EMPLOYER ACKNOWLEDGMENT
WITH RESPECT TO PREPARATION OF
DENTAL BENEFIT PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

This Document Preparation Acknowledgment is dated January 1, 2021 (the "Acknowledgment"), by and between Revolution Company (the "Employer") and Delta Dental of Arkansas (the "Document Provider").

The Employer has established, or is in the process of establishing, the Value Plan (the "Plan") using the Dental Benefit Plan Document/Summary Plan Description (the "Document") prepared by Document Provider.

1. No Legal or Tax Advice. The Employer acknowledges that it is responsible for obtaining independent legal and tax advice with respect to the operation of the Plan, including (but not limited to) the effect of this Acknowledgment, the Document and any applicable forms. **Neither the Document Provider nor any of its Affiliates provides legal or tax advice,** and gives no assurances to the Employer, any Participant or Participant's beneficiary, or to any third party, as to the legal effect of the Document or any forms associated with the Document. The Document Provider disclaims any warranties, express or implied, concerning the legal or tax advice actually obtained by the Employer.

2. Employer Operations. The Employer acknowledges that the Plan Document reflects the Employer's operations as represented to the Document Provider by the Employer, and further that Employer is responsible for conforming its operations to the provisions of the Plan.

3. Combined Document. The Document combines the plan document and the summary plan description into one instrument. Without limiting the comprehensive effect of this Acknowledgment, the Employer specifically acknowledges that Document Provider does not give any assurance that combining the plan document and the summary plan description satisfies the requirement under sections 102 and 104 of the Employee Retirement Income Security Act of 1974 to provide Participants with a summary plan description.

To make this Acknowledgment legal and binding, a proper officer of the Employer and a proper officer of Delta Dental of Arkansas must sign below.

Each signer represents that he or she is a proper officer of and has full authority to execute this Acknowledgment as an obligation of the party for which he or she signs. Each signer represents that his or her party obtained legal advice concerning this Acknowledgment and the Document to the extent that his or her party considered necessary.

EMPLOYER
Revolution Company

By: ________________________________

Name: ______________________________

Title: _______________________________

DOCUMENT PROVIDER
Delta Dental of Arkansas

By: ________________________________

Name: ______________________________

Title: _______________________________

Revolution Company

Dental Benefit Plan Document/ Summary Plan Description

Administered by
Delta Dental of Arkansas

By: ________________________________
(Authorized Signature)

Title:_______________________________

Date:_______________________________

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INTRODUCTION

Revolution Company (EMPLOYER) established a self-funded dental plan, Value Plan (PLAN), *effective* January 1, 2021 for the benefit of its ELIGIBLE EMPLOYEEs and DEPENDENTs. The PLAN is intended to qualify as an accident and health plan within the meaning of Section 105(e) of the CODE, and that the BENEFITS provided under the PLAN be eligible for exclusion from the ELIGIBLE EMPLOYEEs' income under Section 105(e) of the CODE.

This document is the primary source of information about your benefit program under the PLAN; it serves as the PLAN DOCUMENT and the SUMMARY PLAN DESCRIPTION as required by Section 402 of ERISA. It includes information you need to know about eligibility for BENEFITS, BENEFITS available, and how to file a CLAIM for BENEFITS.

All terms and provisions contained herein shall be interpreted, wherever possible so as to be in compliance with the requirements for qualification as an accident and health plan as defined under Section 105(e) of the CODE.

The PLAN will pay BENEFITS only for the expenses incurred while this coverage is in force. No BENEFITS are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this PLAN until the PLAN COVERED PARTICIPANT has exhausted all administrative claims procedures under the PLAN. The CLAIMS PROCEDURES of this SUMMARY PLAN DESCRIPTION describe the claims procedures under the PLAN.

ARTICLE 1. DEFINITIONS

As used in this PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION:

The definitions of certain capitalized words used in this PLAN are set forth in this Article 1. Unless defined within the text of this PLAN or the context clearly denotes otherwise, these capitalized words will have the meaning set forth below.

"ADVERSE BENEFITS DETERMINATION" means any denial, reduction or termination of BENFITS by Delta Dental for which a CLAIM has been filed.

"ANNUAL MAXIMUM BENEFIT" is the sum that will be paid for BENEFITS for any PLAN YEAR.

"BENEFITS" means the amounts paid by the EMPLOYER under the PLAN for limited scope dental services under the PLAN as set out in this document, subject to the conditions, limitations, and restrictions set forth herein.

"BENEFIT PERIOD" is the PLAN YEAR during which BENEFITS are paid. This represents the accumulation period applicable to DEDUCTIBLEs, BENEFIT maximums, and applicable time limits.

"CALENDAR YEAR" means the twelve (12) months beginning on January 1 and ending on December 31 of each year.

"CHILD" means a) a natural born child, b) a stepchild who resides in the ELIGIBLE EMPLOYEE's household, c) an adopted child (from the date of placement with the ELIGIBLE EMPLOYEE for the purpose of legal adoption), d) a child for whom the ELIGIBLE EMPLOYEE is the legal guardian, or e) a child for whom the ELIGIBLE EMPLOYEE is legally required to provide medical coverage.

"CLAIM" means a request for BENEFITS under the PLAN made in accordance with the PLAN's procedures for filing BENEFIT CLAIMs. A CLAIM includes a request for payment for a service, supply, prescription drug, equipment, or TREATMENT covered by the PLAN. A CLAIM must be made in accordance with the CLAIMS PROCEDURES under the PLAN as set forth in THE CLAIMS PROCEDURES section of this PLAN. A CLAIM does not include any BENEFITS inquiries where such inquiries do not follow the requirements established in the CLAIMS PROCEDURES.

"CLAIMS ADMINISTRATOR" is Delta Dental of Arkansas (DDAR).

“CLAIM FORM” is the standard dental form used to file a CLAIM or request a PRE-DETERMINATION of BENEFITS issued by CLAIMS ADMINISTRATOR.

“COBRA” means Title X of Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272).

“COBRA-PARTICIPANT” is a COVERED PARTICIPANT who ceases to be eligible as an EMPLOYEE or DEPENDENT but chooses to continue coverage as allowed for the time periods provided under COBRA.

“CODE” means the Internal Revenue Code of 1986, as amended.

“COVERED EMPLOYEE” is an ELIGIBLE EMPLOYEE who is enrolled in this PLAN.

“COVERED DEPENDENT” is an ELIGIBLE DEPENDENT who is enrolled in this PLAN.

“COVERED PARTICIPANT” is an ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT who is enrolled in this PLAN.

“DDAR” is Delta Dental of Arkansas, the CLAIMS ADMINISTRATOR.

“DEDUCTIBLE” is the amount the COVERED PARTICIPANT must pay for services in any BENEFIT PERIOD before certain BENEFITS will be paid by the PLAN, subject to limitations shown on the SCHEDULE OF BENEFITS.

“DENTIST” is a person licensed to practice dentistry when and where services are performed.

“DEPENDENT” is your SPOUSE or CHILD as further described in Article 2. However, DEPENDENT shall not include the following individuals:

- Any person who is on active duty in any military service of any country (subject to USERRA); or
- Any person who is covered under the Plan as an Employee; or
- Any CHILD who is not a citizen or national of the United States unless such individual is a resident of the United States or unless such CHILD is legally adopted (or lawfully placed for adoption with the EMPLOYEE).

For purposes of this PLAN, the term DEPENDENT will also include those individual who no longer meet the definition of a DEPENDENT, but are beneficiaries under COBRA.

“DISCLOSURE” means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

"EFFECTIVE DATE" of the PLAN is January 1, 2021

"ELIGIBLE DEPENDENT" is a DEPENDENT who meets the eligibility requirements to enroll under the PLAN.

"ELIGIBLE EMPLOYEE" is an EMPLOYEE who meets the eligibility requirements to enroll under the PLAN.

"EMPLOYEE" is any individual that the EMPLOYER classifies as a common-law employee and who is on the EMPLOYER's W-2 payroll and to the extent necessary, a terminated EMPLOYEE who is entitled to BENEFITs under the PLAN. EMPLOYEE does not mean an individual who is (a) a leased employee or an individual classified by the EMPLOYER as an independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not such individual is on the EMPLOYER's W-2 payroll or is determined by the IRS or others to be a common-law employee of the EMPLOYER; (b) any individual who performs services for the EMPLOYER but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be common-law employee of the EMPLOYER; (c)any employee covered under a collective bargaining agreement; and (d) any self-employed individual.

"EMPLOYER" is Revolution Company and any affiliated companies, within the meaning of Section 414(b), (c), or (m) of the Code, which have adopted this PLAN.

"ENROLLMENT FORM" is the form submitted to apply for coverage for an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENTs, if applicable, under the PLAN.

"ENROLLMENT QUALIFYING EVENT" means the occurrence of a specified event, as described in Article 2, which would allow an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT to enroll under the PLAN after the initial eligibility period without LATE ENTRY restrictions, as applicable.

"GROUP DENTAL PLAN" is the group dental benefits program to which the PLAN applies.

"MAXIMUM PLAN ALLOWANCE or MPA" is the maximum payment allowed under the PLAN for the applicable covered service(s) provided by the DENTIST(s). The CLAIMS ADMINISTRATOR shall have the discretionary authority to determine the MPA.

"NON-PARTICIPATING DENTIST" is any DENTIST other than a PARTICIPATING DENTIST.

"PARTICIPATING DENTIST" or **"NETWORK PROVIDER"** is a licensed DENTIST who has contracted with and agreed to abide by the rules and regulations of DDAR or any other organization that is a member of Delta Dental Plans Association, DeltaUSA, or its affiliates. A list of current PARTICIPATING DENTISTs or NETWORK PROVIDERs is available from DDAR free of charge, or you may access the website at www.deltadentalar.com.

"PLAN ADMINISTRATOR" is Revolution Company.

"PLAN DOCUMENT/ SUMMARY PLAN DESCRIPTION (PLAN)" is this Value Plan document (PLAN).

"PLAN TERM" is the time commencing on the EFFECTIVE DATE plus any renewals or extensions while the PLAN is in effect.

"PLAN YEAR" is the twelve (12) months starting on January 1 and ending on December 31 of each year while the PLAN is in effect.

"PRE-DETERMINATION" is an opinion from the CLAIMS ADMINISTRATOR as to payments that would be made by the CLAIMS ADMINISTRATOR as reasonably necessary for anticipated TREATMENT of a COVERED PARTICIPANT. The opinion is based upon information forwarded to the CLAIMS ADMINISTRATOR. It does not guarantee such payment in that actual payment would also depend on applicable coverage being in effect at the time any such services were rendered. The payment may also be subject to DEDUCTIBLE, co-pay, co-insurance, and maximum BENEFITS allowed. Similar terms also used for PRE-DETERMINATION are pre-authorization, prior-authorization, pre-TREATMENT review, and/or, pre-certification. A COVERED PARTICIPANT, however, is not required to seek a PRE-DETERMINATION for any TREATMENT under the PLAN.

"PRE-EXISTING CONDITION" means the state or condition of the mouth that exists prior to the patient's EFFECTIVE DATE of coverage under the PLAN.

"PROVIDER" means a legally licensed DENTIST or any other legally licensed dental practitioner rendering services. Services must be covered under the PLAN and be within the scope of the person's license.

"QUALIFIED MEDICAL CHILD SUPPORT ORDER OR QMCSO" is an order within the meaning of ERISA Section 609(a) that requires coverage under the PLAN for an EMPLOYEE's DEPENDENT CHILD. The PLAN ADMINISTRATOR has established procedures for the qualification of QMCSOs.

"SCHEDULE OF BENEFITS" provides a list of the BENEFITS that will be provided to a COVERED PARTICIPANT. Such SCHEDULE OF BENEFITS shall be the one in effect and for which EMPLOYEE contributions are made, if any, at the time dental care is provided.

