Summary Plan Description

ABOUT YOUR PLAN

This Summary Plan Description is issued to the Subscriber (employee) by Delta Dental Plan of Oklahoma, Inc., sometimes referred to as DDPOK, an Oklahoma nonprofit dental service corporation with its main office in Oklahoma City, Oklahoma. It is intended to be an easy to read outline of the principal features of your Dental Expense Benefits Plan. This Summary Plan Description, with any inserts, constitutes your summary of the contract and is subject to and superseded by the provisions of any applicable agreement between Delta Dental Plan of Oklahoma and your employer or representative of your group.

If any state or federal legislation is in effect, enacted, or amended requiring a change in the Dental Expense Benefits described in this Summary Plan Description, appropriate modification may be made in the benefits provided under the plan.

Eligibility and Enrollment

To be eligible for enrollment under this plan, you, as the Subscriber, must be a full-time employee (unless specified otherwise in the "Summary of Dental Plan Benefits" included in this Summary Plan Description) and certified by the employer as eligible. "Full-time" means an employee who regularly works at least the number of hours in the normal work week set by your employer (but not less than 30 hours) at your employer's place of business or such other place or places as required by your employer. If you meet the requirements of eligibility as the Subscriber, you become eligible for coverage on the day specified in the "Summary of Dental Plan Benefits" included in this Summary Plan Description.

Unless noted otherwise in the *"Eligible Persons"* section of the "Summary of Dental Plan Benefits" included in this Summary Plan Description, you are eligible for dependent coverage on the later of the date you become eligible for coverage or the date you first acquire an eligible dependent. Eligible dependents include: (1) the spouse to whom the Subscriber is legally married; (2) biological children of the Subscriber; and (3) children of the subscriber by legal adoption or placement for adoption, guardianship, marriage (stepchildren), and foster care placement (foster child).

A dependent child, as defined above, is eligible for coverage until 11:59:59 P.M. (CT) of the last day of the month in which such dependent child attains the age of 26 (unless otherwise specified in the "Summary of Dental Plan Benefits" included in this Summary Plan Description). An unmarried dependent child who is incapable of self-support due to a physical or mental incapacity can continue to be covered under this plan as a dependent after reaching age 26, provided he or she is chiefly dependent on the Subscriber for support and a physician's certificate is received by DDPOK within six (6) months of said incapacity, the effective date of the Plan Agreement, the effective date of said dependent child's coverage, or the date on which said dependent child's coverage would otherwise terminate due to said dependent child attaining the maximum age for dependent children coverage, whichever is later.

Enrollment requirements are set forth in the Plan Agreement between Delta Dental Plan of Oklahoma and your employer or representative of your group. If enrollment is mandatory, all eligible Subscribers and their eligible dependents must enroll in the plan within 30 days of initial eligibility and remain enrolled as long as their eligibility continues. If enrollment is not mandatory, eligible Subscribers and dependents that enroll agree to remain enrolled until the next plan anniversary date, or until the next open enrollment date if the plan anniversary date and open enrollment date are not the same.

Your plan benefits may be affected if you have two or more dental plans in effect at the same time. DDPOK will coordinate these benefits as described herein to ensure maximum coverage for the patient. See "**Coordination of Benefits**" in this Summary Plan Description for more detail.

A person cannot be enrolled in this plan as both a Subscriber and a dependent of another Subscriber.

Disqualification, Ineligibility, and Forfeiture

Eligible Subscribers or dependents that fail to enroll in the plan within 30 days of their initial eligibility or who waive coverage at the time of their enrollment eligibility will be eligible to enroll in the plan on any future plan anniversary date or open enrollment date. Any enrolled person who voluntarily discontinues coverage will be eligible to re-enroll on any future plan anniversary date or open enrollment date.

Any eligible person failing to enroll or waiving coverage at the time of initial eligibility, or any enrolled person who voluntarily discontinues coverage, is classified as a "Late Enrollee" upon enrollment and may be subject to limited benefits. Note: Enrolling

during your employer's annual open enrollment period is not considered enrolling at the time of initial eligibility, therefore, any "late enrollee" limitations that apply to your plan will apply to your enrollment. *Please review the "Limitations" section of the "Summary of Dental Plan Benefits" included in this Summary Plan Description to determine what late enrollee limitations, if any, apply to your plan.*

Subscriber Amendments or Termination

Each Subscriber can apply to change from single coverage to family coverage if DDPOK receives the appropriate form requesting such change within 30 days of Subscriber acquiring any eligible dependents. If a Subscriber has family coverage, newly acquired eligible dependents can be added if DDPOK receives the appropriate form requesting such change within 30 days of the Subscriber acquiring the new eligible dependent.

