

Delta Dental of Nebraska

DELTA DENTAL PPO™ PLUS PREMIER® - COMPREHENSIVE ENHANCED

with Orthodontic Coverage

Dental Benefit Plan Summary

Thrasher, Inc.
Client Number 000459

High Option

ADMINISTRATION

The following information is provided as required by the Employee Retirement Income Security Act (ERISA) of1974.

PLAN SPONSOR, FIDUCIARY AND PLAN ADMINISTRATOR:
Thrasher, Inc.
11844 Valley Ridge Dr.
Papillion, NE 68046

AGENT FOR SERVICE OF LEGAL PROCESS:
Thrasher, Inc.
11844 Valley Ridge Dr.
Papillion, NE 68046

PARTICIPATING EMPLOYERS:
Thrasher, Inc.
Support Works, Inc.
GNMC, LLC

FUNDING: Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

EMPLOYER IDENTIFICATION NUMBER: Thrasher, Inc. - 38-3805565, Support Works, Inc. – 38-3805564

PLAN NAME: Thrasher, Inc. Dental Plan

EMPLOYER PLAN NUMBER: 501

TYPE OF PLAN: Health and welfare benefits plan including dental benefits

PLAN YEAR: January 1 – December 31

DELTA DENTAL CLIENT NUMBER: 000459

PLAN BENEFITS ADMINISTERED BY:
Delta Dental of Nebraska
P.O. Box 9124
Farmington Hills, MI 48333-9124
(866) 827-3319
www.DeltaDentalNE.org

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Client Dental Program
(**PROGRAM**) prepared for Covered Persons with:

Thrasher, Inc.
(**CLIENT**)

This Program has been established and is maintained and administered in accordance with the provisions of your Client Dental Plan Contract Number **000459** issued by Delta Dental of Nebraska (**PLAN**).

This booklet is subject to the provisions of the Client Dental Plan Contract. If there is an inconsistencybetween this booklet and the Client Dental Plan Contract, the Client Dental Plan Contract controls.

DELTA DENTAL OF NEBRASKA

Administrative Offices
Delta Dental of Nebraska
P.O. Box 9124
Farmington Hills, MI 48333-9124
(866) 827-3319
www.DeltaDentalNE.org

The Plan Administrator is required by law to maintain the privacy of your Protected Health Information, to provide you with notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. Delta Dental of Nebraska is obligated to protect the privacy of your Protected Health Information because it provides administrative services for your dental benefits. Because Delta Dental is not the Plan Administrator for your dental benefits nor is it acting as an insurer of your dental benefits, your Plan Administrator's Notice of Privacy Practices shall control.

DELTA DENTAL OF NEBRASKA NOTICE OF INFORMATION PRACTICES

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

Delta Dental of Nebraska is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI").
Health care includes dental care.

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health careoperations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has beenpreviously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of dental services that were performed or to check for fraud and abuse.

We may not, however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

We may be asked by the sponsor of your dental benefits to provide your PHI to the sponsor. We will do so if permitted by law.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, orany other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In other situations not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that

authorization to stop any future usesand disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at www.DeltaDentalNE.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set byus. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or addthe missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our informationpractices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in yourrecord, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

Customer Service
P.O. Box 9124
Farmington Hills, MI 48333-9124
(866) 827-3319

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SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta Dental is different for Delta Dental PPO™ dentists, Delta Dental Premier® dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

Service Category Description	***Delta Dental PPO™ Dentists***	***Delta Dental Premier® Dentists***	***Nonparticipating Dentists***
Diagnostic and Preventive Services	100%	100%	100%
Basic Services	85%	85%	80%
Endodontics	85%	85%	80%
Periodontics	85%	85%	80%
Oral Surgery	85%	85%	80%
Major Restorative Services	50%	50%	50%
Prosthetic Repairs and Adjustments	50%	50%	50%
Prosthetics	50%	50%	50%
Orthodontics	50%	50%	50%

Benefit Maximums

The Program pays up to a maximum of $1,500 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Orthodontics is subject to a separate lifetime maximum of $3,000 per Covered Person and limited to those orthodontic treatment plans commenced on or after the Eligible Covered Person's eighth (8th) birthday. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Plan in order to receive continued benefit payments.

Deductible

There is a $50 deductible per Covered Person each Coverage Year not to exceed three (3) times that amount ($150) per Family Unit.