"**SPOUSE**" is the person, recognized as the COVERED EMPLOYEE's husband or wife under the laws of the State where the covered EMPLOYEE lives. The PLAN ADMINISTRATOR may require documentation providing legal marital relationship.

"TOTALLY DISABLED" means, in the case of a DEPENDENT CHILD, the complete inability, as a result of illness or injury, to perform the normal activities of a person of like age and sex in good health.

"TREATMENT" means the provision, coordination, or management of health care and related services by one or more health care PROVIDERs. This includes the coordination or management of health care by a health care PROVIDER with a third party, consultation between health care PROVIDERs relating to a patient, or the referral of a patient for health care from one health care PROVIDER to another.

"URGENT CARE" involves medical care or TREATMENT that is necessary and reasonable and if not provided:

a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
b) In the opinion of a physician with knowledge of the claimant's medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or TREATMENT that is the subject of the CLAIM.

"USE" means, with respect to INDIVIDUALLY IDENTIFIABLE HEALTH INFORMTION, the sharing, employment, APPLICATION, utilization, examination, or analysis of information within an entity that maintains such information.

"USERRA" means the Uniform Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

2.01 ELIGIBLE EMPLOYEES. A FULL TIME EMPLOYEE is eligible to enroll for coverage under this PLAN. The EMPLOYEE must be a resident of the United States.

2.02 ELIGIBLE DEPENDENTS. ELIGIBLE DEPENDENTs include:

- A COVERED EMPLOYEE's legally married SPOUSE (not legally separated).
- Each DEPENDENT CHILD up to age twenty-six (26) or younger.
- Such DEPENDENT must be a resident of the United States. Under certain circumstances, the COVERED EMPLOYEE may be required to provide PLAN ADMINISTRATOR with proof of dependency.

No individual may be covered under this PLAN as both an EMPLOYEE and a DEPENDENT. Also, no individual will be considered an ELIGIBLE DEPENDENT of more than one EMPLOYEE.

2.03 ELIGIBILITY EXTENSION FOR DEPENDENT CHILDREN.
If an unmarried, DEPENDENT CHILD, upon reaching age nineteen (19) is TOTALLY DISABLED and resides with the COVERED EMPLOYEE, such DEPENDENT CHILD will continue to be an ELIGIBLE DEPENDENT under the PLAN until such time as the DEPENDENT CHILD is no longer TOTALLY DISABLED or coverage under the PLAN terminates for any reason.

Those DEPENDENTs must also be eligible to be claimed by the COVERED EMPLOYEE or SPOUSE as under the U. S. Internal Revenue Code during the current Calendar Year

The EMPLOYEE may be required to provide the PLAN with written evidence of a disability status.

2.04 PROBATIONARY PERIOD. ELIGIBLE EMPLOYEE's and ELIGIBLE DEPENDENTs' participation in the PLAN is subject to a probationary period of thirty (30) days for dental BENEFITS coverage.

EMPLOYEEs must remain ELIGIBLE EMPLOYEEs during the probationary period. Benefits will begin the first of the month following the completion of the probationary period.

2.05 INITIAL PLAN ENROLLMENT. The ELIGIBLE EMPLOYEE's and ELIGIBLE DEPENDENTs' eligibility date is the first of the month following thirty (30) days of full time employment of the ELIGIBLE EMPLOYEE.

ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs who elect to participate in the PLAN must enroll for coverage under the PLAN by completing, signing, and returning the necessary ENROLLMENT FORM to PLAN ADMINISTRATOR's personnel department or such other department or individual as designated by the PLAN ADMINISTRATOR, within thirty-one (31) days of the eligibility date. Failure to enroll within this time limit will be deemed waiver of participation.

2.06 OPEN ENROLLMENT. The PLAN ADMINISTRATOR may establish an open enrollment period prior to the beginning of each PLAN YEAR, during which an otherwise ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT may enroll under the PLAN. Open enrollment is January of each year.

2.07 ENROLLMENT QUALIFYING EVENT. ELIGIBLE EMPLOYEEs and their ELIGIBLE DEPENDENTs who do not enroll within thirty-one (31) days from the eligibility date can enroll pursuant to an ENROLLMENT QUALIFYING EVENT, as described below, if such ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs enroll within thirty-one (31) days from the ENROLLMENT QUALIFYING EVENT.

a) **ENROLLMENT DUE TO LOSS OF OTHER COVERAGE**
An ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT may enroll under the PLAN due to the loss of other coverage if the following conditions are met:

1) The ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT was covered under another dental health plan or had dental insurance coverage at the time of initial eligibility and enrollment under this PLAN;
2) The ELIGIBLE EMPLOYEE completed a written waiver of coverage at the time of initial eligibility under this PLAN stating that other dental health coverage was the reason for declining enrollment in this PLAN;
3) The other coverage of the ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT who has lost the coverage was under COBRA and COBRA coverage was exhausted or was not under COBRA, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or EMPLOYER contributions toward the coverage were terminated;
4) The ELIGIBLE EMPLOYEE requests enrollment in this PLAN not later than thirty-one (31) days after the exhaustion of COBRA coverage or the termination of coverage or EMPLOYER contributions as described in 3) above; and
5) The other coverage was not lost as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent CLAIM).

b) **ENROLLMENT DUE TO NEW DEPENDENT STATUS**

An ELIGIBLE EMPLOYEE or an ELIGIBLE DEPENDENT may enroll in the PLAN as a result of new DEPENDENT status through marriage, birth, or adoption if the following conditions are met:

1) An individual becomes an ELIGIBLE DEPENDENT of the ELIGIBLE EMPLOYEE through marriage, birth, adoption, or placement for adoption; and
2) The ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT requests enrollment in this PLAN not later than thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

   An ENROLLMENT FORM must be completed to add any ELIGIBLE DEPENDENTs even if the COVERED EMPLOYEE already has selected DEPENDENT COVERAGE (family coverage) under the PLAN. If no ENROLLMENT FORM is received by the PLAN ADMINISTRATOR within the thirty-one (31) days from satisfaction of the enrollment provisions set forth above, no coverage will be provided under the PLAN on behalf of the ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT as applicable.

2.07 EFFECTIVE DATE OF COVERAGE. Coverage for COVERED PARTICIPANTs who timely enroll in the PLAN will be effective on whichever of the following occurs first:

ELIGIBLE EMPLOYEE:

a) The ELIGIBLE EMPLOYEE's eligibility date, provided ELIGIBLE EMPLOYEE enrolls within thirty-one (31) days of the eligibility date;
b) The day following the date of the ELIGIBLE EMPLOYEE's loss of other coverage, provided ELIGIBLE EMPLOYEE enrolls within thirty-one (31) days from the loss of other coverage;
c) The ELIGIBLE EMPLOYEE's date of marriage, provided ELIGIBLE EMPLOYEE enrolls within thirty-one (31) days from the date of marriage; or
d) As of the first day of the PLAN YEAR following the open enrollment period, if the ELIGIBLE EMPLOYEE enrolls for coverage during the open enrollment period.

ELIGIBLE DEPENDENTs: When a COVERED EMPLOYEE timely enrolls an ELIGIBLE DEPENDENT in the PLAN, the ELIGIBLE DEPENDENT's coverage will be effective on whichever of the following occurs first:

a) The ELIGIBLE DEPENDENT's eligibility date provided ELIGIBLE DEPENDENT enrolls within thirty-one (31) days of the eligibility date.
b) The ELIGIBLE DEPENDENT's date of birth, adoption, or placement for adoption provided ELIGIBLE DEPENDENT enrolls within thirty-one (31) days from the date of birth, adoption, or placement for adoption.

c) The day following the date of the ELIGIBLE DEPENDENT’s loss of other coverage, provided ELIGIBLE DEPENDENT enrolls within thirty-one (31) days from the loss of other coverage.
d) As of the first day of the PLAN YEAR following the open enrollment period, if the ELIGIBLE DEPENDENT enrolls for coverage during the open enrollment period.

2.09 REHIRED EMPLOYEE. A terminated COVERED EMPLOYEE who is rehired by the EMPLOYER within thirty (30) days from his or her termination date shall become immediately eligible for coverage under the PLAN, so long as the former COVERED EMPLOYEE is an ELIGIBLE EMPLOYEE upon his or her reemployment. A terminated COVERED PARTICIPANT re-employed thirty (30) days after his or her termination date will be treated as a new EMPLOYEE and will be required to satisfy all eligibility and enrollment requirements of the PLAN prior to becoming covered under the PLAN. Notwithstanding the foregoing, a former COVERED EMPLOYEE who returns to work for the EMPLOYER directly from COBRA continuation coverage elected under this PLAN will become immediately eligible for coverage.

2.10 IDENTIFICATION CARD. Possession of an identification card does not guarantee a COVERED PARTICIPANT is eligible for BENEFITS. Eligibility is based on information reported to the CLAIMS ADMINISTRATOR by PLAN ADMINISTRATOR. Eligibility may be confirmed by calling the CLAIMS ADMINISTRATOR’s Customer Service Representatives, but the card **is not a guarantee of payment.**

2.11 EMPLOYEES ON MILITARY LEAVE. Pursuant to USERRA, EMPLOYER must provide certain reemployment and benefit rights to EMPLOYEEs who take a leave of absence for military service. ELIGIBLE EMPLOYEEs who meet the requirements under USERRA are generally entitled to reemployment upon their return from uniformed service and to reinstatement and continuation of their employment BENEFITS.

An ELIGIBLE EMPLOYEE who is absent from employment in order to serve in the uniformed services, as well as his or her ELIGIBLE DEPENDENTs, may elect to continue health coverage during the period of uniformed service, if applicable. The maximum length of the continuation coverage required under USERRA is the lesser of:

a) Twenty four (24) months (beginning on the day that the uniformed service leave commences), or
b) a period beginning on the day the uniformed service leave commences and ending on the day the EMPLOYEE fails to return to or reapply for employment within the time allowed by USERRA.

If a COVERED PARTICIPANT elects to continue health coverage pursuant to USERRA, such COVERED PARTICIPANT will be required to pay 102% of the full premium for the coverage elected. However, if the uniformed service leave of absence is less than thirty-one (31) days, the COVERED PARTICIPANT will not be required to pay more than the COVERED PARTICIPANT would have been required to pay if COVERED PARTICIPANT had not been on uniformed service leave.

A COVERED PARTICIPANT whose coverage was terminated during the period of uniformed service shall not be subject to any exclusions or restrictions for PRE-EXISTING CONDITIONS upon reinstatement of the health coverage under the PLAN, if an exclusion would not have been imposed under the PLAN had coverage not been terminated by reason of the uniformed service. However, PLAN exclusions may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of service in the uniformed services.

2.12 CONTINUATION DURING FAMILY AND MEDICAL LEAVE. This PLAN shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, as applicable. During any leave taken under FMLA, the EMPLOYER will maintain coverage under this PLAN on the same conditions as coverage would have been provided if the COVERED EMPLOYEE had been continuously employed during the entire leave period. If PLAN coverage terminates during the FMLA leave, coverage will be reinstated for the COVERED EMPLOYEE and his or her COVERED DEPENDENTs if the COVERED EMPLOYEE returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this PLAN when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminates. For example, PRE-EXISTING CONDITION limitations and other waiting periods will not be imposed unless they were in effect for the COVERED EMPLOYEE and/or his or her COVERED DEPENDENTS when PLAN coverage terminates. Notwithstanding the foregoing, a COVERED PARTICIPANT on FMLA leave shall have no greater rights to BENEFITS for the remainder of the PLAN YEAR in which FMLA leave commences as other PLAN COVERED PARTICIPANTs who continuously worked during the PLAN YEAR.