If enrollment of dependents is not mandatory under the terms of the Plan Agreement, a Subscriber can apply to terminate coverage for one or more dependents if DDPOK receives the appropriate request form within 30 days of the date the termination is requested and provided one of the following conditions exists or has occurred:

- Dependent no longer meets the definition of eligible dependent, as set forth in the Plan Agreement
- Death of dependent
- Divorce of dependent and Subscriber
- Dependent enters military service
- Dependent acquires coverage elsewhere
- Plan anniversary date

If enrollment is voluntary under the terms of the Plan Agreement, a Subscriber can apply to terminate his/her coverage if DDPOK receives the appropriate request form within 30 days of the date the termination is requested. Voluntary termination of Subscriber and/or dependent(s) coverage is subject to the terms of the Plan Agreement.

A Subscriber whose coverage under the Plan Agreement terminates under the retirement guidelines of his or her employer during the period the Plan Agreement is in full force and effect may convert to an individual direct payment contract with DDPOK provided his or her employer has elected to offer the DDPOK Retiree Conversion Program to retiring employees. A Subscriber or eligible dependent whose coverage under the Plan Agreement is terminated for any reason other than the Subscriber's retirement during the period the Plan Agreement is in full force and effect may be eligible to enroll in an individual direct payment contract with DDPOK if such person is a resident of the state of Oklahoma.

Employer Amendments or Termination

It is anticipated that this plan will be continued indefinitely, but the employer reserves the right to change or terminate this plan in the future by agreement between the employer and DDPOK.

Coverage under this Summary Plan Description may be automatically terminated:

- On the last day of the month in which the Subscriber is permanently terminated from full-time service to the employer or becomes ineligible for benefits under the plan; or,
- On the last day of the month for which the Subscriber's contributions have been made, if applicable; or
- On the date this plan is terminated or canceled.

Continuation of Coverage

For possible continuation of your group dental plan, see your employer's benefits office regarding the provisions of COBRA. Participants and beneficiaries can obtain, without charge, a copy of the continuation of coverage procedures from your employer or representative of your group.

A Subscriber whose coverage under the Plan Agreement terminates under the retirement guidelines of his or her employer during the period the Plan Agreement is in full force and effect may convert to an individual direct payment contract with DDPOK provided his or her employer has elected to offer the DDPOK Retiree Conversion Program to retiring employees. A Subscriber or eligible dependent whose coverage under the Plan Agreement is terminated for any reason other than the Subscriber's retirement during the period the Plan Agreement is in full force and effect may be eligible to enroll in an individual direct payment contract with DDPOK if such person is a resident of the state of Oklahoma.

Qualified Medical Child Support Order (QMCSO)

In the event of a Participant receiving a Qualified Medical Child Support Order (QMCSO), the Participant must obtain a copy of the Medical Support Notice Form, supplied by either DDPOK or the employer's benefits office. This Notice form, with a copy of the Order must be mailed to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154. DDPOK shall take the necessary steps to ensure compliance with said QMCSO. Participants and beneficiaries can obtain, without charge, a copy of the QMCSO procedures from DDPOK.

Qualified Domestic Relations Order (QDRO)

In the event of a Participant receiving a Qualified Domestic Relations Order (QDRO), the Participant must obtain a copy of the Medical Support Notice form, supplied by either DDPOK or the employer's benefits office. This Notice form, with a copy of the Order must be mailed to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154. DDPOK shall take the necessary steps to ensure compliance with said QDRO. Participants and beneficiaries can obtain, without charge, a copy of the QDRO procedures from DDPOK.

DDPOK Termination

This Summary Plan Description may be automatically terminated:

- On the last day of the month in which the Subscriber is permanently terminated from full-time service to the Employer or becomes ineligible for benefits under the plan; or,
- On the last day of the month for which the Subscriber's contributions have been made, if applicable; or,
- On the last day of the month for which the last payment has been made if the group fails to make payment as required under the Plan Agreement; or,
- On the date on which the Plan Agreement is terminated or canceled.

Summary of Dental Plan Benefits

Your "Summary of Dental Plan Benefits" is included in this Summary Plan Description and shows the covered services included in your dental program. It also indicates the amount of your deductible and to which types of services the deductible applies.

