Dental Coverage

2018 Plan Year
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Taking good care of your teeth involves daily brushing, flossing, eating a healthy diet, and regular dental check-ups. That is why your Sprint dental benefits give you something to smile about.

The Sprint Dental Plan is administered by Delta Dental of Kansas — part of Delta Dental USA, the nation’s largest dental benefits system. Your coverage under the Basic Plan utilizes Delta Dental’s PPO network only. There are no benefits paid under the Basic plan if you utilize a Delta Premier or Out-of-Network provider. The Premium Plan utilizes the Delta Dental PPO and Delta Dental Premier (Premier) networks.

The PPO network has approximately 288,000 participating dentist locations in its network. Your savings are the greatest when you utilize this network. The Premier network is broader and has about 314,000 participating dentist locations. You also will save money using the Premier network; however, your savings will be more when using a PPO provider.

Check with your dentist to see if he/she participates in either the Delta Dental PPO or Delta Dental Premier Network. Visit www.deltadentalks.com or call Member Services to find a provider near you.

There are two coverage options with the Sprint Dental Plan:

**Basic Dental Plan** or **Premium Dental Plan**

You choose the dental option that best answers your individual and/or family needs for dental care.

The Basic Dental Plan is an in-network plan only. You must utilize a Delta Dental PPO provider in order to have benefits paid under this plan.

The Premium Dental Plan is a dental PPO option. Your benefit levels will change depending on which provider you use. To receive the highest level of benefits, you need to use Delta Dental PPO providers.

Both options cover exams, cleanings, x-rays, oral surgery, periodontal services, and fillings, as well as comprehensive dental work — such as crowns and root canals. The Premium Dental Plan includes additional dental services, such as dental implants, plus orthodontia for both adults and children.
# A Look At Dental Coverage

## Your Provider Network Options

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Basic Plan</th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic &amp; Preventive Care</strong></td>
<td>Delta Dental PPO Network ONLY</td>
<td>Delta Dental Premier Network</td>
</tr>
<tr>
<td>(Routine exams, cleanings, x-rays, sealants and fluoride treatments, etc.)</td>
<td>(coverage not provided for Premier or Out-of-Network)</td>
<td>(coverage not provided for Premier or Out-of-Network)</td>
</tr>
<tr>
<td><strong>General Dental Care</strong></td>
<td>100% of maximum plan allowance covered, 2 visits per year no deductible</td>
<td>100% of maximum plan allowance covered, 2 visits per year no deductible</td>
</tr>
<tr>
<td>(Fillings, extractions, non-surgical periodontal services and other basic dental procedures)</td>
<td>50% of maximum plan allowance covered, $25 annual deductible</td>
<td>80% of maximum plan allowance covered, $50 annual deductible</td>
</tr>
<tr>
<td><strong>Important:</strong></td>
<td>If a member enrolled in the Sprint Premium Plan for more than 12 months has not had a routine cleaning or exam in the preceding 12 months, all listed General Dental Care services are reduced to fifty (50%) percent coverage for services by a PPO dentist or forty (40%) percent for Premier and Out-of-Network dentists. Once the qualifying cleaning or exam has been received, benefits will return to the original coinsurance the first day of the following month.</td>
<td>50% of maximum plan allowance covered, $50 annual deductible</td>
</tr>
<tr>
<td></td>
<td>Newly enrolled members will have 12 months to satisfy this requirement.</td>
<td></td>
</tr>
</tbody>
</table>
## Dental Benefits

### Major & Restorative Care*
(Crowns, root canals, surgical periodontal services, bridges, dentures, etc.)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% of maximum plan allowance covered, $25 annual deductible</td>
<td>$750</td>
</tr>
<tr>
<td>Dental implants at 50% of maximum plan allowance subject to a separate $50 annual deductible</td>
<td>$1,500 (does not include orthodontia)</td>
</tr>
</tbody>
</table>

### Important:

- If a member enrolled in the Sprint Premium Plan for more than 12 months has not had a routine cleaning or exam in the preceding 12 months, all listed Major & Restorative Care services are reduced to forty (40%) percent coverage for services by a PPO or thirty (30%) percent for Premier and Out-of-Network dentists.
- Once the qualifying cleaning or exam has been received, benefits will return to the original coinsurance the first day of the following month.
- Newly enrolled members will have 12 months to satisfy this requirement.