2.13 COBRA. Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain EMPLOYEEs and their families covered under the PLAN will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the PLAN would otherwise end. This notice is intended to inform PLAN PARTICIPANTS and beneficiaries, in summary fashion, of their rights and

obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the PLAN ADMINISTRATOR or its designee to PLAN PARTICIPANTS who become QUALIFIED BENEFICIARIES under COBRA.

What is COBRA continuation coverage?
COBRA continuation coverage is the temporary extension of group dental plan coverage that must be offered to certain PLAN PARTICIPANTS and their eligible family members (called "QUALIFIED BENEFICIARIES") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the PLAN (the "Qualifying Event"). The coverage must be identical to the PLAN coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active EMPLOYEEs who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?
In general, a QUALIFIED BENEFICIARY can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under the PLAN by virtue of being on that day either a COVERED EMPLOYEE or a COVERED DEPENDENT. If, however, an individual who otherwise qualifies as a QUALIFIED BENEFICIARY is denied or not offered coverage under the PLAN under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the PLAN coverage and will be considered a QUALIFIED BENEFICIARY if that individual experiences a Qualifying Event.

(2) Any CHILD who is born to or placed for adoption with a COVERED EMPLOYEE during a period of COBRA continuation coverage, and any individual who is covered by the PLAN as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a QUALIFIED BENEFICIARY is denied or not offered coverage under the PLAN under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the PLAN coverage and will be considered a QUALIFIED BENEFICIARY if that individual experiences a Qualifying Event.

An individual is not a QUALIFIED BENEFICIARY if the individual's status as a COVERED EMPLOYEE is attributable to a period in which the individual was a nonresident alien who received from the individual's EMPLOYER no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a QUALIFIED BENEFICIARY, then a DEPENDENT of the individual will also not be considered a QUALIFIED BENEFICIARY by virtue of the relationship to the individual. A domestic partner is not a QUALIFIED BENEFICIARY.

Each QUALIFIED BENEFICIARY (including a CHILD who is born to or placed for adoption with a COVERED EMPLOYEE during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?
A qualifying event is any of the following if the PLAN provided that the PLAN PARTICIPANT would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage:

(1) The death of a COVERED EMPLOYEE.

(2) The termination (other than by reason of the EMPLOYEE's gross misconduct), or reduction of hours, of a COVERED EMPLOYEE's employment.

(3) The divorce or legal separation of a COVERED EMPLOYEE from the EMPLOYEE's SPOUSE. If the EMPLOYEE reduces or eliminates the EMPLOYEE's SPOUSE's PLAN coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event even though the SPOUSE's coverage was reduced or eliminated before the divorce or legal separation.

(4) A COVERED EMPLOYEE's enrollment in any part of the Medicare program (if it includes dental benefit coverage)

(5) A DEPENDENT CHILD's ceasing to satisfy the PLAN's requirements for a DEPENDENT CHILD (for example, attainment of the maximum age for dependency under the PLAN).

If the qualifying event causes the COVERED EMPLOYEE or the COVERED DEPENDENT to cease to be covered under the PLAN under the same terms and conditions as in effect immediately before the qualifying event, the persons losing such coverage become QUALIFIED BENEFICIARIES under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a COVERED EMPLOYEE or the DEPENDENT, for

coverage under the PLAN that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a qualifying event. A qualifying event will occur, however, if an EMPLOYEE does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the PLAN provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the COVERED EMPLOYEE and family members will be entitled to COBRA continuation coverage even if they failed to pay the EMPLOYEE portion of premiums for coverage under the PLAN during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

The failure to continue Plan coverage will affect a COVERED PARTICIPANT’s rights under federal law. First, a COVERED PARTICIPANT can lose the right to avoid having pre-existing condition exclusions applied by other dental plans if there is more than a 63-day gap in coverage and election of COBRA continuation coverage may help avoid such a gap. Second, if COVERED PARTICIPANTS do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available, they will lose the right to convert to an individual insurance policy, which does not impose such pre-existing condition exclusions. Finally, there are special enrollment rights under federal law (HIPAA). COVERED PARTICIPANTS have the right to request special enrollment in another group dental plan for which they are otherwise eligible (such as a plan sponsored by the COVERED EMPLOYEE’s SPOUSE's employer) within 30 days after PLAN coverage ends due to a qualifying event listed above. COVERED PARTICIPANTS will also have the same special right at the end of COBRA continuation coverage if they get COBRA continuation coverage for the maximum time available to them.

Note that if the COVERED PARTICIPANTS are eligible for COBRA continuation coverage and if they were eligible for Medicare prior to the qualifying event, Medicare is deemed the primary payer and the PLAN will only pay COBRA benefits as secondary payer. For this purpose, Medicare will be deemed primary payer whether or not the COVERED PARTICIPANTS have actually enrolled in Parts A and Parts B.

What is the procedure for obtaining COBRA continuation coverage?

The PLAN has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?
The election period is the time period within which the QUALIFIED BENEFICIARY must elect COBRA continuation coverage under the PLAN. The election period must begin not later than the date the QUALIFIED BENEFICIARY would lose coverage on account of the qualifying event and ends 60 days after the later of the date the QUALIFIED BENEFICIARY would lose coverage on account of the qualifying event or the date notice is provided to the QUALIFIED BENEFICIARY of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a COVERED EMPLOYEE who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the EMPLOYEE and his or her COVERED DEPENDENTs have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group dental plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the PLAN ADMINISTRATOR for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired EMPLOYEEs who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a COVERED EMPLOYEE or QUALIFIED BENEFICIARY responsible for informing the PLAN ADMINISTRATOR of the occurrence of a qualifying event?
The PLAN will offer COBRA continuation coverage to QUALIFIED BENEFICIARIES only after the PLAN ADMINISTRATOR or its designee has been timely notified that a qualifying event has occurred. The EMPLOYER (if the EMPLOYER is not the

PLAN ADMINISTRATOR) will notify the PLAN ADMINISTRATOR of the qualifying event within 30 days following the date coverage ends when the qualifying event is:

(1) the end of employment or reduction of hours of employment,
(2) death of the EMPLOYEE,
(3) commencement of a proceeding in bankruptcy with respect to the EMPLOYER, or
(4) enrollment of the EMPLOYEE in any part of Medicare.

IMPORTANT:
For the other qualifying events (divorce or legal separation of the EMPLOYEE and SPOUSE or a DEPENDENT CHILD losing eligibility for coverage as a DEPENDENT CHILD), the EMPLOYEE or DEPENDENT or someone on his or her behalf must notify the PLAN ADMINISTRATOR or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the PLAN ADMINISTRATOR or its designee during the 60-day notice period, any DEPENDENT who loses coverage will not be offered the option to elect continuation coverage. This notice must be sent as designated pursuant to the notice procedures set forth below.

NOTICE PROCEDURES:
Any notice provided must be in writing. Oral notice, including notice by telephone, is not acceptable. A notice must be mailed, faxed or hand-delivered to the PLAN ADMINISTRATOR at the address shown at the end of this SUMMARY PLAN DESCRIPTION.

If mailed, the notice must be postmarked no later than the last day of the required notice period.

Any notice must state:

- the name of the PLAN under which coverage is lost or will be lost,
- the name and address of the EMPLOYEE covered under the PLAN,
- the name(s) and address(es) of the QUALIFIED BENEFICIARY(ies), and
- the qualifying event and the date it happened.

If the qualifying event is a divorce or legal separation, the notice must include a copy of the divorce decree or the legal separation agreement.

In addition, there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the PLAN ADMINISTRATOR or its designee receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the QUALIFIED BENEFICIARIES. Each QUALIFIED BENEFICIARY will have an independent right to elect COBRA continuation coverage. COVERED EMPLOYEEs may elect COBRA continuation coverage for their SPOUSEs, and parents may elect COBRA continuation coverage on behalf of their CHILDren. For each QUALIFIED BENEFICIARY who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that PLAN coverage would otherwise have been lost. If the EMPLOYEE or DEPENDENT does not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a QUALIFIED BENEFICIARY's election rights?

If, during the election period, a QUALIFIED BENEFICIARY waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the PLAN ADMINISTRATOR or its designee, as applicable.

Is COBRA coverage available if a QUALIFIED BENEFICIARY has other group dental plan coverage or Medicare?

QUALIFIED BENEFICIARIES who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group dental plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a QUALIFIED BENEFICIARY's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare (if it provides for dental benefits) or becomes covered under other group dental plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

Note that if you are eligible for COBRA continuation coverage and if you were eligible for Medicare prior to the qualifying event, Medicare is deemed the primary payer and the PLAN will only pay COBRA benefits as secondary payer. For this purpose, Medicare will be deemed primary payer whether or not the QUALIFIED BENEFICIARY has actually enrolled in Parts A and Parts B.

When may a QUALIFIED BENEFICIARY's COBRA continuation coverage be terminated?

During the election period, a QUALIFIED BENEFICIARY may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a QUALIFIED BENEFICIARY must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the PLAN with respect to the QUALIFIED BENEFICIARY.

(3) The date upon which the EMPLOYER ceases to provide any group dental plan (including a successor plan) to any EMPLOYEE.

(4) The date, after the date of the election, that the QUALIFIED BENEFICIARY first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the QUALIFIED BENEFICIARY.

(5) The date, after the date of the election that the QUALIFIED BENEFICIARY first enrolls in the Medicare program (either part A or part B, whichever occurs earlier) if it includes dental benefit coverage.

(6) In the case of a QUALIFIED BENEFICIARY entitled to a disability extension, the later of:

    (a) (i) 29 months after the date of the qualifying event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled QUALIFIED BENEFICIARY whose disability resulted in the QUALIFIED BENEFICIARY's entitlement to the disability extension is no longer disabled, whichever is earlier; or

    (b) the end of the maximum coverage period that applies to the QUALIFIED BENEFICIARY without regard to the disability extension.

The PLAN can terminate for cause the coverage of a QUALIFIED BENEFICIARY on the same basis that the PLAN terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a QUALIFIED BENEFICIARY and who is receiving coverage under the PLAN solely because of the individual's relationship to a QUALIFIED BENEFICIARY, if the PLAN's obligation to make COBRA continuation coverage available to the QUALIFIED BENEFICIARY ceases, the PLAN is not obligated to make coverage available to the individual who is not a QUALIFIED BENEFICIARY.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the qualifying event and the status of the QUALIFIED BENEFICIARY, as shown below:

(1) In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the qualifying event if there is not a disability extension and 29 months after the qualifying event if there is a disability extension.

(2) In the case of a COVERED EMPLOYEE's enrollment in the Medicare program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for QUALIFIED BENEFICIARIES other than the COVERED EMPLOYEE ends on the later of:

    (a) 36 months after the date the COVERED EMPLOYEE becomes enrolled in the Medicare program; or

    (b) 18 months (or 29 months, if there is a disability extension) after the date of the COVERED EMPLOYEE's termination of employment or reduction of hours of employment.

(3) In the case of a QUALIFIED BENEFICIARY who is a CHILD born to or placed for adoption with a COVERED EMPLOYEE during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the qualifying event giving rise to the period of COBRA continuation coverage during which the CHILD was born or placed for adoption.

(4) In the case of any other qualifying event than that described above, the maximum coverage period ends 36 months after the qualifying event.

Under what circumstances can the maximum coverage period be expanded?
If a qualifying event that gives rise to an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second qualifying event that gives rise to a 36 months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are QUALIFIED BENEFICIARIES at the time of and with respect to both qualifying events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first qualifying event. The PLAN ADMINISTRATOR must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA ADMINISTRATOR in accordance with the procedures above.

