DELTA DENTAL PPO PLUS PREMIER - COMPREHENSIVE ENHANCED with Orthodontic Coverage

Dental Benefit Plan Summary

Kawasaki
Group Number 51028 & 759066

Effective January 1, 2017
ADMINISTRATION

The following information is provided as required by the Employee Retirement Income Security Act (ERISA) of 1974.

PLAN NAME
Kawasaki Welfare Benefits Plan

NAME AND ADDRESS OF EACH PARTICIPATING EMPLOYER

Kawasaki Motors Manufacturing Corp., U.S.A.

  Lincoln Consumer Products Plant
  6600 Northwest 27th St
  Lincoln, NE 68524

  Lincoln Rail Car Plant
  6500 Northwest 27th St
  Lincoln, NE 68524

  Lincoln Aerospace
  6600 Northwest 27th Street
  Lincoln, NE 68524

  Maryville Plant
  28147 Business HWY 71
  Maryville, MO 64468

Kawasaki Heavy Industries (USA), Inc.
60 East 42nd Street, Suite 2501
New York, NY 10165

Kawasaki Motors Corp., U.S.A.
26972 Burbank
Foothill Ranch, CA 92610

Kawasaki Precision Machinery (U.S.A.), Inc.
3838 Broadmoor
Grand Rapids, MI 49512

Kawasaki Motors Finance Corporation
26972 Burbank
Foothill Ranch, CA 92610

PLAN SPONSOR, FIDUCIARY AND PLAN ADMINISTRATOR:
Kawasaki Motors Manufacturing Corp., U.S.A.
6600 Northwest 27th Street
Lincoln, NE 68524
Telephone: (402) 476-6600

AGENT FOR SERVICE OF LEGAL PROCESS:
Kawasaki Motors Manufacturing Corp., U.S.A.
6600 Northwest 27th Street
Lincoln, NE 68524
Telephone: (402) 476-6600
FUNDING: This Plan is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

EMPLOYER IDENTIFICATION NUMBER: 47-0640533

EMPLOYER PLAN NUMBER: 501

DELTA DENTAL GROUP NUMBER: 51028 & 759066

PLAN BENEFITS ADMINISTERED BY:
DELTA DENTAL OF NEBRASKA
National Dedicated Service Center
Atrium Executive Square
11235 Davenport Street, Suite 105
Omaha, NE 68154
(402) 397-4878 or (800) 736-0710

ERISA And Other Federal Compliance

The purpose of this document is to provide you and your covered dependents, if any, with summary information on benefits available under, as well as information on your rights and obligations under, the KAWASAKI WELFARE BENEFITS PLAN (the "Plan") (the term this "Plan" when used in this SPD (as defined below) refers to the dental benefit component program under the Plan and includes this SPD, but such term does not include any other component program available under the Plan). This document summarizes the benefits and limitations of the dental benefit component program available under the Plan and will serve as the SPD for the dental benefit component program under the Plan. Therefore, it will be referred to and constitutes the Summary Plan Description ("SPD"). It is being furnished to you in accordance with ERISA.

It is intended that this SPD meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict. In the event of any conflict between the Plan and this SPD, the provisions of the Plan shall be deemed controlling, and any conflicting part of this SPD shall be deemed superseded to the extent of the conflict.
Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this SPD is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrator for this Program (Delta Dental of Nebraska). Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrator shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrator shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this SPD constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrator make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.
DENTAL BENEFIT PLAN SUMMARY

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

Kawasaki (GROUP)

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

IMPORTANT

This booklet is subject to the provisions of the Group Dental Agreement and cannot modify this agreement in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.