### Annual Individual Benefit Maximum
(Diagnostic & Preventive Care does NOT apply towards the Annual Maximum)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia</td>
<td>$750</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not covered</td>
</tr>
<tr>
<td>Orthodontia Lifetime Benefit Maximum</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Newly enrolled participants may only be covered for certain Major and Restorative services after a waiting period. Newly enrolled participants are defined as those who meet the new hire definition in the Eligibility and Enrollment Section of the Summary Plan Description and/or members who have not been enrolled in the Plan for 12 consecutive months prior to the date of service.
Dental Benefits

If you choose to use a dentist not participating in the Delta Dental networks, you may need to file your claims. Any reimbursement for those claims will be paid directly to you. You will be responsible for paying the dentist.

Maximum Plan Allowance

Dental benefits are based on Delta Dental’s maximum plan allowance. Deductibles apply to each individual person covered.

Delta Dental’s maximum plan allowance is determined by the lesser of the participating dentist’s submitted fee or the Delta participating dentist maximum fee. The Delta participating dentist maximum fee is developed from a number of sources, including but not limited to contracts with dentists, input from dental consultants, consideration of the relative simplicity or complexity of the procedure, the billed charges for the same procedures by other dentists, and such other information as Delta Dental, in its sole discretion, deems appropriate.

Non-participating dentists’ reimbursement is based, in part, on the average fee submitted by participating dentists.

If you use a dentist participating in the Delta Dental PPO or Premier network, you will not be billed for the remaining balance over the maximum allowable amount, whether you select the Basic Dental Plan or Premium Dental Plan.

It is recommended that the Dentist submit a treatment plan (predetermination) whenever extensive dental work is being considered. The Plan will determine the Allowed Amount for covered services and advise the provider. This allows You to plan for the cost of the services that will be Your responsibility to pay. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of the Delta Dental consultant, the treatment is not necessary or the Least Expensive Alternative Treatment (LEAT). Even if the Dentist does predetermine benefits, it does not obligate Delta Dental if You are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to Delta Dental by the treating Dentist or a new treatment plan should be obtained and resubmitted to Delta Dental.

Eligibility & Enrollment

For rules on who is eligible to be covered, enrollment, and effective dates of coverage, see the separate Eligibility & Enrollment Section of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

What Is Covered

Both dental coverage options cover a wide array of dental care services at different coverage levels. Each year, you pay an annual deductible; then the plan pays benefits — typically a percentage of the
Dental Benefits

charges. You pay the co-insurance amount, up to the annual or lifetime maximum benefit amount. The Basic and Premium Dental Plans have different deductibles, co-insurance and maximums.

Benefit Provisions

This document is intended to be an easy-to-read outline of the principal features of your dental program and is not all inclusive of payment determinations for every covered procedure under the plan. The Company reserves the right to change or discontinue any of all benefits under this option, or any statement in this summary plan description (SPD), at any time.

The dental benefits provided are fixed, and limited to those defined within this SPD. Only the Least Expensive Alternative Treatment (LEAT) is covered under this program and then only if identified as a covered dental benefit in this SPD. Only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth are benefits under the dental plan and then only if identified as a covered dental benefit in the “What Is Covered” section. Certain restrictions may be applicable to your coverage. It is important to review the entire document.

Where the SPD is silent on benefit provisions, benefits are administered according to the plan administrator’s standard benefit provisions for the self-insured dental option. Self-funded or self-insured means that the financial resources used to pay these claims are provided by Sprint. Delta Dental provides administrative claims payment services only.

The guidelines used include but are not limited to: medically appropriate to meet the basic dental needs of the member; consistent with generally accepted treatment guidelines within the dental profession; consistent with the diagnosis of the condition; consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by dental research, the American Dental Association, and the U. S. Food and Drug Administration guidelines.

The following sections discuss the various dental services covered.

Preventive And Diagnostic Care

The Basic Dental Plan covers 100% of allowable charges when utilizing a Delta Dental PPO provider and the Premium Dental Plan covers 100% (for Delta Dental PPO providers) or 70% (for Premier or Out of Network Providers) of allowable charges for preventive and diagnostic care — with no deductible. Services for Preventive and Diagnostic Care do NOT apply towards the Annual Maximum. Here is a chart that summarizes preventive and diagnostic care coverage.