How does a QUALIFIED BENEFICIARY become entitled to a disability extension?
A disability extension will be granted if an individual (whether or not the COVERED EMPLOYEE) who is a QUALIFIED BENEFICIARY in connection with the qualifying event that is a termination or reduction of hours of a COVERED EMPLOYEE's employment, is determined under Title II or XVI of the Social

Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the QUALIFIED BENEFICIARY must also provide the PLAN ADMINISTRATOR with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18 month maximum coverage. This notice should be sent to the COBRA ADMINISTRATOR in accordance with the procedures above.

Does the PLAN require payment for COBRA continuation coverage?
For any period of COBRA continuation coverage under the PLAN, QUALIFIED BENEFICIARIES who elect COBRA continuation coverage must pay for COBRA continuation coverage. QUALIFIED BENEFICIARIES will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled QUALIFIED BENEFICIARY due to a disability extension. The PLAN will terminate a QUALIFIED BENEFICIARY's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the PLAN allow payment for COBRA continuation coverage to be made in monthly installments?
Yes. The PLAN is also permitted to allow for payment at other intervals.

What is timely payment for payment for COBRA continuation coverage?
Timely payment means a payment made no later than 30 days after the first day of the coverage period.

Notwithstanding the above paragraph, the PLAN does not require payment for any period of COBRA continuation coverage for a QUALIFIED BENEFICIARY earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that QUALIFIED BENEFICIARY. Payment is considered made on the date on which it is postmarked to the PLAN.

If timely payment is made to the PLAN in an amount that is not significantly less than the amount the PLAN requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the PLAN's requirement for the amount to be paid, unless the PLAN notifies the QUALIFIED BENEFICIARY of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a timely payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Additional Questions.
For additional questions about COBRA continuation coverage, EMPLOYEEs or DEPENDENTs should contact the PLAN ADMINISTRATOR. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group dental plans, EMPLOYEEs or DEPENDENTs may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the PLAN ADMINISTRATOR Informed of address changes.
In order to protect their families' rights, EMPLOYEEs should keep the PLAN ADMINISTRATOR informed of any changes in the addresses of family members. EMPLOYEEs should also keep a copy, for their records, of any notices sent to the PLAN ADMINISTRATOR.

ARTICLE 3. TERMINATION

3.01 TERMINATIONS

COVERED EMPLOYEES:

Coverage will end for a COVERED EMPLOYEE at the earliest time stated below subject to the COVERED EMPLOYEE's right to elect continuation of coverage through COBRA, continuation during FMLA, or USERRA, as applicable:

a) Upon termination of this PLAN.

b) On the last day of the calendar month in which the COVERED EMPLOYEE's employment terminates.

c) On the last day of the calendar month in which the COVERED EMPLOYEE shifts to a non-eligible classification under the PLAN and is no longer an ELIGIBLE EMPLOYEE.

d) At the end of the period for which the required premiums or any other payments required under the PLAN have been paid, if the premiums or any other required payments for the next period are not paid when due.

e) The last day of the calendar month in which the COVERED EMPLOYEE retires.

f) The last day of the calendar month in which the COVERED EMPLOYEE begins FMLA unless the appropriate premium payments are made.

g) The last day of the calendar month in which the COVERED EMPLOYEE enters active duty service in the armed forces of any country.

h) The last day of the calendar month in which the COVERED EMPLOYEE fails to return to work from an EMPLOYER-approved leave of absence.

COVERED DEPENDENTs:

Coverage will end for COVERED DEPENDENTs at the earliest time stated below, subject to the COVERED DEPENDENTs right to elect continuation of coverage through COBRA, continuation during FMLA, or USERRA, as applicable:

a) Upon termination of the COVERED EMPLOYEE's coverage for any reason.

b) Upon the termination of this PLAN or DEPENDENT coverage under this PLAN.

c) When such individual ceases to be an ELIGIBLE DEPENDENT.

d) At the end of the period for which the required premiums or any other payments required under the PLAN have been paid if the premiums or any other required payments for the next period are not paid when due.

e) The last day of the calendar month in which the COVERED DEPENDENT reaches age twenty-six (26).

e) The last day of the calendar month in which the COVERED DEPENDENT enters active duty service in the armed forces of any country.

There will be no coverage upon any termination as specified above unless continuation coverage is available, pursuant to COBRA, continuation during FMLA, or USERRA, if applicable.

Article 4. Covered Dental Benefits

Schedule of Benefits for Revolution Company

Effective Date: 12:01 a.m. Central Standard Time, January 1, 2021.

Group Number: 9652

Deductible: $50 per person for BENEFITs received in Coverage B, Coverage C, and Orthodontic Services per benefit period with a maximum of $150 per family, per benefit period. There is no deductible on Coverage A.
Annual Maximum Payment: $1,500 per Person per Calendar Year. Applies to all services except Orthodontics.

Covered Services

Coverages and Maximum Plan Allowances

Coverage A – Diagnostic and Preventative Services	**Premier In-Network 100% MPA** **PPO In-Network 100% MPA** **Out-of-Network 90% MPA**
Coverage B – Basic Restorative Services	**Premier In-Network 80% MPA** **PPO In-Network 80% MPA** **Out-of-Network 72% MPA**
Coverage C – Major Restorative Services	**Premier In-Network 50% MPA** **PPO In-Network 50% MPA** **Out-of-Network 45% MPA**

Coverage A: Diagnostic and Preventative Services and their Limitations & Exclusions

4A.1.00 Diagnostic and Preventative Benefits

Diagnostic and Preventative Services	Services and procedures to determine dental health or to prevent or reduce dental disease. These services include examinations, evaluations, and prophylaxis (cleanings).
Sealants	A sealant is a thin, plastic coating painted on the chewing surfaces of the first and second permanent molars to prevent tooth decay.

Fluoride Treatments	Topical application of fluoride for a dependent child.
Bitewing and Periapical Radiographs	Oral brush biopsy procedure and laboratory analysis used to detect oral cancer.
Full Mouth Radiographs	X-rays for routine care to diagnose the condition of teeth.

4A.2.00 Diagnostic and Preventative Benefits Limitations & Exclusions

Diagnostic and Preventative Services

- Routine periodic and specialty evaluations are Covered Services up to two (2) time(s) in any Calendar Year. This is inclusive of an initial, oral evaluation.
- An initial oral evaluation by the same Provider or Provider's office is a Covered Service one (1) time(s) in a thirty-six (36) consecutive month period.
- A Limited Oral Evaluation is a Covered Service for a specific oral health problem or complaint. Limited Oral Evaluations are not subject to the time limitation of routine periodic evaluations. Additional information may be required for consultant review.
- Prophylaxis (Cleaning) is a Covered Service up to two (2) time(s) per Calendar Year. (*Please see information on Evidence Based Dentistry.)
- Adult cleanings are a Covered Service for Participant(s) age fourteen (14) and older.
- Preventive control programs (e.g., oral hygiene instructions, caries susceptibility tests, dietary control, tobacco counseling, etc.) are not Covered Services.
- Diagnostic casts, photographs, and cephalometric films are Covered Services only if orthodontic services are Covered Services and are a Benefit at the orthodontic Maximum Plan Allowance.
- Pulp vitality tests are Covered Services only for the diagnosis of emergency conditions as long as no other definitive procedure is performed on the same day. A pulp vitality test is a Covered Service available per visit, not per tooth.
- Full mouth scaling in the presence of gingival inflammation is a Covered Service and subject to the time limitation of a routine prophylaxis (Cleaning).
- Full-mouth debridement is a Covered Service up to one (1) time(s) in a lifetime.

Sealants

- A sealant is a Covered Service only for the first and second permanent molars when applied to a tooth with an unrestored occlusal surface.
- Sealants are Covered Services for Eligible Dependents prior to age sixteen (16).
- Sealants are Covered Services one (1) time(s) per tooth per lifetime.

Fluoride Treatments

- Topical application of fluoride is a Covered Service one (1) time(s) per Calendar Year for Eligible Dependents prior to age nineteen (19).
- Fluoride rinses or self-applied fluorides are not Covered Services.
- One (1) additional fluoride application per Calendar Year is a Covered Service for Eligible Dependents prior to nineteen (19) who are identified at a moderate or high risk (as defined by the American Dental Association's Dental Procedure Codes) for developing caries.
- DDAR will pay for two (2) applications of silver diamine fluoride in a BENEFIT PERIOD with a maximum benefit of four (4) per tooth in a lifetime. The benefit is not to exceed any four 4) teeth in any one day. Benefits for restorations within three (3) months of placing silver diamine fluoride are not a covered service. Sealants and preventive restorations are not a benefit if silver diamine fluoride has been applied to the tooth.

Bitewing and Periapical Radiographs

- Bitewing and periapical x-rays are Covered Services as required in any Calendar Year.

Full Mouth Radiographs

- A full mouth series x-ray or panoramic x-ray is a Covered Service one (1) time(s) within any sixty (60) consecutive month period.
- A combination of periapical and bitewing x-rays (fourteen (14) or more films) or a panoramic film and additional x-rays make up a full mouth series.

Caries Risk Assessment

- A Caries Risk Assessment is a Covered Service once every three (3) years for Eligible Dependents age three (3) - nineteen (19).

- General Limitations and Exclusions found in Article 6 of this PLAN also apply to Diagnostic and Preventive BENEFITS.

Coverage B: Basic Restorative Services and their Limitations & Exclusions

4B.1.00 Basic Restorative Benefits

Minor Restorative Services	Services to rebuild and repair Your teeth damaged by disease, decay, fracture, or injury. This includes minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings.
Emergency Palliative Treatment	Emergency treatment to temporarily relieve pain.
Space Maintainers	Space Maintainers for prematurely lost teeth of a child.
Brush Biopsy	Oral brush biopsy procedure and laboratory analysis used to detect oral cancer.
Endodontic Services	The treatment of teeth with diseased or damaged nerves (for example, root canals).
All Other Endodontic Services	Hemisection performed on multirooted teeth.
Non-Surgical Periodontic Services	The treatment of diseases of the gums and supporting structures of the teeth.
Periodontal Maintenance Services	The treatment of diseases of the gums and supporting structures of the teeth following active periodontal treatment
Oral Surgery Services	Surgical extractions and dental surgery, including pre-operative and post-operative care.
Simple Extractions	Extraction of an erupted tooth or teeth.
Stainless Steel Crowns	Used as a restoration to natural teeth for a child when the teeth cannot be restored with a filling material.

4B.2.00 Basic Restorative Services Limitations & Exclusions

Minor Restorative Services

- Restorative benefits (fillings) are Covered Services once per surface, per tooth in a twenty-four (24) month period. This is a Covered Service

irrespective of the number of combinations of procedures requested or performed.
- Composites on molars are not a covered benefit. An amalgam allowance will be made for molars with any fee difference the responsibility of the patient.

Emergency Palliative Treatment

- Palliative treatment is a Covered Service once per visit as long as no other procedures, except for x-rays, exams, or any diagnostic service, are performed on the same date.

Space Maintainers

- A space maintainer is a Covered Service when used to replace prematurely lost or extracted teeth for Eligible Dependents prior to age fourteen (14).
- A space maintainer is a Covered Service up to one (1) time(s) in a sixty (60) consecutive month period.
- Recementation of a space maintainer is a Covered Service one (1) time(s) in twenty-four (24) consecutive months. Recementation of a space maintainer within six (6) months of the seating date is part of the original procedure.
- A space maintainer is not considered an orthodontic appliance.
- The cost of removal is included in the services of the Provider who provided the space maintainer. If the maintainer is removed by another Provider, the procedure is a Covered Service.
- A distal shoe space maintainer is a Covered Service to guide the eruption of the first permanent molar for Eligible Dependents to age nine (9) once in a lifetime per space.

Brush Biopsy

- Brush biopsy is a Covered Service upon consultant review.

