DENTAL BENEFIT

<table>
<thead>
<tr>
<th>Diagnostic/Preventive Coverage A</th>
<th>Basic and Restorative Coverage B</th>
<th>Prosthodontics Coverage C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Period: None</td>
<td>Waiting Period: None</td>
<td>Waiting Period: 6 Months</td>
</tr>
<tr>
<td>Covered at *100%</td>
<td>Covered at *80%</td>
<td>Covered at *50%</td>
</tr>
<tr>
<td><strong>Diagnostic:</strong></td>
<td><strong>Restorative:</strong></td>
<td><strong>Prosthodontics:</strong></td>
</tr>
<tr>
<td>Evaluations</td>
<td>Amalgam (silver) fillings</td>
<td>Replacement of dentures</td>
</tr>
<tr>
<td>X-Rays (Complete series or panoramic film); Bitewing x-rays; X-rays of individual teeth as necessary</td>
<td>Composite (white) fillings</td>
<td></td>
</tr>
<tr>
<td>Oral cancer screening once in a 12-month period</td>
<td>Root canal therapy</td>
<td></td>
</tr>
<tr>
<td>Preventive:</td>
<td><strong>Periodontics:</strong></td>
<td></td>
</tr>
<tr>
<td>Cleanings</td>
<td>Treatment of gum disease</td>
<td></td>
</tr>
<tr>
<td>Fluoride</td>
<td>Space maintainers</td>
<td></td>
</tr>
<tr>
<td>Periodontics:</td>
<td>Sealant application</td>
<td></td>
</tr>
<tr>
<td>Periodontal maintenance</td>
<td>Emergency Palliative Treatment</td>
<td></td>
</tr>
<tr>
<td>(cleaning)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthodontics Coverage D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Period: 6 Months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correction of crooked teeth for adults and children</td>
</tr>
</tbody>
</table>

Calendar Year Maximum: $1,500 per person (Coverages A, B and C combined) NOTE: Your plan has Special Dental Expense Benefits as described in this document.

| Orthodontic Lifetime Maximum: $1,500 Per Person |

*Benefit percentages shown are based upon the actual charge submitted to a maximum of the participating dentist’s approved fees, or the Delta Dental's allowance for non-participating dentists.

This chart represents the level of coverage for services performed by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks. Visit www.nedelta.com for an updated list of participating dentists. Your dental program includes all of the coverage categories described above. The schedule is provided for summary purposes only and certain benefit limitations may apply. Please refer to the information that follows for complete benefit information. In the event of a conflict or discrepancy between the chart and the following information, the information will control.
INTRODUCTION
This Summary Plan Description describes the benefits available to you under the Dental Plan through Allegiant Care. Please read this section carefully to become familiar with your benefits. Claims are administered by Northeast Delta Dental (NEDD). To speak to a representative concerning participating providers, claims or benefits, call NEDD at 1-800-832-5700 (Monday-Friday 8:00 AM to 4:45 PM EST). You may also reach the NEDD 24-hour automated inquiry system at 1-800-253-7852 or visit www.nedelta.com/patients.

Important Notes:
1. Before the plan pays benefits for most dental care, you must satisfy the deductible. You do not pay a deductible for preventive care. Each calendar year, you pay the first $25 (the deductible) toward all other covered expenses for yourself and each covered dependent up to the family maximum deductible.

2. The plan has the following features to help reduce the amount you have to pay in deductibles each year:
   a. The annual maximum deductible for your entire family is $75, regardless of how large your family may be. If three or more covered family members’ expenses in a calendar year equal $75, then the family deductible has been met. You pay no further deductible in that calendar year.
   b. No more than $25 will be applied to any one family member.

3. If you incur your deductible during the last quarter of the year (October-December), dental expenses incurred in the following year will not be subject to the deductible. For example, if you have a filling in November 2017 and pay the deductible, you will not be subject to the deductible in the calendar year 2018.

4. The plan provides up to $1,500 each year in dental benefits, exclusive of orthodontia, for you and each of your covered family members. For orthodontia, a separate lifetime maximum of $1,500 applies for each covered person. No annual or lifetime maximum applies to special dental expenses.

FILING CLAIMS
To Use Your Plan, Follow These Steps:
1. Please read this document carefully to familiarize yourself with the benefits and provisions of your dental benefit.

2. Ask your dentist if s/he participates with Delta Dental; visit NEDD’s website (www.nedelta.com); refer to your NEDD Participating Dentist Directory; or call NEDD for information.

3. When you visit your dental office, inform them that you are covered under a NEDD-administered program and show your identification card or other means of verifying Delta Dental coverage. Your dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to NEDD for payment for covered services.