DELTA DENTAL OF NEBRASKA

Administrative Offices
Atrium Executive Square
11235 Davenport Street, Suite 105
Omaha, NE 68154
(402) 397-4878 or (800) 736-0710

TO BE ELIGIBLE FOR ANY BENEFIT UNDER THIS SPD, YOU MUST BE ELIGIBLE FOR A BENEFIT CLASS IDENTIFIED BELOW.

a) TO BE ELIGIBLE FOR ANY BENEFIT UNDER THIS SPD, YOU MUST RECEIVE AN IRS FORM W-2 FROM KAWASAKI MOTORS MANUFACTURING CORP., U.S.A.

b) TO BE ELIGIBLE FOR ANY BENEFIT UNDER THIS SPD, YOU MUST RECEIVE AN IRS FORM W-2 FROM KAWASAKI HEAVY INDUSTRIES (USA), INC.

c) TO BE ELIGIBLE FOR ANY BENEFIT UNDER THIS SPD, YOU MUST RECEIVE AN IRS FORM W-2 FROM KAWASAKI MOTORS CORP., U.S.A.

d) TO BE ELIGIBLE FOR ANY BENEFIT UNDER THIS SPD, YOU MUST RECEIVE AN IRS FORM W-2 FROM KAWASAKI PRECISION MACHINERY (U.S.A.), INC.

e) TO BE ELIGIBLE FOR ANY BENEFIT UNDER THIS SPD, YOU MUST RECEIVE AN IRS FORM W-2 FROM KAWASAKI MOTORS FINANCE CORPORATION.
SUBGROUP CLASSIFICATIONS/DEFINITIONS

1011-Lincoln-Consumer Prod Active EE
1012 Lincoln-Consumer Prod Active KHI Transfer
1013-Lincoln-Consumer Prod Term EE COBRA
1014-Lincoln-Consumer Prod Term EE Ret
1021-Lincoln-Rail Car Active EE
1022-Lincoln-Rail Car Active KHI Transfer
1023-Lincoln-Rail Car Term EE COBRA
1024-Lincoln-Rail Car EE Ret
1031-Maryville-Active EE
1032-Maryville-Active KHI Transfer
1033-Maryville-Term EE COBRA
1034-Maryville-Term EE Ret
1040-KMC Actives
1041-KPM Actives
1042 KHI Actives
1043 KMFC Actives
1044-KMC COBRA
1046 KPM COBRA
1047-KHI COBRA
1048-KMFC COBRA
1051KMC – KHI Transfer
1052-KPM – KHI Transfer
1053-KHI – KHI Transfer
1054-KMFC – KHI Transfer
1055-Lincoln - Aero – Active EE
1056-Lincoln - Aero – Active KHI Transfer
1057- Lincoln - Aero – Term EE Cobra
1058- Lincoln - Aero – Term EE Ret
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SUMMARY OF DENTAL BENEFITS

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental PPO</th>
<th>Delta Dental Premier</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td>80%</td>
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<tr>
<td>Endodontics</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
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<tr>
<td>Periodontics</td>
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<td>80%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Major Restorative Services</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Prosthetic Repairs and Adjustments</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
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<tr>
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</tr>
<tr>
<td>Orthodontics</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Benefit Maximums

The Program pays up to a maximum of $1,500.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Orthodontics is subject to a separate lifetime maximum of $2,000.00 per Covered Person and limited to those orthodontic treatment plans commenced on or after the Eligible Dependent Child’s eighth (8th) birthday and through the Dependent Child’s eighteenth (18th) birthday. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Plan in order to receive continued benefit payments.

Deductible

There is a $50.00 deductible per Covered Person each Coverage Year that only applies to Major Restorative or Prosthetic Services.

Coverage Year

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

Pretreatment Estimate
(Estimate of Benefits)

It is recommended that a pretreatment estimate be submitted to the plan prior to treatment if your dental treatment involves Major Restorative, Periodontic or Prosthetic Care (see Description of Coverages), to estimate the amount of payment. The pretreatment estimate is a valuable tool for both the dentist and the patient. Submission of a pretreatment estimate allows the dentist and the patient to know what benefits are available to the patient before beginning treatment. The pretreatment estimate will outline the patient’s responsibility to the dentist with regard to coinsurance, deductibles and non-covered services and allows the dentist and the patient to make any necessary financial arrangements before treatment begins. This process does not prior authorize the treatment nor determine its dental or medical necessity. The estimated Delta Dental payment is based on the patient’s current eligibility and current available contract benefits. The subsequent submission of other claims, a change in eligibility, a change in the contract coverage or the existence of other coverage may alter the Delta Dental final payment amount as shown on the pretreatment estimate form.