Endodontic Services

- Root canal treatment is a Covered Service once in a lifetime, per tooth, by the same Provider or Provider’s office that performed the root canal. Benefits for root canal treatment include charges for temporary restorations.
- Root canals on primary teeth are not Covered Services, unless there is no permanent successor. If there is no permanent successor the primary tooth is limited to pulpal therapy one (1) time(s) in a lifetime.
- Retreatment of a root canal by the same Provider or Provider’s office will be considered after twenty-four (24) consecutive months have lapsed

since the initial treatment and is limited to one (1) per twenty-four(24) consecutive month period.

Other Endodontic Services

- Hemisection is a Covered Service on multirooted teeth once per tooth per lifetime.

Non-Surgical Periodontic Services

- Non-surgical periodontics are Covered Services up to one (1) time(s) in a twenty-four (24) consecutive month period per quadrant.
- Root planing and scaling is a Covered Service for Participant(s) fourteen (14) and older.

Periodontal Maintenance Services

- Periodontal Maintenance is a Covered Service up to two (2) per Calendar Year following active periodontal treatment. (*Please see information on Evidence Based Dentistry below.)
- Periodontal maintenance is a Covered Service after thirty (30) days following active periodontal treatment.

Oral Surgery Services

- Oral surgery, except TMJ surgery, is a Covered Service.
- General anesthesia/intravenous sedation is not a Covered Service except when administered in conjunction with covered oral surgery.
- General anesthesia/intravenous sedation is a Covered Service for Eligible Dependents three (3) years of age and under.
- Extractions are limited to once per lifetime.
- Extractions, root removal, alveoplasty, and surgical exposure of impacted or unerupted tooth are Covered Services once per tooth in a lifetime.
- Treatment of complications (post-surgical) or unusual circumstances are not Covered Services 30 days following an extraction by the same Provider or Provider’s office. Treatment by a Provider other than the Provider who performed the extraction is a Covered Service but is subject to consultant review.
- Analgesia, anxiolysis, inhalation of nitrous oxide, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not Covered Services.
- Removal of bone tissue is a Covered Service one (1) procedure(s) per lifetime.

Simple Extractions

- General anesthesia/intravenous sedation is not a Covered Service for single tooth extractions (ADA procedure code 7140).

Stainless Steel Crowns

- Replacement of a stainless steel crown within sixty (60) month period after the initial placement is not a Covered Service.
- Stainless Steel Crowns used as a restoration to natural teeth are Covered Services for Eligible Dependent(s) to age sixteen (16) when the teeth cannot be restored with a filling material.
- Prefabricated resin crowns are not Covered Services on posterior teeth. A stainless steel crown allowance will be made with any fee difference being the Participant's responsibility.
- Prefabricated porcelain/ceramic crowns are not Covered Services for primary teeth. Allowance will be given for a stainless steel crown on a molar tooth or a prefabricated resin crown on an anterior tooth with the fee difference the responsibility of the Participant.
- General Limitations and Exclusions found in Article 6 of this PLAN also apply to Basic Restorative BENEFITS.

Coverage C: Major Restorative Services and their Limitations & Exclusions

4C.1.00 Major Restorative Benefits

Prosthodontic Services	Services and appliances that replace missing natural teeth. This includes bridges and partial or complete dentures.
Relines and Repairs	Complete or Partial Denture Reline. Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
Surgical Periodontic Services	The surgical treatment of diseases of the gums and supporting structures of the teeth.
Crowns	Crowns, inlays, onlays, and veneers are Benefits for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
Implants	Coverage for an endosteal implant to support a crown

4C.2.00 Major Restorative Services Limitations & Exclusions

Prosthodontic Services

- A fixed partial denture (Bridge) where a partial denture is constructed in the same arch is not a Covered Service.
- A posterior, fixed partial denture (bridge) and a removable partial denture in the same dental arch is not a Covered Service. The Benefit is limited to the allowance for the partial, removable denture.
- Replacement of a fixed partial denture (Bridge) that the Participant received in the sixty (60) consecutive months is not a Covered Service unless the loss of additional teeth requires the construction of a new appliance.
- Replacement of a fixed partial denture (bridge) is not a Covered Service unless the existing fixed partial denture (Bridge) cannot be made satisfactory.
- A fixed partial denture (bridge) is not a Covered Service for Eligible Dependents prior to age sixteen (16).
- Benefits for a partial or complete denture shall include charges for any necessary adjustment within a six (6) consecutive month period. Adjustments after the post six (6) month delivery period are Covered Services up to two (2) in any twelve (12) consecutive month period.
- The Group Health Plan limits Benefits for standard dentures to the Maximum Plan Allowance for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the Participant is responsible for the difference.
- Replacement of partial removable or complete dentures that the Participant received in the previous sixty (60) consecutive months are not Covered Services except where the loss of additional teeth requires the construction of a new appliance.
- Replacement of a partial removable or complete denture is not a Covered Service unless the existing partial removable or complete denture cannot be made satisfactory.
- A full or partial removable denture is a Covered Service for Eligible Dependents age sixteen (16) and older.
- Tissue conditioning is a Covered Service up to 2 time(s) in a thirty-six (36) consecutive month period. Tissue conditioning is not a Covered Service if performed on the same day a denture is delivered or a reline/rebase is provided.
- Overdentures as removable partial or complete dentures are not a Covered Service. Allowance will be given for a standard partial or complete denture with the fee difference the responsibility of the Participant.

Relines and Repairs

- Reline or rebase of a partial or complete denture is a Covered Service up to one (1) in a thirty-six (36) consecutive month period.
- Repair of a removable partial or complete denture is a Covered Service up to one (1) time(s) in a sixty (60) consecutive month period.
- Repair of a fixed partial denture (Bridge) is a Covered Service up to one (1) time(s) in a sixty (60) consecutive month period.
- Adjustments made within the first six (6) consecutive month period after delivery are not Covered Services except in the case of an immediate denture.
- Adjustments more than six (6) months after delivery are Covered Services up to two (2) time(s) in any twelve (12) consecutive month period.
- The fee for relines and rebases, and repairs should be included in the cost of the new appliance within six (6) consecutive months of the seat date.
- Recementation of a fixed partial denture (bridge) within six (6) consecutive months of the seating date is part of the original procedure and is then a Covered Service once in a twelve (12) consecutive month period.

Surgical Periodontic Services

- Payment for periodontal surgery shall include charges for three (3) months' post-operative care and any surgical re-entry for thirty-six (36) consecutive month period.
- Curettage and osseous surgery are not Covered Services for Participants prior to age fourteen (14).

Crown Services

- Crowns, inlays, onlays, and veneers are Covered Services for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
- Crowns, inlays, onlays, and veneers and fixed partial denture recements within the first six (6) consecutive months of the seating date is part of the original procedure. Recements are limited to one (1) per tooth in one (1) consecutive months.
- Replacement of a crown, inlay, onlay, or veneer is a Covered Service only after sixty (60) months of the previous prosthetic.
- Porcelain, ceramic or cast crowns are not Covered Services for Participants prior to age twelve (12).
- Temporary and provisional crowns and partial dentures are not Covered Services.
- Gold Foil or Metallic onlays are paid at the allowance of an amalgam or composite restoration.

- Repair of crowns, inlays, onlays, and veneers within twenty-four (24) consecutive months of the seating date is part of the original procedure and is a Covered Service up to one (1) time(s) in twenty-four (24) consecutive months per tooth.
- A limited occlusal adjustment is not a Covered Service within six (6) months of a restoration or prosthetic appliance.
- An occlusal adjustment in conjunction with a restoration or prosthetic appliance is considered part of the total fee of the restoration or appliance.
- A complete occlusal adjustment is not a Covered Service.

Implant Services

- Endosteal implants are Covered Services once in a lifetime per tooth.
- Implant maintenance procedure is a Covered Service one (1) time(s) in any twelve (12) consecutive months.
- An implant supported abutment crown is a Covered Service one (1) time(s) in any sixty (60) consecutive month period.
- An implant supported abutment retainer is a Covered Service (1) time(s) in any sixty (60) consecutive month period.
- An implant supported prosthesis is a Covered Service (1) time(s) in any sixty (60) consecutive month period.
- Implant removal is a Covered Service one (1) time(s) in a lifetime per tooth.
- Recementation of implant /abutment supported crown or fixed partial denture is a Covered Service one time in any twelve (12) consecutive month period after six (6) months have elapsed since initial placement.
- Repair of implant supported prosthesis or implant abutment is a Covered Service one (1) time(s) in any sixty (60) consecutive month period.
- Scaling and debridement in the presence of inflammation of a single implant, including cleaning of the implant surface is a Covered Service once per tooth in any twenty-four (24) consecutive month period after twelve months have passed from the placement of the implant supported restoration. This procedure is not allowed on the same date of service as a prophylaxis (cleaning) or a periodontal procedure which includes periodontal maintenance, root planing and scaling, gingival flap procedure, and osseous surgery.
- General Limitations and Exclusions found in Article 6 of this PLAN also apply to Major Restorative BENEFITS.

4F.1.10 Evidence Based Dentistry Benefit

In accordance with the best evidence available today, we are now providing the following benefits based on the health condition of the participant:

Pregnancy – Allow an additional two (2) prophylaxes (cleanings) per calendar/benefit year, meaning the participant could receive up to four (4) cleanings within the same benefit period. The participant will be allowed extra dental benefits for twelve (12) months (nine months of pregnancy plus three (3) months post-delivery. Time period is based on due date.)

Diabetes– Allow an additional two (2) prophylaxes (cleanings) per calendar/benefit year, meaning the participant could receive up to four (4) cleanings within the same benefit period.

Heart Disease – Allow an additional two (2) prophylaxes (cleanings) per calendar/benefit year, meaning participants could receive up to four (4) cleanings within the same benefit period.

Periodontal Disease – Allow an additional two (2) periodontal maintenance procedures per calendar/benefit year if there is documented prior history of periodontal therapy. The periodontal maintenance allowances of four (4) will include a history cross check against any routine cleaning within the same benefit period.

NOTE: To receive these additional benefits, EMPLOYEEs and/or their covered DEPENDENTs with any of the above conditions need only to contact our office by phone or letter or, prior to treatment, notify your dentist that you have one of the above mentioned conditions and qualify for Delta Dental's evidence-based dentistry benefits.

The additional benefits may not be combined by Participants with more than one of the above conditions.

ARTICLE 5. DEDUCTIBLE, ANNUAL MAXIMUM, AND COORDINATION OF BENEFITS

5.01 The CLAIMS ADMINISTRATOR will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied, unless the covered procedure is not subject to the DEDUCTIBLE. The DEDUCTIBLE will apply as indicated on the SCHEDULE OF BENEFITS.

5.02 The DEDUCTIBLE applies to the BENEFIT categories as shown on the SCHEDULE OF BENEFITS. Only fees a COVERED PARTICIPANT pays for services covered under the BENEFIT schedules included in this PLAN will count toward satisfying the DEDUCTIBLE.

5.03 Unless otherwise indicated on the SCHEDULE OF BENEFITS, the DEDUCTIBLE and maximum apply to each BENEFIT PERIOD.

5.04 COORDINATION OF BENEFITS

If a COVERED PARTICIPANT is entitled to coverage under more than one benefit plan or benefit program, the BENEFITS of this PLAN will be subject to the following conditions:

a) If the other program is not primarily a dental program, this PLAN is primary.
b) If the other program is for dental coverage, the following rules apply:
   1) The program covering the patient as an EMPLOYEE is primary over a program covering the patient as a DEPENDENT.
   2) Where the patient is a DEPENDENT CHILD, primary dental coverage will be determined as follows:
      i) The coverage of the parent whose date of birth occurs earlier in the CALENDAR YEAR will be primary.
      ii) Except for a DEPENDENT CHILD of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's SPOUSE (i.e., stepparent) will be primary, unless there is a court decree stating that one parent has financial responsibility for a CHILD's health care expenses. If so, any DEPENDENT coverage of that parent will be primary to any other DEPENDENT coverage.
   3) When primary coverage cannot be determined according to a) and b), the program that has covered the patient for the longer period will be primary.
   4) Coordination of BENEFITS within this PLAN will not be allowed.

If a COVERED PARTICIPANT is covered under more than one group PLAN, including this PLAN, BENEFITS will be coordinated with the BENEFITS from the "other plan". <u>The intent is to provide combined BENEFITS for the MAXIMUM</u>

PLAN ALLOWANCE (MPA), as defined in Article 1, which do not exceed BENEFITS which would be eligible as if PLAN ADMINISTRATOR were primary.

ARTICLE 6. EXCLUSIONS FOR ALL BENEFITS

6.01 The CLAIMS ADMINISTRATOR will only pay the BENEFITS stated for each type of dental service set out in the SCHEDULE OF BENEFITS. **Not all dental services are BENEFITS under this PLAN**. BENEFITS will only be provided for COVERED PARTICIPANTs who are enrolled on the date of TREATMENT. BENEFITS will be determined based on the date services were rendered. Services must be provided by a DENTIST or properly licensed employee of the DENTIST. Services must be necessary and customary. Services must be provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. The CLAIMS ADMINISTRATOR will pay allowable BENEFITS based upon the percentages and subject to the ANNUAL MAXIMUM BENEFIT as stated on the SCHEDULE OF BENEFITS. Such percentages will be applied to the lesser of the MAXIMUM PLAN ALLOWANCE (MPA) or the fees the DENTIST charges for the service. **The maximum payment for NON-PARTICIPATING DENTISTs will be ten percent (10%) less than to a PARTICIPATING DENTIST.** Payments for covered services performed by NON-PARTICIPATING DENTISTs will be sent to the patient(s). NON-PARTICIPATING DENTISTs may balance-bill patients for the difference of their charges and the CLAIMS ADMINISTRATOR's payment; PARTICIPATING DENTISTs shall not balance-bill patients for charges exceeding the MPA for BENEFITS under this PLAN.

6.02 OPTIONAL SERVICES

a) Services that are more expensive than the TREATMENT usually provided under accepted dental practice standards are called optional services. Optional services also include the use of specialized techniques instead of standard procedures. BENEFITS for optional services will be based on and paid the same as the usual service. The COVERED PARTICIPANT will be responsible for the remainder of the DENTIST's fee.

b) Payment made by the CLAIMS ADMINISTRATOR for any surgical service will include charges for routine, post-operative evaluations or visits.

c) If a COVERED PARTICIPANT transfers from one DENTIST to another during the course of TREATMENT, BENEFITS will be limited to the amount that would have been paid if one DENTIST rendered the service.

6.03 EXCLUSIONS

The following dental services are not eligible under this PLAN:

a) Benefits or services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws. Benefits or services available from any federal or state government agency; municipality, county, other

political subdivision; or community agency; or from any foundation or similar entity.

b) Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

c) Charges for services or supplies for which no charge is made that the patient is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.

d) Charges for TREATMENT by other than a DENTIST except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the DENTIST in accordance with generally accepted dental standards.

e) Charges for the completion of forms and/or submission of supportive documentation required by the CLAIMS ADMINISTRATOR for a benefit determination. A charge for these services is not to be made to a patient by a PARTICIPATING DENTIST in the DDAR network.

f) Benefits to correct congenital or developmental malformations.

g) Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the TREATMENT (cosmetic dentistry).

h) BENEFITS for services or appliances started prior to the date the COVERED PARTICIPANT became eligible under this PLAN, including, but not limited to, restorations, prosthodontics, and orthodontics.

i) Services with respect to diagnosis and TREATMENT of disturbances of the temporomandibular joint (TMJ).

j) Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.

k) Experimental and/or investigational services, supplies, care, and TREATMENT which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards or a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The CLAIMS ADMINISTRATOR must make an independent evaluation of the experimental or non-experimental standings of specific technologies. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use.

l) Charges for replacement of lost, missing, or stolen appliances/devices.

m) Charges for services when a CLAIM is received for payment more than twelve (12) months after services are rendered.

n) Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards.

o) Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.

p) Behavior management.

q) Those services and BENEFITS excluded by the rules and regulations of DDAR, including DDAR's processing policies.

r) Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.

s) Analgesia, anxiolysis, inhalation of nitrous oxide, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not covered. Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery excluding single tooth extractions (ADA procedure code 7140) and for CHILDren three (3) and under.

t) Procedures for purely cosmetic reason are not BENEFITS.

u) Procedures that do not comply with the CLAIMS ADMINISTRATOR's CLAIMs procedures.

v) Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations, and hospital-related services.

w) All other BENEFITS and services not specifically covered in the PLAN and/or SCHEDULE OF BENEFITS.

ARTICLE 7. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

7.01 CHOICE OF DENTIST. Neither the PLAN ADMINISTRATOR nor the CLAIMS ADMINISTRATOR furnishes covered services directly. The CLAIMS ADMINISTRATOR pays for licensed DENTISTs to provide these services. A COVERED PARTICIPANT may choose any DENTIST. COVERED PARTICIPANTs should determine the qualifications of the DENTIST they select. Participation in the DDAR network is open to all DENTISTs who meet DDAR's standards and who are licensed in Arkansas unless they have previously had their participation in DDAR terminated. DDAR only controls credentialing in Arkansas. However, there is currently in effect a policy by Delta Dental Plans Association (National), which is applicable to DeltaUSA groups, that requires all Delta Plans to have credentialing. Other state's credentialing policies are available upon request. Whether a DENTIST is a PARTICIPATING or NON-PARTICIPATING DENTIST should not be viewed as a statement about that DENTIST's abilities.

PLAN ADMINISTRATOR shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, neither PLAN ADMINISTRATOR nor the CLAIMS ADMINISTRATOR can ensure the DENTIST's use of precautions against the spread of such diseases. Neither PLAN ADMINISTRATOR nor the CLAIMS ADMINISTRATOR can compel the DENTIST to be tested for HIV or to disclose test results to DDAR or to the COVERED PARTICIPANT. If there are questions about a DENTIST's health status or use of recommended clinical precautions, COVERED PARTICIPANT should discuss them with the DENTIST.

7.02 CLINICAL EXAMINATION. Before approving a CLAIM, the CLAIMS ADMINISTRATOR may obtain from any DENTIST or hospital such information and records they may require to administer the CLAIM. PLAN ADMINISTRATOR may require that a COVERED PARTICIPANT be examined by a dental consultant, retained by PLAN ADMINISTRATOR, in or near his/her place of residence.

7.03 PRE-DETERMINATION. A DENTIST may file a CLAIM FORM showing the services he or she recommends. The CLAIMS ADMINISTRATOR will then pre-determine the BENEFITS payable under this PLAN. Payment will only be made for pre-determined services if the COVERED PARTICIPANT receives TREATMENT for which BENEFITS are payable, remains eligible, and has not exceeded his or her ANNUAL MAXIMUM BENEFITS. A CLAIM FORM requesting a PRE-DETERMINATION may be submitted electronically.

7.04 PROOF OF LOSS. CLAIMs must be furnished to CLAIMS ADMINISTRATOR within twelve (12) months after completion of TREATMENT for which BENEFITS are payable. Any CLAIM filed after this period will be denied.

7.05 TREATMENT OF BENEFITS ON LACK OF ELIGIBILITY. The CLAIMS ADMINISTRATOR will not pay BENEFITS for any services received by a patient who is not eligible under this PLAN at the time of TREATMENT.

7.06 TO WHOM BENEFITS ARE PAID. BENEFITS provided under this PLAN will be paid as follows:

a) For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.

b) For services provided by a NON-PARTICIPATING DENTIST, payment will be made to the EMPLOYEE. The EMPLOYEE is responsible for all payment(s) to a NON-PARTICIPATING DENTIST.

ARTICLE 8. CLAIMS PROCEDURES

8.01 CLAIMS. CLAIMs must be filed by COVERED PARTICIPANT or COVERED PARTICIPANT's authorized representative with DDAR within twelve (12) months after completion of TREATMENT for which BENEFITS are payable. Any CLAIM filed after this period will be denied. The CLAIMS ADMINISTRATOR has the discretion to interpret the terms of the BENEFITS under the PLAN but may consult with EMPLOYER.

8.02 FILING CLAIMS/PARTICIPATING DENTISTS. PARTICIPATING DENTISTS will complete and submit CLAIM FORMS for COVERED PARTICIPANTs at no charge. PARTICIPATING DENTISTs may ask COVERED PARTICIPANTs to fill out the patient section of the CLAIM FORM, which includes the COVERED EMPLOYEE's name, social security number (SSN), and address; the COVERED PARTICIPANT's name, date of birth, and relationship to COVERED EMPLOYEE; FULL TIME STUDENT information, if DEPENDENT; and coordination of BENEFITS information, if applicable.

8.03 FILING CLAIMS/NON-PARTICIPATING DENTISTS. If the COVERED PARTICIPANT visits a NON-PARTICIPATING DENTIST, COVERED PARTICIPANT may be required to complete the CLAIM FORM or pay a service charge. The patient section should be completed, which includes the COVERED EMPLOYEE's name, SSN, and address; the COVERED PARTICIPANT's name, date of birth, and relationship to COVERED EMPLOYEE; FULL TIME STUDENT information, if DEPENDENT; and coordination of BENEFITS information, if applicable.

COVERED PARTICIPANT will also be responsible for ensuring the NON-PARTICIPATING DENTIST completes the DENTIST and the Diagnostic (TREATMENT) Sections of the CLAIM FORM. The DENTIST Section includes the DENTIST's name, address, SSN or TIN number, license number, and phone number. The DENTIST must also indicate whether x-rays are attached and answer questions regarding TREATMENT that is the result of an accident. The DENTIST must also indicate if dentures, bridges, and crowns are replacements, and if so, the date of prior placement and reason for replacement must be noted.

The Diagnostic Section (TREATMENT) includes services performed (name description and ADA procedure code), including date of service, fee for service, and if applicable, tooth number or letter and tooth surface. For any unusual services, the Remarks Section of the CLAIM FORM must give a brief description. The CLAIM FORM needs to be signed by the DENTIST who performed the services and by the COVERED PARTICIPANT.

8.04 PROCESSING THE CLAIM. If COVERED PARTICIPANT visits a PARTICIPATING DENTIST, the CLAIM will be processed according to the PLAN BENEFITS. For COVERED PARTICIPANTS who visit a PARTICIPATING DENTIST, notification of the benefit determination will be sent to the COVERED EMPLOYEE in the form of an Explanation of BENEFITS, which details by service rendered what the PLAN allowed and the COVERED PARTICIPANT's obligation, if any.

If COVERED PARTICIPANT visits a NON-PARTICIPATING DENTIST, the COVERED EMPLOYEE will receive a CLAIM Payment Statement, which will detail by service rendered what the PLAN allowed and the COVERED PARTICIPANT's obligation, if any. The CLAIM Payment Statement will also include a benefit check made payable to the COVERED EMPLOYEE.

8.05 INITIAL CLAIM DETERMINATION. If the CLAIMS ADMINISTRATOR denies all or a portion of the CLAIM, COVERED PARTICIPANT will receive an Explanation of BENEFITS (for COVERED PARTICIPANTs visiting a PARTICIPATING DENTIST) or a CLAIM Payment Statement (for COVERED PARTICIPANTs visiting a NON-PARTICIPATING DENTIST) indicating the reason for the denial. The denial explanation will be printed at the bottom of the page and will include the following information:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan or Summary Plan Description provisions on which the determination was based.

(c) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on appeal.

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The following statement, "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."

(f) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(g) If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(h) In the case of an adverse benefit determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claim.