After you satisfy any dental deductible required, your dental benefits will pay a specific amount of the cost of covered services, up to your benefits plan maximum for each benefit period. You will be responsible for the remaining co-payment amount, if any. *For your benefit maximum(s), deductible, and co-payment amounts, refer to your "Summary of Dental Plan Benefits" included in this Summary Plan Description.*

Your dental benefits are provided according to a benefit period, which begins initially on the date your coverage becomes effective with Delta Dental Plan of Oklahoma. A new benefit period (Plan Benefit Year) begins each year on either the group dental plan anniversary date or January 1. *For your Plan Benefit Year, refer to your "Summary of Dental Plan Benefits" included in this Summary Plan Description.*

Benefits for some services are subject to certain limitations, such as age of patient, frequency of procedure, etc., and benefits may not be available under certain circumstances. ***Refer to your "Summary of Dental Plan Benefits" included in this Summary Plan Description to determine what limitations and exclusions, if any, apply to your dental plan.***

HOW TO USE YOUR PLAN

Delta Dental Networks of Participating Dentists

You may visit the properly licensed dentist of your choice, because your plan provides for in-network as well as limited out-of-network benefit coverage. Delta Dental Plan of Oklahoma uses two nationwide networks of dentists through Delta Dental Plan of Oklahoma's membership in a nationwide system known as Delta Dental Plans Association. These networks are among the largest in the dental benefits industry, both locally and nationwide, providing you easy access to participating dentists in most geographical areas. Please refer to your "Summary of Dental Plan Benefits" included in this Summary Plan Description for specific network information pertaining to your plan.

Delta Dental Plans have unique "participating agreements" with those dentists in the networks described above. In most cases, these agreements mean you simply present your identification card to the dentist at the time of treatment and he or she will file your claim for you. Delta Dental Plan of Oklahoma will pay the participating dentist direct for any covered services.

Emergency Care and Claim Predetermination

If you require emergency care, there is no preauthorization requirement. If the cost of the dental care you need is less than $250, your participating dentist will probably proceed with treatment. If the cost estimate is more than $250 and the treatment is not emergency care, your dentist can determine the treatment needed and submit a treatment plan to DDPOK for predetermination of benefits. This procedure will enable you and the dentist to know in advance of treatment what services are covered, how much of the cost will be paid by your dental plan, and how much of the cost you will be responsible for paying.

This plan does not require any preauthorization for any dental services; however, said services are subject to the plan's specific limitations, non-covered charges, deductibles, and co-payment amounts, as well as any charges over your plan maximum.

Claim Filing

You or someone in the dental office must complete the information portion of the claim form with the Subscriber's full name; Subscriber's social security number or, if applicable, unique identification number; the name and date of birth of the person receiving dental care; and the group name and number.

If you have any questions about the plan, please check with your employer's benefits office or write to Delta Dental Plan of Oklahoma, Customer Service Department, P.O. Box 54709, Oklahoma City, Oklahoma 73154-1709. *All correspondence with DDPOK should include the group name and group number; the Subscriber's social security number, telephone number, and address; name of patient; and date of service.*

Once treatment is completed, the participating dentist will submit the claim form to Delta Dental Plan of Oklahoma for payment.

Participants and beneficiaries can obtain, without charge, the necessary claim filing forms from DDPOK. The complete claim appeal procedure is furnished upon request, without charge, as a separate document.

Claim Filing Deadline

Delta Dental Plan of Oklahoma is not obligated to pay any claim submitted later than 12 months following the date of service.

WARNING: *Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.*

Explanation of Benefits

Anytime you or a dentist file a claim, you will receive a form called an Explanation of Benefits (EOB) from Delta Dental Plan of Oklahoma within a reasonable time, but no later than 30 days after receipt of a claim. DDPOK may extend this time period one time up to 15 days, prior to the expiration of the 30-day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be given 45 days from receipt of the notice within which to provide the necessary information.

The EOB indicates what services were covered and what services, if any, were not. You are responsible to pay only the amount designated as "Patient Payment"; if you are billed for amounts over those identified, please contact DDPOK's Customer Service Department. An explanation of how to appeal a claim is included on the EOB, as well as in this Summary Plan Description.

Coordination of Benefits

The Coordination of Benefits provision is designed to provide maximum coverage if a patient is eligible for benefits under two or more dental plans and more than one of those plans provides coverage for a particular service. In no event will either plan pay a greater amount than it would have paid had dual coverage not existed, and the dental programs together will not pay more than 100% of covered expenses.

HOW TO APPEAL A CLAIM

Claim Benefits Denial

A copy of the Explanation of Benefits will be sent to the Subscriber by DDPOK, indicating if any services are denied, in whole or in part, and stating the reason or reasons for the denial, according to the time frame described in the Explanation of Benefits section in this Summary Plan Description.

Appeal of Claim Benefits Denial

Within 180 days after receipt of a notice of denial, a Subscriber or dentist may make a written request for review of such denial by addressing the request to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154, stating the reason(s) re-evaluation of the denial is being requested. The Subscriber or dentist may submit written comments, documents, records, and other information relating to the claim for benefits. As a Subscriber, you may request reasonable access to and, at no charge, copies of all documents, records, and other information relevant to your claim for benefits. All requests for review of denials shall be made taking into account all comments, documents, records, and other information submitted by the Subscriber relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Full and Fair Review of Request

DDPOK shall make a full and fair review of each request for re-evaluation and may require additional documents, as it deems necessary or desirable in making such a review. The Subscriber shall receive a decision on his/her initial request for a review, in writing, within 30 days after DDPOK receives the request.

If the Subscriber wishes to have the initial review determination appealed further, the Subscriber must make a written request for a second review of the denial by addressing the request to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154, stating the reason(s) re-evaluation of the denial is being requested. The Subscriber shall receive a decision on his/her second request for a review, in writing, within 30 days after DDPOK receives the second request.

Any complaints other than those involving the denial of services should also be addressed, in writing, to the office identified above. Such complaints will be reviewed according to the same procedure. The complete claim appeal procedure is furnished upon request, without charge, as a separate document.

Upon final determination of the second request for appeal, you have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act.

GENERAL INFORMATION

Assignment

Services to eligible persons are for the personal benefit of such persons and cannot be transferred or assigned. Any attempt to do so shall automatically terminate all rights of the eligible person, except in those states where assignment is required by law.

Obtaining and Releasing Information

To determine how the terms of this Summary Plan Description shall be applied and implemented, DDPOK may, without the consent of or notice to any eligible person, release to or obtain from any insurance company, group hospitalization plan, or dental care plan any information with respect to payments or benefits which it deems to be necessary for such purposes.

Any eligible person claiming benefits under this plan shall furnish DDPOK such information as may be necessary to implement this provision.

Doctor-Patient Relationship

The eligible person has freedom of choice of any properly licensed dentist. Each dentist rendering service under this Summary Plan Description is an independent contractor and shall maintain the doctor-patient relationship with his or her patient hereunder and shall be solely responsible to the patient for dental advice and treatment or any liability resulting there from.

STATEMENT OF ERISA RIGHTS

As a plan participant, you have certain rights under the Employee Retirement Income Security Act of 1974 (ERISA). The Act provides that you are entitled to:

Receive Information About Your Plan

You may examine, without charge, at your employer's benefits office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to your employer, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated summary plan description. Your employer may make a reasonable charge for the copies.

You may receive a summary of the plan's annual financial report. The employer is required by law to furnish each participant with a copy of this summary annual report. This statement must be requested in writing, and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

You may or may not be eligible for continued health care coverage, which may or may not include continued dental care coverage for yourself, spouse, or 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, the Plan, and the rules and regulations governing COBRA continuation coverage rights and consult your employer's benefits office for further information.

Some of these rights, if applicable, may be the reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You may, if applicable, be provided a Certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, if you become entitled to elect COBRA continuation coverage, if/or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of this employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 schedules.

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 30 days, you may file suit in federal court. In such a case, the court may require your employer to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of your employer. 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and 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 questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your employer, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting their website at http://www.dol.gov/ebsa/.

THIS SUMMARY PLAN DESCRIPTION IS ONLY A SUMMARY OF THE DENTAL PLAN, NOT A CONTRACT. ALL BENEFITS ARE GOVERNED BY, AND SUBJECT TO, THE PROVISIONS OF THE PLAN AGREEMENT BETWEEN YOUR EMPLOYER OR REPRESENTATIVE OF YOUR GROUP AND DELTA DENTAL PLAN OF OKLAHOMA.

SUMMARY OF DENTAL PLAN BENEFITS

SUPPLEMENTAL PLAN DESCRIPTION- Revised January 1, 2018

NAME OF PLAN	THE CUMMINS CONSTRUCTION COMPANY, INC. Group Dental Plan Group No. 0002115-0002
PLAN SPONSOR/ EMPLOYER	THE CUMMINS CONSTRUCTION COMPANY, INC. P O BOX 748 ENID, OK 73702
TYPE OF PLAN	Employee Welfare Benefit Plan
PLAN BENEFIT YEAR	January 1 - December 31 each year
PLAN BENEFITS PROVIDED BY	DELTA DENTAL PLAN OF OKLAHOMA P.O. BOX 54709 OKLAHOMA CITY, OKLAHOMA 73154 (405) 607-2100 OR (800) 522-0188
AGENT FOR LEGAL SERVICE	THE CUMMINS CONSTRUCTION COMPANY, INC. 1420 W CHESTNUT ENID, OK 73703

GENERAL PROVISIONS

Eligible Persons

Persons eligible for coverage under this Plan include all full-time employees and their eligible dependents.