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontic or prosthetic care, a participating dentist should submit a claim form to the Plan outlining the proposed treatment.

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

Benefits

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

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

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

Delta Dental of Nebraska does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental of Nebraska evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan
payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

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

**PREVENTIVE CARE (Diagnostic & Preventive Services)**

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

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office visit, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

**Radiographs (X-rays)**
- **Bitewings** - Covered at 1 series of bitewings per calendar year.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 3 calendar years.
- **Periapical(s)** - Single X-rays.
- **Occlusal** - Covered at 1 series per 12 months.

**Dental Cleaning**
- **Prophylaxis or Periodontal Maintenance** - Shall be benefited as follows:
  - Two (2) dental prophylaxis per calendar year;
  - OR
  - Four (4) periodontal prophylaxis per calendar year;
  - OR
  - A combination of the above NOT to exceed a total of four (4) cleanings per calendar year.

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

NOTE: A prophylaxis performed on a Covered Person under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Covered Person age 14 or older will be benefited as an adult prophylaxis.

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

**Fluoride Treatment** (Topical application of fluoride) - Covered 1 time per calendar year for dependent children through the age of 18.

**Oral Hygiene Instructions** - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered 1 time per lifetime.
Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

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

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 15.

**EXCLUSIONS - Coverage is NOT provided for:**
1. Amalgam or composite restorations placed for preventive or cosmetic purposes.

**BASIC SERVICES**

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

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

**Composite (white) Resin Restorations**
- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

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

Other Basic Services
- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.
- **Crown, Inlay, Onlay and Veneer Repair** – Covered 1 time per 12-month period.

Adjunctive General Services
- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical service.

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

**EXCLUSIONS - Coverage is NOT provided for:**
1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Pulp vitality tests.
7. Diagnostic casts.
8. Adjunctive diagnostic tests.
9. Amalgam or composite restorations placed for preventive or cosmetic purposes.
10. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

**BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)**

Endodontic Therapy on Primary Teeth
- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth
- Root Canal Therapy
- Apicoectomy
- Root Amputation on posterior (back) teeth

Complex or other Endodontic Services
- Apexification - For dependent children through the age of 16.
- Retrograde filling
- Hemisection, includes root removal

**LIMITATION:** All of the above procedures are covered 1 time per tooth per lifetime.

**EXCLUSIONS - Coverage is NOT provided for:**
1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Pulp vitality tests.
6. Incomplete root canals.

**PERIODONTICS (GUM & BONE TREATMENT)**

**Basic Non Surgical Periodontal Care** - Treatment for diseases for the gingival (gums) and bone supporting the teeth.
- Periodontal scaling & root planing - Covered 1 time per 24 months.
- Full mouth debridement - Covered 1 time per lifetime.
Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this Plan.

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

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

EXCLUSIONS - Coverage is NOT provided for:
1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.
6. Guided tissue regeneration.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

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

Complex Surgical Extractions
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures
- Oroantral fistula closure
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy
- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

**LIMITATIONS**

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

**EXCLUSIONS - Coverage is NOT provided for:**

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
7. Inpatient or outpatient hospital expenses.

**COMPLEX OR MAJOR RESTORATIVE SERVICES**

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

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

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

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

**Onlays** - Covered 1 time per 5 year period per tooth.

**Permanent Crowns** - Covered 1 time per 5 year period per tooth.
Implant Crowns - See Prosthetic Services.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5 year period when done in conjunction with covered services.

Canal prep & fitting of preformed dowel & post

EXCLUSIONS - Coverage is NOT provided for:

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

PROSTHETIC REPAIRS & ADJUSTMENTS (DENTURES, PARTIALS, AND BRIDGES)

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

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

Adjustments - Covered 2 times per 12-month period:

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

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

7. Services or supplies that have the primary purpose of improving the appearance of your teeth.

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

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

10. Coverage shall be limited to the least expensive professionally acceptable treatment.

**PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)**

**Removable Prosthetic Services (Dentures and Partials)** - Covered 1 time per 5 year period:
- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

**Fixed Prosthetic Services (Bridge)** - Covered 1 time per 5 year period:
- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

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

**LIMITATION:** This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient’s responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the benefited service.