(i) The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice.

The COVERED EMPLOYEE will be notified within thirty (30) days of the receipt of the CLAIM by CLAIMS ADMINISTRATOR of the benefit determination.

In the case of an URGENT CARE CLAIM, the SUBSCRIBER will be notified within seventy-two (72) hours from the time the CLAIM is received by the CLAIM ADMINISTRATOR of the benefit determination.

8.06 APPEAL OF DENIED CLAIM. If the CLAIMS ADMINISTRATOR has denied a CLAIM, claimant may appeal the denial. Both the claimant and CLAIMS ADMINISTRATOR must take the following steps to complete an appeal (decision review):

a) Procedures the claimant must follow:

1) Write to the CLAIMS ADMINISTRATOR at the following address:

   Customer Service Support, Post Office Box 15965, North Little Rock, Arkansas, 72231 within one-hundred-eighty (180) days of the date on the notice of COVERED PARTICIPANT's CLAIM denial.

2) State why the CLAIM should not have been denied.

3) Include the denial notice and any other documents, data information, or comments that claimant believes may have an influence on the appeal of the CLAIM.

4) If requested, claimant will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied CLAIM.

5) For an expedited review of an URGENT CARE CLAIM, the request may be submitted orally (by telephone) or in writing (by facsimile or another similarly expeditious method).

b) Procedures CLAIMS ADMINISTRATOR must follow for a full and fair appeal: CLAIMS ADMINISTRATOR:

1) Identify the medical or vocational experts whose advice was obtained and utilized on behalf of CLAIMS ADMINISTRATOR in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

2) Not consider the initial denial in the review.

3) Conduct a review that includes one or more of the members of the CLAIMS ADMINISTRATOR's Appeals Committee (to be determined at the sole discretion of CLAIMS ADMINISTRATOR), but in no event will the individual who made the initial CLAIM denial, nor the subordinate of that individual be part of the review.

4) Consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted initially, nor who is the subordinate of such individual if your denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular TREATMENT, drug, or other item is experimental, investigational, or not medically necessary or appropriate.

c) Procedures CLAIMS ADMINISTRATOR must follow to notify claimant of its decision (if adverse):

1) Provide claimant with a notice that includes the following information:

i) The specific reason(s) for the adverse determination.

ii) Reference to the specific PLAN provision(s) on which the adverse determination is based.

iii) A statement that claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, or other information relevant to the CLAIM.

iv) A statement describing any voluntary appeal procedures, if any, and the claimant's right to obtain information about such procedures, and

a statement of claimant's right to bring an action under section 502 (a) of the Employee Retirement Income Security Act.

v) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

vi) If adverse determination is based on a medical necessity or experimental investigational TREATMENT or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

vii) The following statement: "You and your PLAN may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

2) Provide claimant with the aforementioned notice within seventy-two (72) hours if the CLAIM is an URGENT CARE CLAIM.

3) Provide claimant with the aforementioned notice within sixty (60) days if the CLAIM is a post-service CLAIM.

8.07 LEGAL ACTIONS. Any action must be brought within three (3) years from the time proof of loss is required by this PLAN. Notwithstanding the foregoing, an action may only be brought after a COVERED PARTICIPANT has exercised all the review and appeal rights and completed all administrative remedies under this PLAN.

ARTICLE 9. PRIVACY OF PROTECTED HEALTH INFORMATION

9.01 DEFINITIONS. The following definitions shall be used only for purposes of this Article. Other defined terms in this Article shall have the meanings given to them by the Privacy Regulations, or if there is no definition in the Privacy Regulations, by the PLAN.

(a) "Health Care Operations" means any of the activities of the PLAN that would be within the definition of "Health Care Operations" in section 164.501 of the Privacy Regulations, but only to the extent the activities were actually undertaken by the PLAN.

(b) "Individually Identifiable Health Information" means information that is Health Information, including demographic information collected from an individual, and:

(1) Is created or received by the EMPLOYER to carry out the administration functions it performs for the PLAN or by the PLAN; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or
(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(c) "Privacy Regulations" means regulations promulgated by the Department of Health and Human Services at 45 Code of Federal Regulations ("CFR") part 160 and 45 CFR part 164, as amended, to regulate the uses and disclosures of Protected Health Information as required by the Health Insurance Portability and Accountability Act of 1996, as amended.

(d) "Protected Health Information" means Individually Identifiable Health Information:

(1) Except as provided in paragraph (2) of this definition, that is:
(i) Transmitted by Electronic Media;

(ii) Maintained in any medium described in the definition of Electronic Media; or

(iii) Transmitted or maintained in any other form or medium.

(2) Protected Health Information does not include Individually Identifiable Health Information in:

(i) Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g;

(ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and

(iii) Employment records held by the PLAN in its role as an employer.

9.02 RESTRICTIONS ON PLAN DISCLOSURES. The PLAN will not disclose Protected Health Information to the EMPLOYER, except in accordance with the provisions of this Article or as allowed in the Privacy Regulations. Specifically, the PLAN will not disclose Protected Health Information to the EMPLOYER for the EMPLOYER's use in employment-related actions or decisions, and will not disclose Protected Health Information to the EMPLOYER for the EMPLOYER's use in connection with any other benefit or employee benefit plan of the EMPLOYER without the COVERED PARTICIPANT's authorization.

9.03 PERMITTED PLAN DISCLOSURES. The PLAN may disclose Protected Health Information to the EMPLOYER to carry out the PLAN's administrative functions that the EMPLOYER performs, but only after the EMPLOYER certifies to the PLAN that the PLAN amendments required by the Privacy Regulations to allow such disclosures were made.

9.04 EMPLOYER DISCLOSURES TO AN AGENT. The EMPLOYER will not disclose Protected Health Information received from the PLAN to its agent, unless such agent has agreed to the same restrictions and conditions that apply to the EMPLOYER with respect to such Protected Health Information.

9.05 AVAILABILITY OF PROTECTED HEALTH INFORMATION. The EMPLOYER will make Protected Health Information available only as follows:

(a) Access to Protected Health Information. The EMPLOYER will make available Protected Health Information in accordance with Section 164.524 of the Privacy Regulations.

(b) Amendment of Protected Health Information. The EMPLOYER will make available Protected Health Information in accordance with Section 164.526 of the Privacy Regulations.

(c) Accountability of Protected Health Information. The EMPLOYER make available Protected Health Information in accordance with Section 164.528 of the Privacy Regulations.

(d) Disclosure to the Department of Health and Human Services. The EMPLOYER will make its internal practices, books, and records relating to its uses and disclosures of Protected Health Information received from the PLAN available to the Secretary of Health and Human Services ("Secretary") or other officer or employee of the Department of Health and Human Services so delegated by the Secretary for purposes of determining compliance by the PLAN with respect to the Privacy Regulations.

(e) Destruction of Protected Health Information. To the extent feasible, the EMPLOYER will return or destroy all Protected Health Information received from the PLAN that the EMPLOYER has retained in any form (and will retain no copies of such Protected Health Information) when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the EMPLOYER will limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

9.06 EMPLOYER REPORT TO THE PLAN. The EMPLOYER will report to the PLAN any use or disclosure of Protected Health Information of which the EMPLOYER becomes aware that is inconsistent with the permitted uses and disclosures allowed in the Privacy Regulations.

9.07 ACCESS BY INDIVIDUALS RESPONSIBLE FOR PLAN ADMINISTRATION. The EMPLOYER will give access to the Protected Health Information, if any, from the PLAN that is used by the EMPLOYER in the administration of the PLAN only to those employees of (or other persons under the control of) the EMPLOYER who must have access to the Protected Health Information, as identified by the PLAN pursuant to the PLAN's policies and procedures with respect to disclosure and use of the PLAN's Protected Health Information. The PLAN will create and maintain a list of the persons or classes of persons who will be allowed access to Protected Health Information pursuant to this Section, which list is incorporated in the PLAN by this reference. No other employees of the EMPLOYER or other persons under the control of the EMPLOYER shall have access to Protected Health Information that is held or used by the EMPLOYER.

Any person given access to Protected Health Information under this Section must abide by the terms of the PLAN with respect to disclosure and use of the PLAN's

Protected Health Information. Failure to follow the terms of the PLAN with respect to use or disclosure of Protected Health Information will result in actions being taken against the person in accordance with the PLAN's policies and procedures establishing sanctions for those violating the PLAN's policies and procedures about Protected Health Information. The EMPLOYER will ensure that to the extent its involvement is needed, it will ensure that the adequate separation required by section 164.504(f)(2)(iii) of the Privacy Regulations is established.

9.08 RESTRICTIONS ON EMPLOYER'S USES AND DISCLOSURES. The EMPLOYER may not use or disclose Protected Health Information it has received from the PLAN:

(a) Other than as permitted by this Article, the Privacy Regulations and other applicable law.

(b) For employment-related decisions or actions with respect to the individual identified in the Protected Health Information or members of his family.

(c) In connection with any other benefit or employee benefit plan of the EMPLOYER without the COVERED PARTICIPANT's authorization.

9.09 SECURITY RULE. The PLAN will comply with the security regulations under HIPAA and shall be construed consistent with that purpose. For purposes of this section, the term “Electronic Protected Health Information” shall have the meaning set forth in Section 160.103 of the Privacy Regulations under HIPAA. The EMPLOYER shall:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health information that it creates, receives, maintains or transmits on behalf of the group health plan.

(b) Ensure that adequate separation between the health plan and plan sponsor is supported by reasonable and appropriate security measures.

(c) Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the PLAN any security incident of which the EMPLOYER becomes aware.

The PLAN agrees to disclose to EMPLOYER Protected Health Information necessary for EMPLOYER to comply with the requirements of the Medicare Modernization Act of 2003, including without limitation, 42 CFR § 423.884(b) and its filing requirements, and in turn EMPLOYER agrees to comply with the Privacy Regulations and all other applicable law with regard to such Protected Health Information.

ARTICLE 10. GENERAL PROVISIONS

10.01 PLAN AMENDMENTS. The EMPLOYER reserves the right to amend or terminate this PLAN at any time. PLAN amendments will be made by action of the EMPLOYER. In addition, premiums and contribution rates may change from time to time as determined by the EMPLOYER.

10.02 PROHIBITION OF ASSIGNMENT. No BENEFITS under this PLAN shall in any manner or to any extent be assigned, alienated, or transferred by any COVERED PARTICIPANT, or be subject to attachment, garnishment, or other legal process, except that PLAN ADMINISTRATOR shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations agreement), which is determined to be a Qualified Medical Child Support Order ("QMCSO"), pursuant to the procedures established under the PLAN.

10.03 DOES NOT REPLACE WORKER'S COMPENSATION. This PLAN does not affect any requirements for coverage by Worker's Compensation Insurance.

10.04 CONFLICTS. The terms of the PLAN, along with any amendments or endorsements issued by PLAN ADMINISTRATOR, will in all cases be controlling. Should the wording of the PLAN, along with any amendments or endorsements issued conflict with another document, the PLAN, along with any amendments or endorsements will govern.

10.05 RIGHT TO REVIEW CLAIMS AND RECEIVE NECESSARY INFORMATION. For the purpose of implementing the terms of the coverage under the PLAN, the CLAIMS ADMINISTRATOR may, without the consent of or notice to any person and subject to Article 9, release or obtain from any insurance company or other organization or person any information with respect to any person which it deems necessary for determining BENEFITS payable. The CLAIMS ADMINISTRATOR shall determine of whether a CLAIM falls under the eligible BENEFITS but may consult with EMPLOYER in reaching this determination.

10.06 PHYSICAL EXAMINATION. The CLAIMS ADMINISTRATOR shall, upon the request and at the expense of the PLAN and by a DENTIST of its own choice, have the right and opportunity to physically examine any COVERED PARTICIPANT with respect to the BENEFITS listed in this PLAN.