The deductible does not apply to Diagnostic and Preventive or Orthodontic services.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 to December 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

IT IS A GOOD IDEA TO GET A PRETREATMENT ESTIMATE FOR YOUR DENTAL CARE THAT INVOLVES MAJOR RESTORATIVE, PERIODONTIC, PROSTHODONTIC, OR ORTHODONTIC CARE. THE PRETREATMENT ESTIMATE IS RECOMMENDED, BUT NOT REQUIRED FOR YOU TO RECEIVE BENEFITS FOR COVERED DENTAL CARE. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS YOU HAVE AND IF THE TREATMENT IS COVERED.THE PRETREATMENT ESTIMATE OUTLINES WHAT YOU HAVE TO PAY TO THE DENTIST, SUCH ASCO-PAYMENTS AND DEDUCTIBLES. IT ALLOWS THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE YOUR TREATMENT BEGINS. THIS PROCESSDOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED PAYMENT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE ESTIMATE. THIS IS AN ESTIMATE ONLY. FINAL PAYMENT WILL BE BASED ON THE CLAIM THAT IS SUBMITTED ONCE THE TREATMENT IS COMPLETED. SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN YOUR COVERAGE, OR OTHER COVERAGE YOU HAVE MAY ALTER THE PAYMENT.

After the exam, your dentist will tell you the dental treatment that should be given. If the dental treatment involves major restorative, periodontics, prosthetics, or orthodontic care, the dentist should submit a claim form to the Plan for the proposed treatment. The plan will review and determine if the treatment is coveredand estimate the amount of payment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible to pay for any deductibles and coinsurance amounts. You will also be responsible to pay for any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Thebenefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in whicha dentist's care is provided, such information and records relating to a Covered Person as may be requiredto pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PREMIER®AND DELTA DENTAL PPO™ NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Nebraska performs dental necessity reviews to determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition,they may not be covered by us. There may be an alternative

dental care service available to you that is covered under your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. The decision as to what dental care treatmentis best for you is solely between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summaryof Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

We cover the following dental care services when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of films per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)** - 4 single X-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.
- **Extraoral** – Covered 2 times per calendar year.

Dental Cleaning

- **Prophylaxis or Periodontal Maintenance** - Any combination of these procedures is covered 2 times per calendar year.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per calendar year through the age of 13.

Silver Diamine Fluoride Silver Diamine Fluoride – Covered 2 times per tooth, per calendar year.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered 1 time per lifetime.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 18 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

Sealants or Preventive Resin Restorations - Covered 1 time per 36-month period for permanent first and second molars of eligible dependent children through the age of 13.

Genetic Test for Susceptibility to Oral Diseases – Covered 1 time per lifetime for members ages 18 and over.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Consultation, other than practitioner providing treatment – Covered 1 time per 12-month period.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth Composite (white) Resin Restorations**
  - If the posterior (back) tooth requires a restoration due to decay or fracture;
  - If no other posterior (back) composite (white) resin restoration for the same or additional tooth surface(s) was performed within the last 24 months.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only 1 service per tooth surface per 24-month period.

Pre-fabricated or Stainless Steel Crown - Covered once per 36-month period for eligible dependent children through the age of 18.

LIMITATION: Prefabricated resin crowns are covered for primary and permanent anterior teeth only.

Laboratory Processing of Microbial Specimen and Accession of Tissue, Gross and Microscopic Examination – Covered only when submitted in conjunction with codes D7285-D7288, D7440-D7461. This benefit pays secondary to medical and must have a pathology report.

Therapeutic Drug Injections

Infiltration of Sustained Release Therapeutic Drug, Per Quadrant

Adjunctive General Services

- **Deep Sedation/General Anesthesia, Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical services.

  LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS - Coverage is NOT provided for:

1. Medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents and tooth bonding.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Pulp vitality tests.
7. Diagnostic casts
8. Adjunctive diagnostic tests.
9. Restorations placed for preventive or cosmetic purposes.
10. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

Basic Endodontic Services (Nerve or Pulp Treatment)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Apicoectomy**
- **Root Amputation on posterior (back) teeth**

Complex or other Endodontic Services

- **Apexification** - For dependent children through the age of 18.
- **Retrograde filling**
- **Hemisection, includes root removal**

Pin Retention – Per Tooth, In Addition to Restoration – Covered 1 time per 10-year period.

EXCLUSIONS - Coverage is NOT provided for:

1. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
2. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
3. Intentional reimplantation.
4. Pulp vitality tests.
5. Incomplete root canals.