Participating Dentists
Participating dentists will have claim forms available in their offices. A participating dentist will not charge at the time of treatment for covered services but may request payment for non-covered services, deductibles, or copayments. NEDD will pay the participating dentists directly based on their allowed charges. An Explanation of Benefits form will be sent or will be accessible to you that will indicate the amount you should pay, if any, to your dentist.

Non-Participating Dentists or Other Dental Providers
NEDD provides coverage regardless of your choice of dentist, participating or not. When visiting a non-participating dentist or ODP (who is a person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are rendered), you
may be required to submit your own claim (available at www.nedelta.com) and pay for services at the time they are provided. All claims should be submitted to NEDD. Payment will be made directly to the subscriber. In either case, payment for treatment performed by a Non-Participating Dentist or ODP will be limited to the lesser of the actual submitted charge or Delta Dental’s allowance for non-participating dentists or ODPS in the geographic area in which services were provided. It is your responsibility to make full payment to the Dentist or ODP. When there is not sufficient fee information available for a specific dental procedure, NEDD will determine an appropriate payment amount. You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure the information is complete and accurate to ensure the prompt and correct payment of your claim.

**Predetermination of Benefits**

NEDD strongly encourages predetermination of benefits involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding NEDD’s payment and your financial obligation to the dentist.

Please note that predetermination does NOT guarantee payment. Rather, predetermination is an estimate of payment based on your current benefits. A new coverage period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service) which may be different than information available at the time the predetermination estimate was given. Any changes in a dentist’s fee schedule or participating status may also affect NEDD’s final payment.

The predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office. Questions concerning predetermination should be directed to

**NEDD’s Customer Service Department at:** 800-832-5700 or 603-223-1234

**Assignment of Benefits**

Benefits will be paid directly to the dentist if the dentist is a participating provider with the local Delta Dental member company. If the dentist does not participate with the local Delta Dental member company, payment will be made to the subscriber unless the state in which the services are rendered requires that assignments of benefits be honored and NEDD receives written notice of an assignment on the claim form before payment for benefits is made.

**Disputed Claims Procedure**

After you have followed the General Claims Inquiry procedure and if you have reason to believe your benefit determination was not in accordance with the Allegiant Care plan, you have the option of using NEDD’s Disputed Claims Procedure. This may be requested within 6 months of the issuing of NEDD’s original Explanation of Benefits. It is recommended that your written request for a review of your claim be mailed certified mail, return receipt requested, to the Vice President, Professional Relations, NEDD, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002. You may also submit your request by standard mail.

Your request for a review of your claim should refer to the claim(s) in question, include your name and address, the reasons you think the denial should be evaluated and provide any additional materials you wish to present.

The Vice President, Professional Relations, or his/her designee, may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is wholly or partially denied, you will be furnished with a notice of the decision within 30 days after receipt of the disputed claim. The written notice will include:

1. the specific reason(s) for denial; and
2. the specific reference to the provision upon which the denial is based.

If your request for review results in an additional payment, it will be made within 15 working days of the Vice President, Professional Relations’ response.
If you do not receive notice within the 30-day period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

If you have any problem securing a review of your claim, contact Allegiant Care for assistance.

**Disputed Claims Review Procedure**
The Disputed Claims Review Procedure allows you to request a review from NEDD’s Disputed Claims Review Committee after receipt of written notice of the Vice President, Professional Relations’ denial of your claim. The Review Committee is composed of Participating Dentists, non-Dentist members of the Board of Directors and representatives of group purchasers/groups.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review before the final appeal date set forth in the Vice President, Professional Relations’ notice denying the claim, or, if no date is given, within 6 months of the notice. It is recommended that your written request be sent certified mail, return receipt requested, to the Review Committee at the NEDD address noted previously but you may also submit your request by standard mail. It must state specifically the reasons for requesting a review. It should contain issues, comments and supporting materials stating why you believe the NEDD Vice President, Professional Relations’ response was incorrect. Not later than 30 days after receipt of your request, the Review Committee will render its written decision, including specific reasons for the decision.

In addition, or as an alternative to the written request procedure, you may request a hearing from the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by legal counsel or other duly authorized representatives; to request the presence of a stenographer to transcribe the hearing; to present evidence; to request the testimony of witnesses; and to cross-examine witnesses. You or your representative may review the Agreement and related pertinent documents. The hearing will be scheduled with prompt written notice to you not later than thirty (30) days after your request. A decision will be rendered not later than thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

**COORDINATION OF BENEFITS (DUAL COVERAGE)**
The Coordination of Benefits provision is designed to provide maximum coverage, but not to exceed 100% of the total fee for a given service. If any eligible person is entitled to benefits under any other health care program, the following Coordination of Benefits provision shall determine the sequence and extent of payment. Other health care programs may include any other sponsored plan or group insurance plan.

When an eligible person is covered under another health care program, the following rules shall be followed to establish the order of determining liability.

1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.
2. The plan covering an eligible person solely as an employee shall determine its benefits before the plan which covers the eligible person solely as a Dependent.
3. The plan covering the eligible person solely as a Dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the eligible person solely as a Dependent of the parent whose birthdate occurs later in a calendar year (“Birthday Rule”). A parent’s year of birth is not relevant. If both parents have the same birthdate (month and day) the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period. If the other health care program does not use the birthday rule, then that plan’s provisions will determine the order of liability.
4. If paragraphs 2 and 3 above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period shall be determined first.
5. The order of payment for the claims of a dependent child of divorced or legally separated parents will be as follows:
   a. the plan of the parent with custody;
(b) the plan of the spouse of the parent with custody (step-parent);
(c) the plan of the parent without custody;
(d) if the parents have joint legal custody, paragraph 3 above will apply.

However, when the parents are separated or divorced and there is a court decree which establishes financial responsibility with respect to the child, the benefits of the plan which cover the child as a dependent of the parent with financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent.

6. When NEDD is the first to determine its benefits under the foregoing, benefits hereunder shall be paid without regard to Coverage under any other plan. When NEDD is not the first to determine its benefits and there are remaining expenses of the type allowable, NEDD will pay only the amount by which its benefits exceed the amount of benefits payable under the other plan up to the amount NEDD would have paid without regard to the payment by the other plan or the amount of such remaining expenses, whichever is less. In other words, the combined payment of both plans will not exceed the total cost of the service.

(a) NEDD may use reasonable efforts to determine the existence of other benefit programs but shall be under no obligation to do so.

(b) The eligible person is required to furnish NEDD with information relative to any other health care program to determine liability.

7. For the purposes of determining the applicability and implementing the terms of this provision in the Agreement, NEDD may release or obtain from any third party, without consent or notice, any information which it deems to be necessary to determine its liability. NEDD shall be free from any liability that might arise in relation to such action.

8. Multiple Coverage: When benefits are coordinated with another NEDD plan, or any other plan providing dental benefits, time limitations and frequency of service limitations will not change. Coverages for services for which a specified number are provided per a specified time period shall not be added together to provide more than the number of services specified per time period under this plan. For example, if each plan covers one prophylaxis (cleaning) in a 6-month period, the combined Coverages will still only cover one prophylaxis in any 6-month period. If such a service is covered under this plan, but has been paid for, whether in full or part, by another plan, such service will still be counted toward the maximum number of such services allowed per period under this plan.

9. Right of Recovery: NEDD has the right to recover from the payee excess benefit payments.

10. Subrogation: In the event of any payments for Dental Care under this plan, Delta Dental shall be subrogated to all the subscriber’s or eligible dependent’s right of recovery thereof against any third person or organization who may be liable for such payment. The subscriber or eligible dependents shall execute and deliver such instruments and papers and do whatever else is necessary to secure such rights. Such subrogation shall be on a just and equitable basis and not based on a priority lien.

**DENTAL BENEFITS AFTER COVERAGE ENDS**
Your Plan will not pay for services or supplies furnished after dental coverage ends, even if an estimate of benefits has already been made. Benefits will be payable for the following procedures, only if work is already in process when coverage ends and your dentist completes the service within 90 days of the end of coverage:

- an appliance or modification of an appliance
- a crown, bridge or gold restoration
- root canal therapy
DENTAL BENEFIT EXCLUSIONS
In addition to the General Plan Exclusions, the dental portion of the Allegiant Care Plan does not cover expenses for the following:

1. Services that are unnecessary or otherwise do not qualify as a covered expense.
2. Charges that exceed reasonable and customary levels.
3. Oral surgery relating to tongue or mouth tissue which may be covered under your separate medical plan. For example, removal of a tumor in the mouth would not be a covered dental expense.
4. Supplies other than those used in a dentist or doctor’s office.
5. Instructions in dental hygiene.
6. The amount of expenses discounted or reduced or for which you received a credit from the provider.
7. Service for which no charge is made or no payment would be required if you did not have this coverage.
8. Amounts charged for failure to keep a scheduled appointment (no show charges).
9. Services furnished by a U. S. Government, State or Local facility unless for emergency treatment and you are required to pay; services furnished or payable under a plan or program operated by a National Government or on of its agencies.
10. Services furnished or payable under a state cash sickness or similar law including any group insurance policy approved under such law.
11. Injury or illness resulting from an act of war (declared or undeclared), insurrection, atomic explosion or other release of nuclear energy (except when used solely as a medical treatment) or in connection with military service.
12. Injury or illness resulting from taking part in an assault or felony.
13. Illness covered by Workers’ Compensation, occupational disease law or similar laws.
14. Injury if it arises out of employment for pay, profit or gain.
15. Injury or illness caused by another person or organization in certain circumstances as described.
16. Expenses incurred after coverage ends or before coverage begins.
17. Services or therapy that are considered experimental.