
245 NE 30 Rd
Great Bend, KS 6750
Phone: 620-792-9222

PLAN ADMINISTRATOR

Barton County Community College
245 NE 30 Rd
Great Bend, KS 6750
Phone: 620-792-9222

NAMED FIDUCIARY

Barton County Community College
245 NE 30 Rd
Great Bend, KS 6750
Phone: 620-792-9222

AGENT FOR SERVICE OF LEGAL PROCESS

Barton County Community College- Dean of Administration
245 NE 30 Rd
Great Bend, KS 6750
Phone: 620-792-9222

CLAIMS ADMINISTRATOR

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