Periodontics (Gum & Bone Treatment)

Basic Non-Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per quadrant in any 24 month period.
- **Full mouth debridement** – Covered 1 time per lifetime

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Apically positioned flap**
- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36 month period per single tooth or multiple teeth in the same quadrant.

Antimicrobial Agents, Per Tooth – Covered 1 time per 12-month period.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

Oral Surgery (Tooth, Tissue, or Bone Removal)

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth

- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Tooth reimplantation – accidentally evulsed or displaced tooth
- Exposure of an unerupted tooth
- Biopsy of oral tissue
- Alveoloplasty
- Vestibuloplasty
- Surgical repositioning of teeth
- Frenulectomy (frenectomy or frenotomy)
- Excision of lesion or tumor
- Removal or nonodontogenic or odontogenic cyst or tumor
- Mobilization of erupted or malpositioned tooth to aid eruption
- Removal of exostosis
- Incision & drainage of abscess
- Partial ostectomy

Temporomandibular Joint Disorder (TMJ)

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre- treatment Estimate of Benefits is recommended.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided, however, that such procedures are dental reconstructive surgical procedures.

2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

   For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

   For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract

shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Transseptal fiberotomy.
2. Oroantral fistula closure.
3. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
4. Medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
5. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
6. Inpatient or outpatient hospital expenses
7. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
8. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
9. Implant maintenance or repair to an implant or implant abutment.

COMPLEX OR MAJOR RESTORATIVE SERVICES

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays – Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays - Covered 1 time per 10 year period per tooth.

Permanent Crowns - Covered 1 time per 10 year period per tooth.

Implant Crowns - See Prosthetic Services.

Crown Repair - Covered 1 time per 12 month period per tooth.

Core Buildup, Includes any pins – Covered 1 time per 10-year period.

Crown Cast Post/Core – Covered 1 time per 10-year period.

Veneers – Covered on anterior teeth only, 1 time per 10 year period for covered persons age 16 and older.

Additional Procedures to Customize a Crown to Fit Under an Existing Partial Denture Framework – Covered 1 time per 10-year period.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown

lengthening.

2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Temporary, provisional or interim crown.
6. Occlusal procedures including occlusal guard and adjustments.
7. Inlays, onlays or crowns placed for preventive or cosmetic purposes.
8. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

Prosthetic Services (Dentures, Partials, and Bridges)

Tissue conditioning

Interim Partial Denture – Covered 1 time per 5-year period for covered persons age 15 and under on anterior (front) teeth.

Denture Repairs

Partial Denture Repairs

Reline Dentures – Covered 1 time per 36-month period.

Rebase Dentures – Covered 1 time per 36-month period.

Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)
- Covered 2 times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments – Covered 1 time per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 10 year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 10 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 10 year period:

- for covered persons age 16 or older;

- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 10 years;
- if 10 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) - A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
4. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
5. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
6. Services or supplies that have the primary purpose of improving the appearance of your teeth.
7. Placement or removal of sedative filling, base or liner used under a restoration.
8. Coverage shall be limited to the least expensive professionally acceptable treatment.
9. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
10. Implant maintenance or repair to an implant or implant abutment.

ORTHODONTICS
Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Limited Treatment
Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment
A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment
Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

LIMITATION: Covered eligible persons from the age of 8.

EXCLUSIONS - Coverage is NOT provided for:
1. Monthly treatment visits that are inclusive of treatment cost;
2. Orthodontic retention/retainer as a separate service;
3. Retreatment and/or services for any treatment due to relapse;
4. Inpatient or outpatient hospital expenses; and
5. Provisional splinting, temporary procedures or interim stabilization of teeth.

Payment for Orthodontic Service
Because orthodontic treatment normally takes place over a long period of time, payments for benefits are made over the course of treatment. The Covered Person must continue to be eligible under the Plan in order to receive ongoing payments for orthodontic benefits. Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits when treatment begins (appliances are installed). Delta Dental will make additional payments as follows: Delta Dental will pay the remaining 70% of the Maximum Payment for Orthodontic Services in 8 (eight) quarterly payments after your benefits and eligibility have been verified at the time of payment. Orthodontics must be performed and supervised by a licensed dentist or orthodontist who has established the need for such procedures through a complete in-person oral examination, and has developed a proper treatment plan through adequate diagnostic activities, including radiographic imaging.

Exclusions
Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance.

b) Dental services or health care services not specifically covered under the Client Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for elective or cosmetic purposes. NOTE: Dental services may be subject to pre-payment clinical review of dental records. If services are found to not be dentally necessary, we reserve the right to deny such services and the member is responsible for the full charge. Dental services are subject to post-payment clinical review of dental records. If services are found not to be dentally necessary, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding.

l) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

m) Incomplete, interim or temporary services.

n) Athletic mouth guards, enamel microabrasion and odontoplasty.

o) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

p) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

q) Bacteriologic tests.

r) Cytology sample collection.

s) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

t) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

u) Transseptal fiberotomy.

v) Oroantral fistula closure.

w) The replacement of an existing partial denture with a bridge.

x) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

y) Provisional splinting, temporary procedures or interim stabilization.

z) Placement or removal of sedative filling, base or liner used under a restoration.

aa) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

bb) Occlusal procedures including occlusal guard and adjustments.

cc) Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.

dd) Implant maintenance or repair to an implant or implant abutment.

ee) Pulp vitality tests.

ff) Adjunctive diagnostic tests.

gg) Diagnostic casts.

hh) Incomplete root canals.

ii) Cone beam images.

jj) Anatomical crown exposure.

kk) Temporary anchorage devices.

ll) Brush biopsy and the accession of a brush biopsy.

mm) Restorations placed for preventive or cosmetic purposes.

nn) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

oo) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

Limitations

a) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician provided, however, that such services are dental reconstructive surgical services.

b) Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodonticcoverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy orcontract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed, are subject to recovery. Delta Dental's right to conduct postpayment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to whichcourse of treatment to be followed shall be solely that of the Covered Person and the dentist; however, thebenefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

Covered Persons under this Program are:

Employees

a) All eligible employees who have met the eligibility requirements as established by the Client and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.

b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

1. Married;
2. Legally separated.

B) Dependent children to the age of 26, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation oftotal or partial support.
2. Stepchildren who reside with you.
3. Grandchildren who are financially dependent on and reside with the covered grandparent.
4. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
5. Children for whom you or your spouse are the legal guardian.
6. Disabled children age 26 and older if:
    - they are primarily dependent upon you; and
    - are incapable of self-sustaining employment because of developmental delay, mental illness or mental disorder or physical disability.

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under eitherparent's coverage, but not both.

Effective Dates of Coverage

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, January 1, 2021, or if you are a new employee of the Client, on the first of the month following 30 days of employment.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.
b) On the date you first acquire eligible dependents, or add dependent coverage subject to the openenrollment requirements of the Client, if any.
c) On the date a new dependent is acquired if you are already carrying dependent coverage. LIMITATION: Dependents of an eligible employee who are in active military service are not eligible forcoverage under the Program.

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption)and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person bythe Client on a

current basis.

Open Enrollment

The Open Enrollment under this Contract shall be held annually.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the CoverageYear, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, placement for adoption or death.
- Change in your or your spouse's employment – either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, such as if a child reaches maximum age under the Plan.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Qualification for Medicare or Medicaid.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it not consistent to drop your dental coverage altogether.

If you experience one of the following eligible Family Status Changes during the year, you have 31 days *(except in the case of the birth/adoption of a child - See Effective Dates of Coverage as stated above)* fromthe event to change your elections. If you do not change your benefits within 31 days of the event, you willnot be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of Benefits: Covered employees who are absent due to service in the uniformed servicesand/or their covered dependents may continue coverage under USERRA for up to 24 months after the date the covered employee is first absent due to uniformed service duty. To continue coverage under USERRA,covered employees and/or their dependents should contact their Employer.

Eligibility: A covered employee is eligible for continuation under USERRA if he or she is absent from employment because of service in the uniformed services as defined in USERRA. This voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered employees and dependents who have coverage under the Plan immediately prior to the date of the covered employee's covered absence are eligible to elect continuation under USERRA.

Contribution Payment: If continuation of Plan coverage is elected under USERRA, the covered employeeor covered dependent is responsible for payment of the applicable cost of COBRA coverage. If, however,the covered employee is absent for not longer than 31 calendar days, the cost will be the amount the covered employee would otherwise pay for coverage (at employee rates). For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the covered employee's share and any portion previously paid by the Employer.

Duration of Coverage: Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months, beginning the first day of absence from employment due to service in the uniformed services;
- the day after the covered employee fails to apply for or return to employment as required by USERRA, after completion of a period of service;
- the early termination of USERRA continuation coverage due to the covered employee's court-martial or dishonorable discharge from the uniformed services; or
- the date on which this Plan is terminated so that the covered employee loses coverage.

Covered employees should contact their Employer with any questions regarding continuation coverage andnotify the Employer of any changes in marital status or a change of address.

Reemployment: An individual whose coverage under the Plan was terminated by reason of service in theuniformed services and who did not continue coverage during leave must, nevertheless, the entitled to reinstatement of coverage upon reemployment.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

a) The end of the month in which (1) you cease to be eligible; (2) your dependent is nolonger eligible as a dependent under the Program.

b) On the date the Program is terminated.

c) On the date the Client terminates the Program by failure to pay the required Client Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Client or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subjectto applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage

Dental benefits may be continued should any of the following events (called Qualifying Events) occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program. You and your dependents may have to pay for this coverage. There are also other coverage options available to you and your family through the Health Insurance Marketplace (also called the Exchange) in your state. Being eligible for Continuation of Coverageunder this Plan does not limit your eligibility for coverage through the Marketplace. For more information about health and dental insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement,leave of absence, lay-off, or areduction in hours that causesthe employee to become ineligible (except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, 2. Enrollment in other group coverage; or 3. Date coverage would otherwise end.
Divorce, marriage dissolution, or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. Enrollment date in othergroup coverage, or 2. Date coverage would otherwise end.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would have otherwise terminated under the contract had the employee lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility dueto Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. Date total disability ends, or 2. Date coverage would otherwise end.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due tothe bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in othergroup coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Client that you wish to continue coverage.

1. Choosing Continuation

   If you lose coverage, due to a termination of employment (except if the termination is for gross misconduct), retirement, leave of absence, lay-off, or reduction in hours, your employer should notify you of the option to

continue coverage within 14 days after your loss of coverage. You or your covereddependents must notify your employer of divorce, legal separation, or any other change in dependent status within 60 days of the event.

You or your covered dependents must choose to continue coverage by completing, in writing, the election notice that your employer sends to you. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or yourcovered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

Charges for continuation are the client rate plus a two percent administration fee. All charges are paiddirectly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the client rate plus a two percent administration fee for the first 18 months. For months19 through 29, the employer may charge the client rate plus a 50 percent administration fee.

2. Second qualifying event

If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies whenthe initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlierof the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage

Continuation of Coverage for you and your eligible dependents, if elected, shall terminate on the lastday of the month in which any of the following events first occur:

a) The expiration of the specified period of time for which Continuation of Coverage can bemaintained; as mandated by applicable State or Federal law;

b) This Program is terminated by the Client Subscriber;

c) The Client Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage;

Questions regarding Continuation of Coverage should be directed to your employer. Your employer willexplain the regulations, qualifications and procedures required when you continue coverage.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental Premier® dentist is a dentist who has signed a Delta Dental Premier® membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist whois a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier® dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier® dentist has also agreed to file the claim directly with Delta Dental.

A Delta Dental PPO™ dentist is a dentist who has signed a Delta Dental PPO™ membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept the Delta Dental PPO™ allowable charge as paymentin full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO™ dentist has agreed not to bill more than the Delta Dental PPO™ allowable charge. A Delta Dental PPO™ Option dentist has also agreedto file the claim directly with Delta Dental.

Listings of participating providers are available to Subscribers as a separate document and are furnished by the Client without charge. Names of Participating Dentists can be obtained, upon request, by calling Delta Dental, from directory listings furnished to the Client or from the Plan's internet web site at www.DeltaDentalNE.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a Delta Dental Premier Delta Dental PPO™ dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentistwith Delta Dental. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PREMIER®AND DELTA DENTAL PPO™ NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Notice of Claim

Written notice of claim must be given to Delta Dental within 20 days after the occurrence or commencementof any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Policyholder or the beneficiary shall be presented to Delta Dental at P.O. Box 9120, Farmington Hills, MI 48333-9120.

Claim Forms

Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished forfiling proofs of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you shall be deemed to have complied with the requirements of this policy.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVEBEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOURPROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING.IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSONOR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier® Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dentalapproves for dental services provided by a Delta Dental Premier ®dentist to a Delta Dental covered patient.The Plan Payment Obligation for Delta Dental Premier® dentists is the lesser of: (1) The Maximum AmountPayable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the DeltaDental Premier® dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Delta Dental PPO™ Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dentalapproves for dental services provided by a Delta Dental PPO ™ dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO ™ dentists is the lesser of: (1) The Delta Dental PPO ™ MaximumAmount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental PPO™ dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the amount established solely by Delta Dental. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE CLIENT CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the "Allowable Charges" is paid jointlyby the programs. "Allowable Charges", as defined above, are determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as adependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits

provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

Time of Payment of Claim

Any benefits due under this Policy for any loss other than loss for which this Policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss.

Claim and Appeal Procedures

Proof of Loss
All claims should be submitted within 12 months of the date of service**.** If you do not submit a claim within the time required, it will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. You must submit your proof as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Initial Claim Determinations
An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive a written notice of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the end of the initial 30-day period. We will tell you the reasons we require an extension and the date by which we expect to make a decision. If the extension is needed for us to get additional information from you, the notice will describe the specific information we need. You will have 45days from the receipt of the notice to provide us with the information. Without complete information, your claim will be denied.

Appeals
In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted to us within 180 days from the claim denial.We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, Client number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Nebraska
Attn: Professional Services Appeals and Grievances
PO Box 30416
Lansing, MI 48909

You may submit written comments, documents, or other information that you feel supports your appeal. Upon request, you will also be given reasonable access to and copies of all relevant records that are used in making the decision. These records will be given to you at no charge. The review will take into account all information about the denied or reduced claim, even if the information was not present or available at the time of the initial determination. In this review, the initial determination of the claim will notbe given any weight.

The review will be done by someone different from the original decision-makers and will not take into consideration any prior decisions made in your claim. Because all decisions are based on a preset schedule of dental services that are covered by your plan, claims are not reviewed to determine dentalnecessity or appropriateness. If we need to consult a professional to determine if a service is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. This professional will not be the same person who was involved in the initial adverse benefit determination

(nor a subordinate of any such person). We will identify any dental professional whose advice was obtained on our behalf, even if the advice was not used in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable toyour estate. Any other accrued indemnities unpaid at your death may, at your option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to you.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta Dental under the Contract. As Claims Administrator, Delta Dental pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

Delta Dental of Nebraska will not disclose non-public personal financial or health information concerning persons covered under this dental benefit Program to non-affiliated third parties except as permitted by lawor required to adjudicate claims submitted for dental services provided to persons covered under this dentalbenefit Program.

Change of Beneficiary

Unless you make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to you and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignmentof this Plan or to any change of beneficiary or beneficiaries, or to any other changes in this Plan.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user friendly web site, www.DeltaDentalNE.org. The Plan highly recommends use of the web site for the most accurate network information. Go to www.DeltaDentalNE.org/find-a-dentist and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site alsoallows you to print out a map directing you to the dental office you select. **The Find A Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Find A Dentist" on the www.DeltaDentalNE.org home page. Select the Product or Network in the drop-down menu, and search bycity and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although

you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to state specifically state that your employer is providing the Dental program.**

- Contact our Customer Service Center at: (866) 827-3319. Customer Service hours are 7 a.m.to 7 p.m., Monday through Friday, Central Time.

- Check with your employer, who has a copy of the Dental provider directory.

Using Your Dental Program

Dentists who participate with Delta Dental under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta Dental cannot and does not make any representations as to the qualityof treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Nebraska - (866) 827-3319

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

* YOUR DELTA DENTAL CLIENT NUMBER
* YOUR EMPLOYER (CLIENT NAME)
* YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Client Dental Plan Contract,or at any time the Client fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Client have no right to continue coverage under the Program or convert to an individual dental coverage contract.

Physical Examination and Autopsy

Delta Dental at its own expense shall have the right and opportunity to examine the person of the insured

when and as often as it may reasonably require during the pendency of a claim hereunderand to make an autopsy in case of death where it is not forbidden by law.

Time Limit on Certain Defenses

(a) After two years from the date of issue of this Program no misstatements, except fraudulent misstatements, made by the applicant in the application for such Program shall be used to voidthe contract or to deny a claim for loss incurred or disability (as defined in the Contract) commencing after the expiration of such two year period. After this Program has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. (b) No claim for loss incurred or disability (as defined in the Contract) commencing after two years from the date of issue of this program shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Program.

Legal Actions

No action at law or in equity shall be brought to recover on this Program prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Program. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary underthe Program and shall be responsible for the management and control of this Program.

The Plan Administrator is responsible for determining the level of benefits for the Program as described inthis brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

Funding Policy and Payment

The funding policy and method requires that the Client Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside frontcover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitledto:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law tofurnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Client, your union, or any other person, may fire you or otherwisediscriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In sucha case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 aday until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or inpart, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S.Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fee, for example, if it finds yourclaim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator.If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the EmployeeBenefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publicationsabout your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DELTA DENTAL OF NEBRASKA

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(866) 827-3319

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