10.07 INTERPRETATION OF THE PLAN. The PLAN ADMINISTRATOR has the power and the discretionary authority to construe the terms of the PLAN and to determine all questions that arise under it. Such power and authority include, for example, the administrative discretion necessary to resolve issues with respect to an EMPLOYEE's or DEPENDENT's eligibility for BENEFITS, or to interpret any other

term contained in plan documents. The PLAN ADMINISTRATOR's interpretations and determinations are binding on all COVERED PARTICIPANTs, EMPLOYEEs, and former EMPLOYEEs.

10.08 ADMINISTRATION OF THE PLAN. The administration of this PLAN, except with regards to any CLAIMS for BENEFITS, the sole discretion to interpret this PLAN, and the responsibility for carrying out this PLAN's provisions shall be vested in the PLAN ADMINISTRATOR. The PLAN ADMINISTRATOR shall have full and complete discretion in the exercise of such administrative power and duties. The power to administer the PLAN with regards to CLAIMS for BENEFITS, including appeals, will be vested in the CLAIMS ADMINISTRATOR, though the CLAIMS ADMINISTRATOR may consult with EMPLOYER as to claims decisions. CLAIMS ADMINISTRATOR will comply with EMPLOYER's instruction regarding the processing of claims, as designated in the PLAN. Any usual and reasonable expenses incurred by the PLAN ADMINISTRATOR in the performance of its duties may be paid by the PLAN. CLAIMS ADMINISTRATOR shall not render investment advice to EMPLOYER. Both the CLAIMS ADMINISTRATOR and EMPLOYER, through the use of their discretion, shall act as fiduciaries.

10.09 NOTICE. All notices under this PLAN must be in writing. Notices for CLAIMs shall be addressed to:

Delta Dental of Arkansas
PO Box 15965
North Little Rock, Arkansas 72231

Notices to PLAN ADMINISTRATOR shall be sent to the address shown on the General Information page of this document. All notices will be effective forty-eight (48) hours after deposit in the United States mail with fully prepaid postage.

10.10 RIGHT TO RECOVERY. Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, CLAIMS ADMINISTRATOR will have the right to recover any excess. CLAIMS ADMINISTRATOR will recover the excess from any persons, insurance companies, or other organizations involved to whom payment was made. Any COVERED PARTICIPANT covered under this PLAN will execute and deliver any necessary documents and do what is necessary to secure such rights to CLAIMS ADMINISTRATOR on behalf of PLAN ADMINISTRATOR.

10.11 SUBROGATION. EMPLOYER acquires the COVERED PARTICIPANT's legal rights to recovery for payment for dental services the patient required because of the action or fault of another. EMPLOYER has the right to recover from the COVERED PARTICIPANT any payment(s) made by or for the other party. In such cases,

EMPLOYER has the right to recover amounts equal to the BENEFITS paid by CLAIMS ADMINISTRATOR, plus all collection costs and attorney's fees.

The CLAIMS ADMINISTRATOR, on behalf of EMPLOYER, has the right to make the recovery by suit, settlement, or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source, such as third party motorist coverage.

The COVERED PARTICIPANT must help EMPLOYER or CLAIMS ADMINISTRATOR recover from other sources. COVERED PARTICIPANT must provide all requested information and sign necessary documents. If the COVERED PARTICIPANT fails to help or settles any CLAIM without written consent, EMPLOYER may recover from the COVERED PARTICIPANT. EMPLOYER will be entitled to any recovery received by the COVERED PARTICIPANT and reasonable and necessary attorney's fees and court costs.

10.12 SUBCONTRACTOR(S) AND AGENT(S). EMPLOYER may subcontract certain functions or appoint an agent or agents to act on EMPLOYER's behalf and fulfill expressed, limited duties under this PLAN. Such agent(s) have no authority to change or amend this PLAN.

10.13 LIABILITY. The CLAIMS ADMINISTRATOR, the EMPLOYER, or the PLAN ADMINISTRATOR shall have no liability for any wrongful conduct. This includes but is not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any person. This includes but is not limited to DENTISTs, dental assistants, dental hygienists, dental EMPLOYEEs, hospitals, or hospital EMPLOYEEs receiving or providing services. The CLAIMS ADMINISTRATOR, the EMPLOYER, or the PLAN ADMINISTRATOR shall have no liability for any services, equipment, or facilities, which, for any reason, are unsafe for or unavailable to any COVERED PARTICIPANT.

10.14 RIGHT TO INFORMATION. In order for CLAIMs to be approved, CLAIMS ADMINISTRATOR, upon its request, shall be entitled to receive from any attending or examining DENTIST or from hospitals in which a DENTIST's care is rendered certain information and records. This data will relate to the attendance to, examination of, or TREATMENT rendered to a COVERED PARTICIPANT. The receipt by any COVERED PARTICIPANT of any service constitutes the consent of such COVERED PARTICIPANT to the release to CLAIMS ADMINISTRATOR of all such information and records. The COVERED PARTICIPANT shall execute a medical release as requested by EMPLOYER or the CLAIMS ADMINISTRATOR.

EMPLOYER agrees to provide CLAIMS ADMINISTRATOR current, complete, and correct information in regard to all EMPLOYEEs who are entitled to coverage. This will enable CLAIMS ADMINISTRATOR to properly affect coverage and to administer CLAIMs and provide service for all related matters.

10.15 MISREPRESENTATIONS. All statements made by an EMPLOYEE shall be deemed representations and not warranties.

10.16 FRAUD NOTICE. Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for benefits is guilty of a crime and may be subject to fines and confinement in prison.

10.17 FUNDING. BENEFITS under the PLAN shall be paid out of the general assets of the EMPLOYER or a trust established for the payments of such BENEFITS, as applicable.

10.18. CLERICAL ERROR. Any clerical error by the PLAN ADMINISTRATOR or an agent of the PLAN ADMINISTRATOR in keeping pertinent records or delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. If, due to a clerical error, an overpayment occurs in a PLAN reimbursement amount, the PLAN retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a COVERED PARTICIPANT, if it is requested, the amount of overpayment will be deducted from future BENEFITS payable.

10.19 CANCELLATION OF BENEFITS. If the EMPLOYER is unable to ascertain the whereabouts of any COVERED PARTICIPANT to whom BENEFITS are payable under this PLAN, and if, after one year from the date such payment is due, a notice of such amount due is mailed to the last known address of such person as shown on the records of the EMPLOYER and within three (3) months after such mailing, such person has not filed with the EMPLOYER written claim therefore, the EMPLOYER may direct that such payment be canceled and forfeited and, upon such cancellation by this PLAN, shall have no further liability therefore.

10.20 WAIVER / ESTOPPEL. No term, condition or provision of the PLAN shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this PLAN, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall

not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

10.21 GOVERNING LAW. This PLAN shall be construed and enforced according to the laws of the State of Arkansas, other than its laws respecting choice of law, to the extent not preempted by any federal law, including but not limited to ERISA.

10.22 RELIANCE ON PARTICIPANT. The PLAN ADMINISTRATOR may rely upon the direction, information, or election of a COVERED PARTICIPANT as being proper under the PLAN and shall not be responsible for any act or failure to act because of a direction or lack of direction by a COVERED PARTICIPANT. The PLAN ADMINISTRATOR will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the PLAN ADMINISTRATOR.

10.23 EFFECT OF MISTAKE. In the event of a mistake as to the eligibility or participation of an EMPLOYEE or DEPENDENT, or the amount of BENEFITS paid or to be paid to a COVERED PARTICIPANT or other person, the PLAN ADMINISTRATOR shall, to the extent it deems administratively possible and otherwise permissible under the CODE or the regulations issued thereunder, cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such COVERED PARTICIPANT or other person the BENEFITS to which he or she is properly entitled under the PLAN. Such action by the PLAN ADMINISTRATOR may include withholding of any amounts due the PLAN or the EMPLOYER from compensation paid by the EMPLOYER.

10.24 HEADINGS. The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this PLAN or as indicating, or controlling the meaning or construction of any provision.

10.25 SEVERABILITY. Should any part of this PLAN subsequently be invalidated by a court of competent jurisdiction, the remainder of the PLAN shall be given effect to the maximum extent possible.

STATEMENT OF ERISA RIGHTS

As a participant in this dental benefits plan, you are entitled to certain rights and protections under the EMPLOYEE Retirement Income Security Act (ERISA) of 1974. ERISA provides that all PLAN participants shall be entitled to:

Receive Information About Your PLAN and BENEFITS

Examine, at no charge, at the PLAN ADMINISTRATOR's office and at other specified locations, such as worksites or union halls, all documents governing the PLAN. This includes the PLAN DOCUMENT and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the PLAN with the US Insurance Department of Labor. This is available at the Public DISCLOSURE Room of the EMPLOYEE Benefits Security Administration.

Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the PLAN. Documents include plan documents and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the PLAN's annual financial report. The PLAN ADMINISTRATOR is REQUIRED BY LAW to furnish each COVERED PARTICIPANT with a copy of the summary annual report.

Continue GROUP DENTAL PLAN Coverage

Continue dental care coverage for yourself or for your DEPENDENTs if there is a loss of coverage under the PLAN as a result of a qualifying event. You or your DEPENDENTs may have to pay for such coverage. Review this summary plan description and the documents governing the PLAN on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for PRE-EXISTING CONDITIONs. Your PLAN does not have exclusionary periods for PRE-EXISTING CONDITIONs. Because the PLAN provides for limited scope dental coverage, it is exempt from the certification of credible coverage provisions of the Health Insurance Portability and Accountability Act (HIPAA) and Section 733 of ERISA.

Prudent Actions of PLAN Fiduciaries

In addition to creating rights for PLAN participants, ERISA gives duties to the people responsible for the operation of the employee benefit PLAN. The people who operate your PLAN are called "fiduciaries" of the PLAN, and they have a duty to do so prudently

and in the interest of you and other COVERED PARTICIPANTs. No one, including your EMPLOYER, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a BENEFIT or exercising your rights under ERISA.

Enforce Your Rights

If your CLAIM for a BENEFIT is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time restraints.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the PLAN and do not receive them within thirty (30) days, you may file suit in a federal court. In such case, the court may require the PLAN ADMINISTRATOR to provide the materials and pay you up to $110.00 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the administrator. If you have a CLAIM for BENEFITS that is denied or ignored in whole or in part, you may file suit in a state or federal court, subject to Section 8.07. In addition, if you disagree with the PLAN's decision or lack thereof concerning a medical child support order, you may file suit in federal court. If it should happen that PLAN fiduciaries misuse the PLAN's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US 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 fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your PLAN, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement or your rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website)

GENERAL PLAN INFORMATION

PLAN NAME	Value Plan
PLAN NUMBER	9652
TYPE OF PLAN	Self-Funded Employee Benefit Plan
TAX ID NUMBER	82-4099672
PLAN EFFECTIVE DATE	January 1, 2021 (Original Effective Date)
PLAN YEAR ENDS	December 31st
EMPLOYER INFORMATION	Revolution Company 8801 Frazier Pike Little Rock, AR 72206
PLAN ADMINISTRATOR	Revolution Company 8801 Frazier Pike Little Rock, AR 72206
AGENT FOR SERVICE OF LEGAL PROCESS	Revolution Company 8801 Frazier Pike Little Rock, AR 72206

Service of legal process may also be made on the Plan Administrator.

CLAIMS ADMINISTRATOR- INITIAL CLAIMS	Delta Dental of Arkansas PO Box 15965 Little Rock, AR 72231 (501) 835-3400
CLAIMS ADMINISTRATOR- CLAIMS APPEAL	Delta Dental of Arkansas PO Box 15965 Little Rock, AR 72231 (501) 835-3400