**Restorative cast post and core build-up, including pins and posts** - Covered 1 time per 5 year period when done in conjunction with covered fixed prosthetic services.

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

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

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

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

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

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

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

**Other Complex Surgical Procedures**
- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Surgical repositioning of teeth

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

**LIMITATION:** Covered eligible dependent children from the age of 8 through the age of 18.

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

**Orthodontic Payments:** Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must have continuous eligibility under the Plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at monthly intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated plan payment amount. This form serves as a claim form when treatment begins.
When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revise Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted after the appliance placement.

**Exclusions**
Coverage is NOT provided for:

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

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

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

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

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

f) Services of anesthesiologists.

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

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolyis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

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

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

k) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.

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

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

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Corrections of congenital conditions.

q) Athletic mouth guards, enamel microabrasion and odontoplasty.
r) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

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

t) Bacteriologic tests.

u) Cytology sample collection.

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

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

x) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

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

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

aa) Provisional splinting, temporary procedures or interim stabilization.

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

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

dd) Guided tissue regeneration.

ee) Occlusal procedures including occlusal guard and adjustments.

ff) Pulp vitality tests.

gg) Adjunctive diagnostic tests.

jj) Diagnostic casts.

kk) Incomplete root canals.

ll) Cone beam images.

mm) Anatomical crown exposure.

nn) Temporary anchorage devices.

oo) Sinus augmentation.

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

hh) Amalgam or composite restorations placed for preventive or cosmetic purposes.

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

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

Limitations

a) Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.
b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided, however, that such services are dental reconstructive surgical services.

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

**Post Payment Review**

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

**ELIGIBILITY**

Covered Persons under this Program are:

**Employees**

a) TO BE ELIGIBLE FOR ANY KAWASAKI BENEFIT, YOU MUST RECEIVE AN IRS FORM W-2 FROM A KAWASAKI PARTICIPATING EMPLOYER AS PROVIDED IN THIS SPD.

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

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

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased employees.
- An Independent Contractor as defined in this SPD.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer’s Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person’s initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer’s classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person’s status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person’s eligibility for benefits.

**Retired Employee (or Retiree)** means a person who was employed full time by a Participating Employer who permanently ceases to work for any Participating Employer after reaching age 55 with a minimum of 5 years of credited full-time service with a Participating Employer.
A Retired Employee may be eligible to continue participating under this Plan after the Retired Employee’s exhaustion of his or her COBRA continuation coverage, provided the Retired Employee has met the criteria stated in the Termination/Separation of Employment Policy with a Participating Employer (See Human Resources for more details) and makes the required contributions continuously after the exhaustion of COBRA coverage. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. A Retired Employee may continue in this Plan until the earlier of when they reach age 65 or become Medicare eligible, fail to timely pay the required contributions in full, or such coverage is sooner terminated in accordance with the provisions of this Plan, as amended from time to time.

Notwithstanding the foregoing, effective on and after June 1, 2014, no new employees or current employees of Kawasaki Heavy Industries (USA), Inc., Kawasaki Motors Corp., U.S.A., Kawasaki Precision Machinery (U.S.A.), Inc., and Kawasaki Motors Finance Corporation are eligible to participate in the retiree coverage; such employees are excluded from the definition of “Retired Employee” and “Retiree” and are not eligible for the continuation of coverage available hereunder to Retired Employees.