Dependent Children

Covered to age twenty-six (26). *Note: Refer to the "About Your Plan" section of the Summary Plan Description for information on extended coverage for handicapped children.*

Probationary Period (New-hire Employees)

New-hire employees will be eligible for coverage under this Plan on the first of the month following six (6) months of continuous, full-time employment.

SELECTED BENEFITS

The dental services included in the Plan Sponsor's group dental plan are listed in this Summary, under "Description of Covered Services", and described by classes of service. After an eligible person satisfies the plan benefit year deductible, if any, the Plan will pay a percentage of the lesser of the dentist's submitted fee or the maximum allowable amount. The Plan's percentage payment will be based on the class of dental service provided, as indicated next to each class of service. ***Note: Some benefits are subject to limitations, e.g. age of patient, frequency of procedure, etc., or excluded in some instances. Please review "LIMITATIONS" and "EXCLUSIONS" in this Summary.***

MAXIMUM CONTRACT BENEFIT

The maximum benefit payable for combined Class I, Class II, and Class III covered dental services rendered to an eligible person during the benefit year shall be Two Thousand Dollars ($2,000). The maximum lifetime benefit payable for covered Class IV services rendered to an eligible person shall be Two Thousand Dollars ($2,000). *Note: Benefits paid by the Plan for covered oral evaluations (procedure codes D0120-D0180) and routine prophylaxis (procedure codes D1110 and D1120) rendered to an eligible person during the benefit year will not reduce such person's maximum benefit for combined Class I, Class II, and Class III covered dental services*.

DEDUCTIBLE

Fifty Dollars ($50) per person per benefit year. *Note: The maximum family deductible is three (3) individual deductibles per benefit year. Note: Deductible is not applicable to Classes I and IV Services.*

BENEFIT PAYMENT PROCEDURE, PARTICIPATING DENTISTS

Under the Delta Dental Plans participating agreements with participating dentists, benefit claims are reimbursed based on the lesser of the dentist's submitted fee for his or her service or the maximum allowable amount he or she has agreed to accept as payment for covered services in accordance with the Participating Agreement applicable to the plan. Participating dentists accept the maximum allowable amount as payment in full.

If a Delta Dental PPO Participating Dentist provides treatment, you are not responsible for paying the dentist any amount that exceeds the maximum allowable amount the Delta Dental PPO Participating Dentist has agreed to accept as payment for covered services. You are responsible for paying the dentist any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

If treatment is provided by a Delta Dental Premier Participating Dentist, you are not responsible for paying the dentist any amount that exceeds the maximum allowable amount the Delta Dental Premier Participating Dentist has agreed to accept as payment for covered services. You are responsible for paying the dentist for any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

The DDPOK Participating Dentists Network lists are furnished upon request, without charge, as separate documents. You may also obtain lists of participating dentists in the Delta Dental PPO and Delta Dental Premier networks by accessing the DDPOK website at www.DeltaDentalOK.org.

BENEFIT PAYMENT PROCEDURE, NONPARTICIPATING DENTISTS, OUT-OF-NETWORK SERVICES

If you obtain treatment from a dentist who has not signed a participating agreement with Delta Dental, any benefit payment will be paid directly to you, or to other participant or beneficiary if required by law, and will be based on the lesser of the dentist's submitted fee for his or her service or the prevailing fee. Prevailing fee is an amount established by the Delta Dental Plan in the state in which the dental services are rendered. You are responsible for paying the dentist and for filing your own claim.

DESCRIPTION OF COVERED SERVICES

CLASS I SERVICES - 100%

Diagnostic Services: Procedures performed by properly licensed dentists in evaluating existing conditions to determine the required dental treatment. By way of description, such covered services include: Oral evaluations (examinations), emergency palliative treatment, and radiographic images (x-rays).

Preventive Services: Procedures performed by properly licensed dentists to prevent the occurrence of disease. By way of description, such covered services include: Routine prophylaxis (cleaning), periodontal maintenance (D4910), and scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346); and topical application of fluoride, limited sealants, and space maintainers for eligible dependent children.

CLASS II SERVICES - 80%

Basic Restorative Services: Procedures performed by properly licensed dentists in the treatment of carious lesions (decay/cavity). By way of description, such covered services include: Amalgam and composite restorations (fillings); and stainless steel restorations (crowns) for eligible dependent children.

Oral Surgery Services: Procedures performed by properly licensed dentists for extractions and other oral surgical procedures.

Endodontic Services: Procedures performed by properly licensed dentists for the treatment of non-vital teeth. By way of description, such covered services include: Pulpal therapy and root canal treatment.

Periodontic Services: Procedures performed by properly licensed dentists for the treatment of diseases of the gums and supporting structures of the teeth, excluding periodontal maintenance (D4910) and scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346) which are payable as Class I dental services.

CLASS III SERVICES - 50%

Major Restorative Services: Provides porcelain or cast restorations (other than stainless steel) for the treatment of carious lesions (decay/cavity) when teeth cannot be restored with another filling material. ***Note: A crown or cast restoration is optional treatment unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or composite restoration.***

Prosthodontic Services: Procedures for construction of fixed partial dentures (bridges), removable partial dentures, and complete dentures, including adjustment or repair of an existing prosthodontic device provided under this Plan.

Implant Services: Procedures for implant placement, implant-supported prosthetics, and maintenance and repair of implants and implant-supported prosthetics provided under this Plan.

CLASS IV SERVICES - 50%

Orthodontic coverage is available to the Subscriber and his or her eligible dependents

Orthodontic Services: The necessary treatment and procedures required for the correction of malposed teeth.

LIMITATIONS

The benefits to be provided to Subscribers and eligible Dependents under this Plan shall be limited as follows:

- For purposes of this Plan, any procedure frequency limitation is measured in a period of continuous calendar-year months (a consecutive-month period), which begins on the date of service for which the procedure was last paid.
- Prophylaxis is a benefit twice in a 12 consecutive month period. *Note: Cleanings/prophylaxis of any type, including periodontal maintenance and scaling in the presence of generalized moderate or severe gingival inflammation, are limited to any combination of two in a twelve consecutive month period.*
- Oral evaluation is a benefit twice in a 12 consecutive month period.
- Limited (emergency) oral evaluation is a benefit twice in a 12 consecutive month period. *Note: Benefits for limited (emergency) oral evaluation may be disallowed if other services are provided on the same day.*
- Bitewing radiographic images are a benefit once in a 12 consecutive month period. *Note: Benefits may be limited if multiple same-day radiographic images are provided on the same day by the same dentist/dental office.*
- Full-mouth radiographic images, a panoramic radiographic image, or multiple same-day radiographic images is a benefit once in a 60 consecutive month period unless necessary for the diagnosis and treatment of a specific disease or injury. *Note: Panoramic radiographic image is a benefit for persons age six (6) and older.*

- Topical application of fluoride solutions is a benefit for patients through age 18, and once in a 12 consecutive month period.
- A space maintainer is a benefit for missing primary posterior teeth for persons through age 15, and not for orthodontic purposes.
- Sealants are a benefit for persons through age 15, limited to permanent first and second molar teeth free of caries and restorations on the occlusal surfaces. Sealants are a benefit once per tooth in a 60 consecutive month period.
- Stainless steel crowns are a benefit only for persons through age 11, and once per tooth in an 84 consecutive month period.
- General anesthesia/IV sedation is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. The fee for general anesthesia/IV sedation is denied when billed by anyone other than a licensed dentist.
- Payment is made for a single tooth surface repair once in a 24 consecutive month period, regardless of the number of combinations of restorations placed therein.
- Root canal therapy is a benefit once per tooth in a 36 consecutive month period.
- Prosthodontics: (1) An upper or lower denture is a payable benefit once per arch in a 60 consecutive month period; (2) a removable partial denture or fixed partial denture (bridge) may not be provided more often than once per arch in a 60 consecutive month period, except where the loss of additional teeth requires the construction of a new appliance; (3) reline and rebase is a benefit once in any 36 consecutive month period for any one appliance.
- Crowns/onlays/veneers on the same tooth are a benefit once in an 84 consecutive month period.
- Orthodontic Benefits: (1) Orthodontic treatment must be provided by a licensed dentist; (2) benefits are limited to periodic payments; and (3) benefits cease the last day of the month in which: (a) such person becomes ineligible for orthodontic coverage under this Plan, (b) treatment is terminated for any reason before completion of the treatment plan, (c) treatment is completed, or (d) the maximum orthodontic benefit has been paid, whichever occurs first.
- Implant Benefits: The implant and the associated crown over the implant are a benefit for persons 16 years of age and over, limited to once in an 84 consecutive month period. *Note: Some implant procedures or procedures associated with implants are not covered services under the plan and no benefits will accrue or be payable for those excluded procedures (please contact DDPOK Customer Service with any questions).*
- Single crowns/onlays/veneers are benefits for persons age 12 and over.
- Fixed partial dentures (bridges) and removable partial dentures are benefits for persons age 16 and over.
- Alternate Benefits/Optional Treatment: DDPOK may consider alternate dental services that are suitable for care of a specific condition if those alternate services will produce a professionally acceptable result, as determined by DDPOK. If patient and dentist elect other treatment, patient will be responsible for any charges in excess of DDPOK's payment.
- DDPOK's obligation to provide benefits for covered dental services terminates on the last day of the month in which the patient becomes ineligible for benefits under this Plan.
- Care terminated due to death will be paid in full, to the limit of DDPOK's liability, for services completed or in progress.
- When services in progress are interrupted and completed later by another dentist, DDPOK will review the claim to determine the payment to each dentist.
- Processing policies, if applied, may limit benefits and can be found on each Explanation of Benefits.
- Charges for any covered dental service or supplies which are included as covered medical expenses under the plan of Major Medical or Comprehensive Medical Expense Benefits Plan must first be submitted for payment to the medical carrier. DDPOK may benefit as the secondary carrier.

EXCLUSIONS

The following shall be excluded from the benefits to be provided to Subscribers and eligible Dependents.

- Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability laws.
- Benefits or services available from any federal or state government agency, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.
- Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.
- Benefits for services or appliances started prior to the date the patient became eligible under this Plan may be excluded.
- Benefits for services when a claim is received for payment more than 12 months after services are rendered.
- Charges for treatment by other than a properly licensed dentist, except that cleaning and scaling of teeth and topical application of fluoride may be performed by a properly licensed hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.
- Charges for completion of forms or submission of documentation required by DDPOK for a benefit determination.
- Charges for missed or cancelled appointments, hospitalization or additional fees charged for hospital treatment, and bleaching of teeth.
- Prescription drugs, pre-medications, and relative analgesia.
- Experimental procedures.
- Benefits or services to correct congenital or developmental malformations.
- 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).
- Restorations for altering occlusion (bite), involving vertical dimensions, replacing tooth structure lost by attrition (grinding of teeth), erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting.
- Charges for replacement of lost, missing, or stolen crowns or appliances, or for repair of an orthodontic appliance.
- Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).
- Services and benefits excluded by the rules and regulations of Delta Dental, including the processing policies.
- All other benefits and services not specified in the Plan Agreement, including but not limited to the following excluded services.

Procedure Code	Description of Excluded Service	Procedure Code	Description of Excluded Service
D0171	Re-evaluation-post operative office visit	D2975	Coping
D0190/D0191	Screening of a patient/Assessment of a patient	D2981	Inlay repair, necessitated by restorative material failure
D0250/D0251	Extra-oral radiographic images	D2990	Resin infiltration of incipient smooth surface lesions
D0310	Sialography	D2999	Unspecified restorative procedure
D0320-D0322	TMJ radiographic images and tomographic survey	**D3110-D3120	Pulp caps
*D0340/D0350	Cephalometric radiographic image/2D oral-facial photographic images	**D3331	Treatment of root canal obstruction
D0351	3D photographic image	D3333	Internal root repair of perforation defects
D0364-D0368	Cone beam CT - image capture and interpretation	D3355-D3357	Pulpal regeneration; does not include final restoration
D0369	Maxillofacial MRI capture and interpretation	D3428-D3429	Bone graft in conjunction with periradicular surgery
D0370	Maxillofacial ultrasound capture and interpretation	D3460	Endodontic endosseous implant
D0371	Sialoendoscopy capture and interpretation	D3470	Intentional reimplantation
D0380-D0384	Cone beam CT	**D3910	Isolation of tooth with rubber dam
D0385	Maxillofacial MRI image capture	**D3950	Canal preparation and fitting of post
D0386	Maxillofacial ultrasound image capture	D3999	Unspecified endodontic procedure
D0391	Interpretation of diagnostic image by practitioner not associated with capture of the image, including report	D4230-D4231	Anatomical crown exposure
D0393-D0395	Post processing of image or image sets	D4320-D4321	Provisional splinting
D0411	HbA1c In-office point of service testing	D4381	Localized delivery of antimicrobial agents via release vehicle into diseased crevicular tissue, per tooth
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	**D4920	Unscheduled dressing change
D0415/D0416	Bacteriologic studies/Viral culture	D4921	Gingival irrigation – per quadrant
D0417/D0418	Collection and preparation of saliva sample for laboratory diagnostic testing/Analysis of saliva sample	***D4999	Unspecified periodontal procedure
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	D5810-D5811	Interim complete dentures
D0423/D0425	Genetic test for susceptibility to diseases–specimen analysis//Caries susceptibility test	D5862	Precision attachment, by report
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	D5867	Replacement of replaceable part of semi- precision or precision attachment
*D0470	Diagnostic cast	D5899	Unspecified removable prosthodontic procedure, by report
**D0472-D0474	Accession of tissue	D5911-D5999	Maxillofacial prosthetics
**D0475-D0479	Oral pathology tests and examinations	**D6011	Second stage implant surgery
**D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	D6040-D6050	Implant services
**D0481-D0483	Oral pathology laboratory procedures	**D6051	Interim abutment
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	D6091	Replacement of semi-precision or precision attachment of implant/abutment supported prosthesis
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	D6103	Bone graft for repair of periimplant defect
D0502	Oral pathology procedures	D6104	Bone graft at time of implant placement
**D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	D6118-D6119	Implant/abutment supported interim fixed denture for edentulous arch
D0999	Unspecified diagnostic procedure	D6190	Radiographic/surgical implant index, by report
D1310	Nutritional counseling	D6199	Unspecified implant services
D1320	Tobacco counseling regarding oral disease	**D6253	Provisional pontic
D1330	Oral hygiene instructions	D6548	Retainer-porcelain/ceramic
D1354	Interim caries arresting medicament application – per tooth	D6600-D6607	Inlays
D1999	Unspecified preventive procedure, by report	D6624	Inlay-titanium
D2410-D2430	Gold foil restorations	**D6793	Provisional retainer crown
**D2949	Restorative foundation for an indirect restoration	D6920/D6940	Connector bar/Stress breaker
**D2953	Each additional cast post-same tooth	D6950	Precision attachment
**D2957	Each additional prefab post-same tooth	D6985	Pediatric partial denture, fixed

Procedure Code	Description of Excluded Service	Procedure Code	Description of Excluded Service
D6999	Unspecified fixed prosthodontic procedure	D7920-D7960	Other repair procedures
D7260	Oroantral fistula closure	**D7963	Frenuloplasty
D7261	Primary closure of a sinus perforation	**D7970-D7971	Other repair procedures
D7270	Tooth re-implantation and/or stabilization	D7972-D7999	Other repair procedures
D7272	Tooth transplantation	*D8000-D8680	Orthodontic services
*D7280	Surgical exposure of unerupted tooth	D8681	Other orthodontic services
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	*D8690	Other orthodontic services
*D7283	Placement of device to facilitate eruption of impacted tooth	D8691-D8692	Other orthodontic services
D7285-D7286	Incisional biopsy of oral tissue	*D8693-D8695	Other orthodontic services
D7287	Cytology sample collection	D8999	Unspecified orthodontic service
*D7290	Surgical repositioning of teeth	**D9210-D9215	Anesthesia
*D7291	Transseptal fiberotomy, by report	D9219	Evaluation for deep sedation or general anesthesia
D7292-D7294	Surgical placement of temporary anchorage device	D9230	Inhalation of nitrous oxide/analgesia, anxiolysis
D7295	Harvest of bone for use in autogenous grafting procedure	D9248	Non-intravenous moderate (conscious) sedation
D7296-D7297	Corticotomy	**D9311	Consultation with a medical health care professional
D7320-D7321	Alveoloplasty not in conjunction with extractions	D9410-D9450	Professional visits
D7340-D7350	Vestibuloplasty	D9610-D9630	Drugs
D7410-D7465	Surgical excision of soft tissue/intra-osseous lesions	D9910-D9930	Miscellaneous services
D7471-D7490	Excision of bone tissue	D9932-D9935	Cleaning and inspection of dentures/partials
**D7511	Incision and drainage of abscess-intraoral soft tissue-complicated	D9940-D9987	Miscellaneous services
D7520-D7560	Surgical incision	**D9991-D9992	Dental case management –addressing appointment compliance barriers/care coordination
D7610-D7780	Treatment of fractures	D9993-D9994	Dental case management – motivational interviewing/patient education to improve oral health literacy
D7810-D7899	Reduction of dislocation & mgmt. of TMJ	**D9995	Teledentistry – synchronous; real-time encounter
**D7910	Suture of recent small wounds up to 5 cm	**D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
D7911-D7912	Complicated suturing	D9999	Miscellaneous services

***Procedure will be disallowed when submitted by a Participating Dentist for periodontal probing and/or laser disinfection (laser charges) in conjunction with other services. Procedure may be denied when submitted for other miscellaneous periodontal procedures or as a stand-alone procedure. **Disallowed – The fee for a procedure or service is disallowed—it is not benefited by DDPOK, nor collectable from the patient by a Participating Dentist. *Orthodontic – Orthodontic services will be allowed if group contract stipulates orthodontic coverage.