<table>
<thead>
<tr>
<th>Preventive and Diagnostic Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>For These Services...</td>
</tr>
<tr>
<td>Routine oral examinations</td>
</tr>
<tr>
<td>Routine and periodontal cleanings</td>
</tr>
</tbody>
</table>
# Dental Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency/Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoride treatments</td>
<td>Four times per year</td>
</tr>
<tr>
<td>Space maintainers and their fitting – limited to non-orthodontic treatment (for your dependents under age 19)</td>
<td>Upon installation and as required because of a change in the condition of the mouth</td>
</tr>
<tr>
<td>Complete dental X-rays</td>
<td>Once every 3 years</td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>Twice a year</td>
</tr>
<tr>
<td>Fissure sealants (for dependents up to 16 years of age)</td>
<td>Not more than two treatments on an unfilled permanent molar</td>
</tr>
</tbody>
</table>

Payment for services is based on a calendar year — January 1 through December 31.

## General Dental Care

The Basic Dental Plan covers 50% of allowable charges, after the $25 deductible, when utilizing a Delta Dental PPO Provider.

The Premium Dental Plan covers 80% (for a PPO provider) or 50% (for a Premier or Out of Network provider) of allowable charges, after the $50 deductible, for general dental care, provided that a member who has been enrolled in the Sprint Dental Plan for least 12 months, has had a routine cleaning or exam in the preceding 12 months prior to the general dental care services.

General Dental Care services are reduced to 50% (for Delta Dental PPO providers) or 40% (for Premier or Out of Network providers) of allowable charges, after the $50 deductible, for members who have been enrolled in the plan for at least 12 months and have not had a qualifying cleaning or exam in the preceding 12 months prior to the general dental care services. Once the qualifying cleaning or exam has been received, benefits for general dental care services will return to the original coinsurance the first day of the following month.

*Note: Newly enrolled members will have 12 months to satisfy this requirement.*

General dental care services include:

- Anesthetics — Covered for children under age 3; otherwise only if medically necessary;
- Dental Pathology — Biopsy and examination of oral tissue including a microscopic examination;
- Extraction — Pulling teeth;
- Fillings — Silver (amalgam), silicate, plastic, porcelain and composite (white) fillings; gold fillings are covered under major/restorative care benefits of dental coverage;
Oral Surgery — Surgical procedures (such as impacted wisdom teeth) in and around the mouth, excluding accidental injury to healthy teeth, are covered. Extra charges for exams after surgery and removing of stitches are not covered; hospitalization charges incurred for oral surgery are not covered by the Sprint dental options and are normally paid by medical plans;

Periodontics — Includes non-surgical procedures for the treatment of diseases of the tissues supporting the teeth.

Stainless Steel Crowns; and

Repairs to broken inlays, onlays, crowns, bridgework, and dentures.

Major And Restorative Care

The Basic Dental Plan covers 50% of allowable charges, after the $25 deductible, when utilizing a Delta Dental PPO Provider.

The Premium Dental Plan covers 50% (for a PPO Provider) or 40% (for Premier or Out of Network providers) of allowable charges, after the $50 deductible, for major and restorative care, provided that a member who has been enrolled in the Sprint Dental Plan for least 12 months, has had a routine cleaning or exam in the preceeding 12 months prior to the major and restorative care services.

Major and restorative care services are reduced to 40% (for Delta Dental PPO providers) or 30% (for Premier or Out of Network providers) of allowable charges, after the $50 deductible, for members who have been enrolled in the plan for at least 12 months and have not had a qualifying cleaning or exam in the preceeding 12 months prior to the general dental care services. Once the qualifying cleaning or exam has been received, benefits for major and restorative care services will return to the original coinsurance the first day of the following month.

Note: Newly enrolled members will have 12 months to satisfy this requirement.

Major and restorative services include:
**Restorative Services and Supplies**

- Crowns and gold fillings to repair a tooth broken down by decay or injury are covered — charges for these restorations are covered only if the tooth cannot be repaired with a less expensive type of filling. If the tooth can be repaired by a less expensive method, only that charge will be covered.

- Endodontics — Procedures to prevent and treat dental diseases of the dental pulp such as root canal therapy.

- Periodontics — Includes surgical periodontal procedures such as root planing, osseous surgery and bone grafting for natural teeth. For a complete list of surgical periodontal procedures, contact Delta Dental.

- Onlays are also covered — charges for these restorations are covered only if the tooth cannot be repaired with a less expensive type of filling. If the tooth can be repaired by a less expensive method, only that charge will be covered.

**Prosthetic Services And Supplies**

- Sprint’s dental plan provides coverage for the initial installation of full or partial dentures and fixed bridgework to replace missing natural teeth. Dentures and bridgework are subject to the least expensive alternate treatment. Only the charge for the alternate treatment will be covered. Benefits are provided for replacing teeth missing prior to coverage; however, your expenses will not be covered unless you have been enrolled in the Sprint Dental Plan for 12 months. If the tooth can be repaired by a less expensive method, only that charge will be covered.

- Full or partial dentures and fixed bridgework to replace an existing denture or bridge that is not serviceable also are covered. But, the existing denture or bridge must be over five years old unless damaged beyond repair due to injury while in the mouth.
Dental Benefits

- A permanent denture may replace a temporary one. But in this case, charges for both are limited to the charge for the permanent one.

- Sprint’s dental plan provides coverage for repairing or recementing onlays, crowns, bridgework and dentures. Adding teeth to existing partial removable dentures or to bridgework also is covered. Replacement of crowns and onlays will be considered for payment but the existing crown or onlay must be over five years old and unserviceable.

- Dental implants and the prosthetic device attached to it are covered under the Premium Dental Plan only and subject to a separate $50 deductible per covered person per year.

Orthodontia Care — Premium Dental Plan Only

Under the Premium Dental Plan only, the plan covers most orthodontia services and supplies (for covered adults and children) necessary to straighten and reposition teeth. Orthodontia benefits also include limited coverage for treatment of temporomandibular joint syndrome (TMJ). Charges for an orthodontia procedure that was performed before the patient was covered will not be covered.

How Orthodontia Benefits Are Paid...

The first payment you (or your orthodontist) receive will be based on 25% of the total covered charges for the entire orthodontia period and your payment will reflect a 50% co-payment. The balance of the total charge is prorated over the number of months your doctor projects your course of treatment will last. The plan does not make lump sum orthodontia payments. All payments will reflect a 50% co-payment. Orthodontia payments will cease when any patient who has been, but no longer is, an enrollee in the Premium Dental Plan. Remember, the plan’s maximum lifetime benefit for orthodontia is $1,500.

Maximum Benefits

General care and major/restorative dental services are limited to $750 per covered person per calendar year under the Basic Dental Plan, and $1,500 per covered person per calendar year under the Premium Dental Plan.

There is also a separate lifetime maximum benefit of $1,500 per covered person for orthodontia charges — regardless of age.
Dental Benefits

So, in a single year, the Premium Dental Plan could pay you up to $1,500 for your non-orthodontia expenses and another $1,500 for your orthodontia expenses. Each year after, you would be eligible for up to another $1,500 in non-orthodontia benefits.

What Is Not Covered

While both dental options cover a wide range of dental services and supplies, there are some charges not covered. These include (but are not limited to):

- Coverage for any patient who has been, but no longer is, an Enrollee.
- 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.
- Benefits or services which are determined by Delta Dental to be for Cosmetic purposes.
- Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the person became an Enrollee.
- Prescription drugs, premedications and relative analgesia; including nitrous oxide; hospital, healthcare facility or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.
- Benefits and services that are not necessary and customary as determined by the standards of generally accepted dental practice.
- Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for cosmetic purposes; for splinting or equilibration.
- Benefits or services for control of harmful habits.
- Treatment to correct congenital or developmental malformations.
- Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in the “What Is Covered” Section. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.
• Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; injuries intentionally self-inflicted; and injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting therefrom.

• Treatment rendered outside of the United States or Canada unless claims are submitted in English and converted to U.S. Dollars.

• Claims not submitted to Delta Dental within six (6) months of the date that the Covered Service was provided, however, if it was not reasonably possible to submit a claim within such six (6) month period, such claim shall be excluded only if it is either not submitted to Delta Dental as soon as reasonably possible or within two (2) years of the date of service, whichever is earlier.

• X-rays taken in conjunction with services which are not Covered Services.

• Temporary services and procedures, including, but not limited to, temporary filling, temporary crowns and temporary prosthetic devices. Sedative fillings are not a covered benefit if a definitive restoration is done on the same surface the same day as the sedative filling.

• Any service which is not a Covered Service.

• Crowns and endodontic treatment in conjunction with an overdenture.

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

• Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in the “What Is Covered” Section. If included as a Covered Service, Orthodontic Services will not be subject to this exclusion, but only if:
  • the Employer maintained a group dental program which was in effect immediately preceding the Effective Date, and
  • such program provided substantially the same coverage for Orthodontic Services as this Plan provides, and
  • the Enrollee was covered under such prior program immediately preceding the Effective Date.
Dental Benefits

- Dental benefits and services resulting from accidental injuries arising out of a motor vehicle accident, including motorcycles, to the extent such benefits and services are payable under any medical or dental expense payment provision (by whatever terminology used – including such benefits mandated by law) of any motor vehicle insurance policy. Such excluded expenses cannot be used for any purpose under the Agreement.

- 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.

- Dental benefits and services which are not completed.

- Charges for Covered Services or related supplies which no charge is normally made, or for which no charge would be made but for the Agreement, are not Covered Services.

- A restoration on the same tooth done within 24 months after a crown is seated.

What Is Covered

The dental benefits and services provided shall be limited as follows:

- If a more expensive Covered Service is provided than Delta Dental 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. The remainder of the fee is not a Covered Service and cannot be used for any purpose under the Plan.

- Some Covered Services may have specific age, frequency and coinsurance limitations and/or requirements for coverage. These are generally identified in the “What Is Covered” Section.

- Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are a Covered Services under the Agreement and then only if specifically included as a Covered Service in the “What Is Covered” Section.

- When Covered Services which are in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the allocation of payment to each Dentist.

- Prophylaxis, periodontal maintenance and oral evaluations may be subject to specific time and frequency limitations. Such
Dental Benefits

limitations are identified in the “What Is Covered” Section. Bitewing x-rays may be subject to specific age, time and frequency limitations. Such limitations are identified in the “What Is Covered” Section.

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

- Benefits for a seven (7) vertical bitewing series are not provided more frequently than once each two (2) years.

- Benefits for restoration of the occlusal surface on teeth 2, 3, 14, 15 are allowed twice in a 24 month period. Benefits which are available for restoration of other surfaces or other teeth are Covered Services only once within a twenty-four (24) month period regardless of the number or combinations of restorations placed therein. Restorations include fillings and inlays.

- Benefits which are available for recementation of space maintainers are covered once (1) per arch or quadrant. Recementation by the same dental office within 6 months of the initial placement of the space maintainer is not payable by the Plan or the Enrollee.

- Benefits which are available for 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 two (2) treatments per tooth per lifetime on unfilled molars unless the "What Is Covered” Section allows for other frequency limitations.

- Anterior inlays will automatically receive benefits equal to surface anterior composites. Posterior inlays will automatically receive benefits equal to surface amalgams. Posterior inlays will automatically receive benefits equal to surface posterior composites.

- Individual crowns on the same tooth are a Covered Service only once in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the 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 24 month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

- Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not Covered Services for any person under age twelve (12).
• Recementation of a crown may be allowed for payment only once in a lifetime.

• Only two (2) repairs per crown will be allowed in a twelve (12) month period.

• Stainless steel crowns are limited to once in a twenty-four (24) month period when placed on a Child under age twelve (12).

• Coverage for core build-ups, including pins, is limited to permanent teeth having insufficient tooth structure to build a crown.

• Not more than one full upper and one 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.

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

• Denture reline and rebase is a Covered Service only once in any thirty-six (36) month period for an Enrollee.

• Denture adjustments are a Covered Service only two (2) times in any twelve (12) month period for an Enrollee.

• Crowns when used for abutment purposes are a Covered Service at the same co-payment percentage as provided under the Agreement for bridges and complete and partial dentures.

• Recementation of a bridge is Covered Service only once in a twelve (12) consecutive month period.

• If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial toward the procedure submitted. If a fixed bridge or other more expensive procedure is selected, the remainder of the fee is not a Covered Service.

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

• Benefits for tissue conditioning are limited to no more than two (2) per arch each thirty-six (36) months.

• When covered, payment for root canal therapy is limited to only once in any twenty-four (24) month period.
• Payment for Periodontal procedures are limited to only once in any twenty-four (24) month period for all periodontal procedures.
  - Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis which is benefited as a prophylaxis and allowed once per lifetime.
  - Periodontal maintenance which is covered twice per year and crown lengthening carries no frequency limitation.

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

• Procedures for dental implants and associated services will be a Covered Service under the Premium Dental Plan, but only as follows:
  - The Dentist must submit to Delta Dental a written report of recommended treatment setting forth the type and number of implants to be used, radiographs to support the dental necessity of the implant procedures as required by Delta Dental, and the proposed fees for the entire procedure.
  - As determined by Delta Dental, the Covered Services may include benefits such as, but not limited to, consultations and surgical placement of implant devices (including the associated device and/or prosthesis) provided in conjunction with the dental implant procedures.
  - Benefits are limited to the lesser of: i) the amount of the lifetime maximum as stated above, or ii) the amount determined by Delta Dental to be allowable for dentures that are conventionally constructed using standard procedures, and which are of the same magnitude, i.e. complete upper, complete lower or complete upper and lower, as appropriate. Benefits in excess of such amounts are not Covered Services.

• If Orthodontic Services are a Covered Service, payment for Orthodontic Services shall be limited to the Maximum Benefit per Enrollee which is specified in the “What Is Covered” Section. Payment for Orthodontic Services shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of the treatment. Orthodontic payments will cease when any patient who has been, but no longer is, an enrollee in the Premium Dental Plan.
Dental Benefits

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

Filing Dental Claims

The Dental Plan is administered by Delta Dental of Kansas:

Delta Dental of Kansas
1-866-913-3375
Mon – Thurs: 7:00 a.m. - 6:00 p.m.
(Central Time)

Friday: 7:00 a.m. – 5:00 p.m.

How To File A Claim

If you use a Delta Dental network provider, there are no claim forms to file.

If you use a dentist not in one of the Delta Dental networks, you may have to file your claim.

Filing dental claims is easy...

- Obtain a claim form from Delta Dental Customer Service or visit www.deltadental.com. Be sure to select Kansas for the state.

- Complete the claim form and include the group/policy number for filing claims — shown on your dental identification card.

- Mail your completed claim form, along with any supporting documentation or itemized bills, to Delta Dental of Kansas. Be sure to keep copies of your claims for future reference.

- Reimbursement for dental services received from non-network dentists always will be paid to you. You will be responsible for paying the dentist.

Note: If you or your dependent has received other group benefits or Medicare benefits for the same expense that you are claiming and you have an Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB) form, you should send that form to Delta Dental along with your claim form.

Claim Filing Deadline

Dental claims must be filed with Delta Dental of Kansas no later than one year from the date of service. Claims submitted after that one-year period will not be paid.
Disputing Your Coverage or Claim Determination

If you or your dependent(s) are denied participation in, or eligibility to participate in, a welfare plan, or if you disagree with a claim determination, you have the right to file an appeal to request reconsideration. See the Legal Information document for important information on how to appeal and the applicable timeframes associated with the appeals process.

Pre-Determination Of Benefits

If any treatment suggested by your dentist is estimated to exceed $300, you should ask your dentist to file a Pre-Determination of Benefits form. This form lets you and your dentist know — in advance — how much will be paid for that charge. That way, there are no surprises and it can help you save money. Here is how it works...

Using the claim form, your dentist tells Delta Dental what your treatment will be and itemizes each service and its associated cost. (Most dentists are familiar with pre-determination procedures and have filled out similar forms before.)

Delta Dental reviews the treatment plan and determines what the benefit payment will be if the treatment is performed. This estimation does not include reductions in the benefit payment, which will occur for things such as:

- Coordination of benefits with other carriers; and
- Annual plan maximums.

For more information, see the “When You Are Covered By More Than One Plan” section.

Following the advice of a dental consultant, Delta Dental may suggest an alternate procedure as a less expensive way to treat a particular dental problem. If the pre-determined benefit you would receive from the plan is less than your dentist’s estimated cost, you can proceed with the treatment and pay the additional costs. Or, you can discuss an alternate course of treatment with your dentist.

If, for some reason, your dentist makes changes in your planned treatment other than those suggested by Delta Dental, a new form should be submitted for pre-determination.

Note: Pre-determination of benefits does not guarantee benefit payment — all other provisions of the dental options apply.
Today, many people are covered by more than one group dental plan. If this applies to you or your covered dependents, you must let Delta Dental know about the other coverage when you file a claim.

With the Sprint dental options, like most group plans, a coordination of benefits provision helps these situations. The provision coordinates benefits from all group dental plans — including benefits paid under a pre-payment, employer-sponsored or government program, except Medicare — covering you and your covered dependents. That is, the Sprint dental coverage and other group dental plans work together to pay covered expenses.

Coverage, however, is non-duplicative. So, if this plan is primary, it will pay benefits as if no other plan exists. If this plan is secondary, benefits paid by your Sprint dental option will be reduced by the benefits paid by the primary plan. Benefits from your Sprint dental option will be paid to the extent that, when benefits from both plans are added together, the total is not more than what your Sprint dental option would have paid if no other plan existed.

This coordination of benefits provision does not apply to any private personal insurance you may have.

**Which Plan Is Primary?**

Delta Dental of Kansas is responsible for determining which plan is considered primary — and, therefore, which pays benefits first. Here is how it works...

- If a covered dependent child is the patient, the plan covering the parent whose birthday comes earlier in the calendar year will pay first.
- If there is a court decree, which establishes financial responsibility for dental care of the child, the benefits of the plan which covers the child as a dependent of the parent so responsible will be determined before any other plan.

Otherwise...

- The benefits of the plan that covers the child as a dependent of the parent with custody will be determined before a plan which covers the child as a dependent of a stepparent or a parent without custody.
- The benefits of a plan that covers the child as dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

**Submitting Claims To Both Primary And Secondary Plans**

When covered expenses are incurred, you must submit a claim to the primary plan before the secondary plan. Once you receive benefits...
from the primary plan, you can submit a claim to the secondary plan. You must include a copy of payment from the primary plan.

When the Sprint dental coverage is considered secondary, benefits will be calculated as if it were primary. Then, the plan will subtract what was paid by the other plan and pay the remaining amount (if any), up to the total that would have been paid under the Sprint dental coverage alone.

### Helpful Numbers

<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>See your dental identification card</th>
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<tbody>
<tr>
<td>Customer Service:</td>
<td>1-866-913-3375</td>
</tr>
<tr>
<td>7:00 a.m. – 6:00 p.m. CT</td>
<td></td>
</tr>
<tr>
<td>Monday – Thursday</td>
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<tr>
<td>7:00 a.m. – 5:00 p.m. CT</td>
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<td>Friday</td>
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To find a PPO or Premier providers...

<table>
<thead>
<tr>
<th>Delta Dental of Kansas</th>
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<tbody>
<tr>
<td>Customer Service</td>
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<td>1-866-913-3375</td>
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<table>
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<tr>
<th>Internet</th>
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<tr>
<td><a href="http://www.deltadental.com">www.deltadental.com</a></td>
</tr>
</tbody>
</table>

### As Your Needs Change

In certain situations, you may change your enrollment in your Dental Plans – see the Life Events Section that is also part of a Summary Plan Description for the Plans, incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

### Right To Recover Payment

The Dental Plan has subrogation rights that are described in detail in the plan document. A copy of the plan document can be obtained by contacting the Employee Help Line.

In general, subrogation means that if you (or one of your dependents) receive benefits under the Dental Plan, and you (or one of your dependents) have a claim for recovery against another party, your claim will belong to the Dental Plan; up to the amount of benefits paid. You are required to assist the Dental Plan in enforcing its subrogated claim.

Any benefits paid by the Dental Plan for an injury or illness in which the plan has a right of subrogation are deemed made on the condition that the Dental Plan will be reimbursed. The Dental Plan also has certain additional rights described in detail in the Dental Plan document.
Dental Benefits

When Coverage Ends

For information on when your coverage under the Dental Plans ends, see the separate Eligibility & Enrollment Section of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

Tax Considerations...
If you have significant non-reimbursed dental expenses during a calendar year, those expenses may be tax deductible — consult your tax advisor if this applies to you.
Dental Benefits

Definitions

**Anesthesia**

Local anesthesia is the administration of specific agents to achieve the loss of conscious pain response in a specific location of the body.

General anesthesia is the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Anesthetic is a drug that produces loss of feeling or sensation either generally or locally.

Appliance is a device used to provide a functional or a therapeutic (healing) effect.

**Bitewing X-ray** is an x-ray showing exposed portions of teeth, used primarily for early detection of hidden decay between teeth.

**Bridge, Bridgework**

Fixed Bridge is a non-removable replacement for a natural tooth or teeth. It is cemented to natural teeth that are used as abutments on either side. Removable Bridge is a partial denture normally held by clasps to natural teeth, permitting removal as desired.

Cavity is a portion of tooth destroyed by decay; requires filling or sometimes more extensive treatment.

Co-insurance is the percentage of the maximum plan allowance of covered dental expenses for which you and the plan share responsibility for payment after you have paid the deductible, if applicable.

Coordination of Benefits is a provision that coordinates benefits from all group dental plans. Dental coverage works together with other group dental plans to pay covered expenses. Coverage is non-duplicative. If you have coverage by more than one group dental plan, this plan, together with payments from other plans, will never pay more than what you would have received if this were your only plan.

Covered Expenses are the expenses that are eligible for reimbursement under the plan. See “What Is Not Covered” for a list of some services not covered. Covered expenses will include only those expenses incurred for such charges when the service is performed by or under the direction of a dentist and is essential for the necessary care of the teeth and starts and is completed while the person is covered.

Crown is a dental restoration usually covering the whole exposed (coronal) portion of a tooth. It is most often made of porcelain, gold or acrylic and frequently used in bridgework or to restore a badly broken or decayed tooth.
Deductible is the amount you pay each year before the plan begins to pay benefits for non-preventive services. No deductible is required before the plan pays benefits for preventive services. The deductible applies to you and each covered person in your family once each calendar year. The deductible is per covered person — there is no family maximum.

Delta Dental PPO and Delta Dental Premier are networks of dentists contracted with Delta Dental to provide discounted services.

Dental Hygienist is an individual licensed to remove calcium deposits and stains from the surfaces of teeth, and to provide additional services and information on the prevention of oral disease.

Dentist is an individual licensed to practice dentistry by the governmental authorities who have jurisdiction over the licensing and practice of dentistry, in the locality where the service is rendered.

Denture is a removable replacement for natural teeth. Full denture is a denture replacing all teeth in an upper or lower jaw. Partial denture is a denture replacing some, but not all, of the upper or lower teeth.

Endodontics is the treatment of diseases within the root, primarily root canal therapy.

Extraction is the removal of a natural tooth.

Filling is material inserted in a tooth to fill a cavity as opposed to that which covers it (crown).

Fluoride is a substance used in preventing tooth decay.

Impaction is a tooth partly or wholly buried under the gum by bone or tissue.

Individual Maximum Benefit is a maximum amount the plan pays for each covered person. There are non-orthodontia annual and orthodontia lifetime individual maximum benefits, and they are separate from one another. Orthodontia expenses are not applied to the non-orthodontia individual maximum benefit, and likewise, non-orthodontia expenses are not applied to the orthodontia individual maximum benefit.

Inlay is a restoration that is extended to cover the entire surface of the tooth. It often is used to restore lost tooth structure and increase height of tooth.

Maximum Plan Allowance is determined by the lesser of the participating dentist’s submitted fee or the Delta participating dentist maximum fee. The Delta participating dentist maximum fee is developed from a number of sources, including but not limited to contracts with dentists, input from dental consultants, consideration of the relative simplicity or complexity of the procedure, the billed charges for the same procedures by other dentists, and such other information as Delta Dental, in its sole discretion, deems appropriate.
Non-participating dentists’ reimbursement is based, in part, on the average fee submitted by participating dentists.

**Medically Necessary** is a term applied to services or supplies required to diagnose or treat a patient in accordance with standards of good dental practice. This includes both the frequency and duration of treatment, as established by appropriate dental associations.

**Onlay** is an indirect filling which is pre-made in a dental lab and must be permanently cemented by the dentist. An onlay sits on the tooth and builds up its shape.

**Oral Surgery** is surgery of the oral mouth cavity, including teeth, tongue and throat. It may be dental or non-dental in nature. If dental in nature, the surgery costs are covered by dental coverage and the hospital costs (if inpatient) are normally covered by medical coverage. If non-dental in nature, the costs are covered by medical coverage.

**Orthodontics** is the branch of dentistry primarily concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in their relationship to the jaws (commonly, teeth straightening or repositioning).

**Periodontics** is the treatment of diseases of the gum and tissue around the teeth.

**Prophylaxis** is the mechanical cleaning of teeth to remove plaque and tartar.

**Prosthetics** is the artificial replacement of natural teeth (bridges and dentures).

**Pulp** is the soft tissue inside the crown and roots of a tooth, composed of nerves, blood vessels and other tissues. This is the part of the tooth in which root canal therapy is done.

**Restoration** is a broad term applied to any filling, inlay, onlay, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

**Root Canal Therapy (Endodontic Therapy)** is the treatment of a tooth having a damaged pulp that is usually performed by completely removing the pulp chamber and root canals, and filling these spaces with scaling material.

**Surface** is a term that refers to one of the four sides of a chewing area of a tooth. A one-surface filling is inserted in only one surface of a tooth; a two-surface filling is one which includes two adjoining surfaces of the same tooth in a single filling.

**TMJ (Temporomandibular Joint Dysfunction)** is a disorder involving the joint linking the jawbone and the skull. Treatment of this disorder is covered with limited coverage by the Orthodontia portion of the Premium Dental Plan.
Topical Fluoride is the painting of the surface of teeth as in fluoride treatment, or application of a cream-like anesthetic formula to the surface of the gum.

Third Party Administrator/Claims Payor is the company that pays benefits or administers the payment of benefits under the plan.

Other Important Information

For other important information about the Dental Plans’ Plan Sponsor and Administrator, participating employees, Plan identification, service of legal process, ERISA rights, including claims and appeals procedures, and other legally required notices regarding the Dental Plans, see the separate Legal Information Section of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.