**Dependents**

A) Spouse, meaning:

1. Your legal spouse, as defined by the state in which the marriage ceremony was performed, provided he or she is not covered as an Employee under this Plan. Individuals of the same sex are married if they were lawfully married in a state (or foreign country) whose laws authorize the marriage of two individuals of the same sex, even if the state in which they now live does not recognize same-sex marriage. For purposes of eligibility under this Plan, a legal spouse does not include a common-law marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

B) A Dependent Child until the Child reaches his or her 26th birthday. The term “Child” includes the following Dependents:

1. A natural biological Child;
2. A step Child;
3. A legally adopted Child or Child legally placed for adoption as granted by action of a federal state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
4. A Child under your (or your Spouse’s) permanent or temporary legal guardianship as ordered by a court;
5. A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);

C) A Dependent does not include the following:

1. A dependent Child if the Child is covered as a Dependent of another Employee at this company;
2. A foster Child;
3. A grandchild;
4. Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.
RIGHT TO CHECK A DEPENDENT’S ELIGIBILITY STATUS: This Plan reserves the right to check the eligibility status of a Dependent any time throughout the year. You and your Dependent have a notice obligation to notify this Plan should the Dependent’s eligibility status change throughout the Plan year. Please notify your Human Resources Department regarding status changes.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the date before the Child’s 26th birthday; or
- The Dependent Child is a Dependent of an employee newly eligible for this Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Family Status Change section of the Plan.

and the Dependent Child fits the following category:

If you have a Dependent Child covered under this Plan who is under the age of 26 and totally disabled, either mentally or physically, that Child’s health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit a written proof that the Child is totally disabled within 31 calendar days after the day coverage for the Dependent would normally end. This Plan may, for two years, ask for additional proof at any time, after which this Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof must be submitted as required; and
- The Employee must still be covered under this Plan.

A totally disabled Child older than 26 who loses coverage under this Plan may not re-enroll in this Plan under any circumstances.

IMPORTANT: It is your responsibility to notify the Plan Sponsor within 60 days if your Dependent no longer meets the criteria listed in this section. If, at any point, the Dependent fails to meet the qualification of totally disabled, this Plan has the right to be reimbursed from the Dependent or Employee for any claims paid by this Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the Continuation of Coverage (COBRA) section in this document.

Employees have the right to choose which eligible Dependents are covered under this Plan.

Effective Dates of Coverage

Eligible Employee:

Applies to Subgroups: 1012, 1022, 1032, 1051, 1052, 1053, 1054, and 1056:

You are effective on the date of your transfer (as long as you enroll within 30 days of the transfer)

Applies to Subgroups: 1011, 1013, 1014, 1021, 1023, 1024, 1031, 1033, 1034, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1055, 1057, and 1058.

You are eligible to be covered under this Program when the Program first became effective, or if you are a new employee of the Group, on the first of the month following 60 days.
Eligible Dependents:

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

a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.
b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Group, if any.
c) On the date a new dependent is acquired if you are already carrying dependent coverage.

LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

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

Late Entrants:

A “late enrollee” is defined as a subscriber of dependent who requests enrollment for coverage more than 31 days after his or her initial eligibility. An eligible person who enrolls for coverage during a “special enrollment period” is not considered a late enrollee. Please contact your Human Resources Department for information.

Open Enrollment
The Open Enrollment under this Contract shall be held annually.

Reinstatement Provision- Applies to Subgroups 1011, 1013, 1014, 1021, 1023, 1024, 1031, 1033, 1034, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1055, 1057, and 1058: Any employee who is rehired within 13 weeks of their termination date, will not need to meet the Waiting Period noted above. Their coverage will be effective on the date they return to work as a full time employee.

Family Status Change

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

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

Due to federal regulations, the changes you make to your benefits must be consistent with the family status change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it not consistent to drop your dental coverage altogether.
If you experience one of the following eligible family status change during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a family status change form by contacting your Employer. All changes are effective the date of the change.

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

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

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

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

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

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

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

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

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

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

a) On the last day of the month in which (1) you cease to be eligible; and (2) on the last day of the month your dependent is no longer eligible as a dependent under the program

b) On the date the Program is terminated.

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

For extended eligibility, see Continuation of Coverage.

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

Continuation of Coverage (COBRA)

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program:

<table>
<thead>
<tr>
<th>QUALIFYING EVENT</th>
<th>WHO MAY CONTINUE</th>
<th>MAXIMUM CONTINUATION PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment ends, retirement, leave of absence, lay-off, or</td>
<td>Employee and dependents</td>
<td>Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
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<tr>
<td>employee becomes ineligible (except gross misconduct</td>
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<td>dismissal)</td>
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<tr>
<td>Divorce, marriage dissolution, or legal separation</td>
<td>Former Spouse and any dependent children who lose coverage</td>
<td>Earliest of: 1. 36 months or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Death of Employee</td>
<td>Surviving spouse and dependent children</td>
<td>Earliest of: 1. 36 months or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Dependent child loses eligibility</td>
<td>Dependent child</td>
<td>Earliest of: 1. 36 months, 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Dependants lose eligibility due to Employee’s entitlement</td>
<td>Spouse and dependents</td>
<td>Earliest of: 1. 36 months, 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
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<tr>
<td>to Medicare</td>
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<tr>
<td>Event Type</td>
<td>Eligible Group</td>
<td>Earliest of:</td>
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<tr>
<td>Employee's total disability</td>
<td>Employee and dependents</td>
<td>Earliest of: 1. 29 months or 2. Date total disability ends or 3. Enrollment date in other group coverage or Medicare.</td>
</tr>
<tr>
<td>Retirees of employer filing Chapter 11 bankruptcy (includes substantial</td>
<td>Retiree and dependents</td>
<td>Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.</td>
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<tr>
<td>reduction in coverage within 1 year of filing)</td>
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</tr>
<tr>
<td>Surviving Dependents of retiree on lifetime continuation due to the</td>
<td>Surviving Spouse and dependents</td>
<td>Earliest of: 1. 36 months following retiree’s death, or 2. Enrollment date in other group coverage.</td>
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<tr>
<td>bankruptcy of the employer</td>
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</tbody>
</table>

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

1. Choosing Continuation

If you lose coverage, your employer must notify you of the option to continue coverage within 14 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

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

Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to the COBRA Administrator. If you or your covered dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

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

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

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.
Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of this Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

3. Terminating Continuation of Coverage - COBRA

Continuation of Coverage - COBRA for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

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

b) This Program is terminated by the Group Subscriber;

c) The Group Subscriber’s or Covered Person’s failure to make the payment for the Covered Person’s Continuation of Coverage

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

PLAN PAYMENTS

Participating Dentist Network

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

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental of Nebraska. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request or by calling Delta. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan’s internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating Delta Dental PPO or Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta Dental. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta Dental.
TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PPO AND DELTA DENTAL PREMIER NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Claim Payments

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

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

Delta Dental Premier Dentists:

Claim payments are based on the Plan’s Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient’s Delta Dental program.

Delta Dental PPO Dentists:

Claim payments are based on the Plan’s Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient’s Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan’s Payment Obligation, which for nonparticipating dentists is the treating dentist’s submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.

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

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the Plan Payment Obligation is paid jointly by the programs. The Plan Payment Obligation is determined prior to calculating all percentages, deductibles and benefit maximums.
The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

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

Claim and Appeal Procedures

Initial Claim Determinations
Proof of loss must be submitted within 90 days or as soon as reasonably possible, but in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

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

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

Delta Dental of Nebraska
Attention: Appeals Unit
PO Box 551
Minneapolis, MN 55440-0551

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan’s schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.
To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA.

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

GENERAL INFORMATION

Health Plan Issuer Involvement

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

Privacy Notice

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

How to Find a Participating Dentist

You have several options that are available to help you find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. Be sure to specifically state that your employer is providing the Dental program.
- Contact our Customer Service Center at: (800) 553-9536

Using Your Dental Program

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

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

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Nebraska - 1-866-827-3319

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.
The dental office will file the claim form with the Plan; however, you may be required to assist in completing
the patient information portion on the form (Items 1 through 14).

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

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

Cancellation and Renewal

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

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

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

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

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

Funding Policy and Payment

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

Procedure to Request Information

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

Statement of ERISA Rights

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

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work
sites and union halls, all Plan documents, including insurance contracts, and copies of all documents
such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of
Labor.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan
Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a 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 the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If it finds your claim is frivolous, you will be responsible for these costs and fees. 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, 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.

**PLAN AMENDMENT AND TERMINATION INFORMATION**

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this SPD. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount.