Liberty Mutual Dental Plan
Summary Plan Description
(SPD Version for Eligible Retirees)
(For U.S. Employees Only)

Effective January 1, 2018
DENTAL PLAN
(SPDBG Version for Eligible Retirees)

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DENTAL PLAN
(SPD Version for Eligible Retirees)

Overview

If you are covered by the Liberty Mutual Dental Plan (the “Plan”) immediately prior to your retirement and you have at least 10 years of continuous Eligible Credited Service and are at least age 55, you may continue coverage after retirement until you attain age 65 by electing either retiree coverage or COBRA coverage.

The Plan provides an annual benefit payment for covered charges incurred by participating retirees and their eligible covered dependents. For purposes of this Summary Plan Description, “Company” means Liberty Mutual Group Inc. and “Participating Employers” means the Company and its subsidiaries that participate in the Plan.

You will elect a coverage option and category at the time of retirement. You may only continue coverage for your covered dependents if they are enrolled in the Plan at the time you retire. For example, if you have employee only coverage as an active employee, you may not select employee plus spouse coverage at retirement.

If you retire on or after January 1, 2018, are age 65 or older, have at least 10 years of continuous Eligible Credited Service and are currently enrolled in dental coverage, you will not be eligible for coverage under the Plan. However, you will be eligible to elect coverage through Willis Towers Watson’s Via Benefits, and with financial support from Liberty Mutual in the form of a Health Reimbursement Arrangement (HRA). You will be able to use your HRA to help you pay for dental coverage and eligible expenses. For information on coverage for retirees age 65 and older, please contact Benefits Express at 1-800-758-4460 or Willis Towers Watson at 1-866-202-9582. Benefits Express can provide you with the HRA Summary Plan Description.

Coverage Options

Basic Plan: This plan provides 100% payment, with no deductible, for covered preventive care expenses like semi-annual cleanings and x-rays, and 50% payment of all other covered dental expenses after you pay the annual deductible. The Basic Plan does not offer orthodontia coverage and carries an annual maximum benefit of $1,000 per person per year for all covered charges.

Plus Plan: The Plus Plan provides 100% payment, with no deductible, for covered preventive care expenses like semi-annual cleanings and x-rays, and 80% payment of all other covered dental expenses after you pay the annual deductible. The annual maximum benefit is $2,000 per person per year for all covered charges. The Plus Plan also provides 50% payment for covered orthodontia expenses with a $1,500 lifetime maximum benefit per covered individual up to age 18.

Delta Dental Preferred Provider Organization (PPO)

The Plan is administered through Delta Dental of Massachusetts (“Delta Dental”), the Plan claims administrator. The Delta Dental PPO Plus Premier is made up of two networks: Delta Dental Premier and Delta Dental PPO.

- The PPO network is the core network with more than 283,000 dental locations nationwide. The PPO provides the best value because Delta Dental has negotiated the best prices for your care. This means your benefit dollars go further.
• The Premier network expands your choice even further and provides access to more than 385,000 dental locations across the country.

You can always choose a dentist from either network for your care. The reimbursement percentages remain the same whether or not you use a network provider but you will pay more if you use a non-network provider.

To find a dentist, visit www.deltadentalma.com or use the Delta Dental mobile app and click on the Find a Dentist link at the top of the screen. Select the Delta Dental PPO, where you will be redirected to the national provider search. Choose “Delta Dental PPO Plus Premier” and search for your dentist.

Eligibility

If you are covered by the Plan immediately prior to your retirement and you have at least 10 years of continuous employment, you may continue this coverage after retirement until you attain age 65. (Please refer to the “Overview” section for an explanation on coverage after you turn age 65.) You elect a coverage option and category at the time of retirement. You may not defer your election to a later date; it is important that you give this decision careful consideration because this is the only time that you may enroll.

It is important to note that you may not increase your coverage option after you retire. Also, you may not change your dental coverage at a later date unless you are changing your coverage option from the Plus Plan to the Basic Plan, dropping coverage or decreasing your coverage category (i.e. going from family to retiree only coverage).

Eligible Dependents

• As an eligible retiree, you may also choose to enroll your eligible dependents for coverage if they are enrolled for coverage immediately prior to your retirement. Eligible dependents include: your legally married spouse or eligible domestic partner. The Plan does not allow dependent coverage for an ex-spouse even if a court mandates that you provide coverage; and

• Your child (including any stepchild, foster child, legally adopted child, or child for whom a court order of custody or guardianship has been obtained) under age 26. This does not include a child for whom your parental rights have been legally terminated. You may be required to prove that you have not relinquished parental rights. Coverage for an adult child who attains age 26 will continue until the last day of the month in which his or her birthday occurs.

Coverage for an adult child who is age 26 and older may only continue under the Plan if the adult child is unable to earn his own living because of a physical disability, mental illness, or developmental disability. Coverage will be continued in accordance with "Dependents: Coverage Continuation under Special Circumstances."

If you and your spouse or domestic partner are both employees and/or retirees of Participating Employers, you may each be covered as an employee/retiree or as a dependent, but not both. In addition, only one of you is eligible to choose coverage for your dependent children.

Important Note: When you elect coverage for a dependent, you are certifying that the individual meets the eligibility requirements based on the definition of a dependent as outlined in this Summary Plan Description. Knowingly enrolling or continuing coverage for an individual who does not meet the dependent eligibility requirements may result in disciplinary action up to, and including, termination of employment for cause.

Domestic Partners

An unmarried, eligible retiree may enroll an unmarried same-sex or opposite-sex domestic partner as a dependent under the Plan. If you and your domestic partner meet the eligibility criteria set forth below and
enroll in the Plan, benefit coverage generally is provided under the Plan as though your domestic partner were your spouse, except where federal tax and other applicable laws and regulations prohibit doing so. To be eligible to enroll your domestic partner in the Plan, you and your domestic partner must:

(1) have entered into a state-registered domestic partnership and provide proof that you (1) are registered as domestic partners in a state that formally recognizes domestic partners, (2) have entered into a civil union in a state that formally recognizes civil unions, or (3) are registered as reciprocal beneficiaries in a state that formally recognizes reciprocal beneficiaries to the extent that you are in a spouse-like relationship with and are not related to your reciprocal beneficiary; or

(2) if you do not meet the requirements of section (1), you and your domestic partner must:
   (a) share an exclusive, committed relationship together and intend to do so indefinitely;
   (b) have shared a common residence together for the past 12 months;
   (c) be at least 18 years of age or older;
   (d) be jointly responsible for each other’s common welfare and financially interdependent;
   (e) not be related to a degree of closeness that would prohibit legal marriage in the state where you legally reside;
   (f) not be legally married to, or the domestic partner of, anyone else; and
   (g) satisfy such other criteria as the Company may require from time to time, including providing proof at the Company’s request that your domestic partner meets the eligibility criteria set forth above.

If you and your eligible domestic partner are both employees and/or retirees of Participating Employers, you may each be covered as an employee/retiree or as a domestic partner, but not both. In addition, only one of you is eligible to choose coverage for your dependent children.

You may also cover your domestic partner’s children (including any stepchild, foster child, legally adopted child, or a child for whom a court order of custody or guardianship has been obtained) under age 26. This does not include a child for whom your domestic partner’s parental rights have been legally terminated. You may be required to prove that your domestic partner has not relinquished his or her parental rights. Coverage for a dependent child of your domestic partner who is age 26 or older may only be continued under this Plan if the adult child is unable to earn his own living because of a physical disability, mental illness or developmental disability. Coverage will be continued in accordance with the provisions of “Dependents: Continuation of Coverage under Special Circumstances”. Coverage for an adult child of your domestic partner who attains age 26 will continue until the last day of the month in which his or her birthday occurs.

Important Note: When you elect coverage for a dependent, you are certifying the eligibility of that individual as meeting the definition of a dependent as outlined in this Summary Plan Description. Knowingly enrolling or continuing coverage for an individual who does not meet the dependent eligibility requirements may result in corrective action up to, and including, termination of coverage.

Termination of Domestic Partnership
If your state-registered domestic partnership terminates, you must complete a status change on the Your Total Rewards web site within thirty (30) days of the termination. If you have any questions, you can call Benefits Express at 1-800-758-4460. Upon termination of domestic partner coverage, coverage of the domestic partner’s children also stops. Your former domestic partner may be eligible to continue coverage in accordance with the provisions of the section “COBRA-Like Continuation Coverage for Domestic Partners”.

Making Changes after Retirement

Please note: As a retiree, there are restrictions on changes that can be made once you are enrolled. If at the
time you retire your spouse or domestic partner declines coverage, he or she will not be allowed to elect coverage at any point in the future, unless one of the situations below occurs. After you retire, coverage under the Plan can only be changed in the following situations:

- You may make a coverage election change from the Plus Plan to the Basic Plan, change to no coverage or you may drop covered dependents during the annual benefits enrollment period, usually held during the fall of each year.

- You may change your coverage category if your spouse or domestic partner involuntarily loses coverage under his or her employer's plan and has no other group coverage available. To cover a domestic partner, you meet the eligibility requirements detailed in the section “Domestic Partners” and provide any proof the Company may require from time to time.

- You may change your coverage category if a covered dependent dies and there are no other covered dependents, or if, in accordance with the Health Insurance Portability and Affordability Act of 1996 (“HIPAA”) special enrollment rights, you acquire an eligible dependent through marriage, domestic partnership, birth, or adoption or placement for adoption of a child after your retirement. Once a dependent has disenrolled from coverage, they will not be allowed to reenroll at a future date. Call Benefits Express at 1-800-758-4460 to request the change.

- You may voluntarily drop coverage effective a date in the future any time during the plan year. Please note: This is not a COBRA qualifying event and once you elect to drop coverage, you cannot enroll in coverage at any time in the future.

COBRA Continuation Coverage

All employees who are enrolled in a Plan option and who retire, including those with more than ten (10) years of employment, will be eligible for COBRA coverage for 18 months, at a cost of 102% of the full price of coverage under the Plan. If you retire with ten (10) or more years of continuous eligible employment from your most recent date of hire, although you are eligible for COBRA, if you elect COBRA instead of retiree coverage, you will not be eligible for retiree coverage at the end of the COBRA period. For more information, refer to the section "Right to Continue Coverage".

Cost

Retirement on or after January 1, 2014

Coverage for retirees younger than age 65 is provided through a cost-sharing arrangement with an annual fixed dollar Company contribution based on your years of eligible credited service. An active employee’s age and service as of December 31, 2013, is used to determine the age and service category to establish the contribution amount annual multiplier. Employees hired after December 31, 2013 will be placed in the less than 60 category. Eligible credited service for the purposes of determining your age and service category is based on the greater of your continuous years of service from your most recent hire date or years of vested service in the pension plan as of December 31, 2013. The annual contribution amount will be multiplied by your total number of years of eligible service at your retirement date (up to a maximum of 35 years). In the event you have a break in service, different rules apply as outlined in the section “Break in Service.” For detailed information on cost of coverage, contact Benefits Express. Please note that rates and contribution levels for all retirees are subject to change at any time in the Company’s sole discretion.
The following chart shows the 2018 contribution schedule for employees who qualify for retirement coverage, and who are enrolled in the Dental Plan immediately prior to their retirement date:

<table>
<thead>
<tr>
<th>Age + Eligible Credited Service as of December 31, 2013</th>
<th>Dental Coverage&lt;sup&gt;2&lt;/sup&gt; (Full-Time Employees)</th>
<th>Dental Coverage&lt;sup&gt;2&lt;/sup&gt; (Part-Time Employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85 or more</td>
<td>$7.00</td>
<td>$4.69</td>
</tr>
<tr>
<td>80 – 84</td>
<td>$6.73</td>
<td>$4.51</td>
</tr>
<tr>
<td>75 – 79</td>
<td>$6.46</td>
<td>$4.33</td>
</tr>
<tr>
<td>70 – 74</td>
<td>$6.19</td>
<td>$4.15</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$5.92</td>
<td>$3.97</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$5.65</td>
<td>$3.79</td>
</tr>
<tr>
<td>Less than 60</td>
<td>$5.39</td>
<td>$3.61</td>
</tr>
</tbody>
</table>

<sup>1</sup>Pension credited service through 12/31/2013 will be based on the applicable vesting schedule in place as of your initial termination date (i.e., 5 or 10 years).

<sup>2</sup>The Company contribution amount may increase by 2.5% on an annual basis, dependent upon the Company's annual review of costs.

Example – Retiree Dental Cost: As of December 31, 2013, an employee was age 61 with 26 years of eligible credited service. If the employee retires in December 2017 at age 64, cost-sharing would be determined as follows:

**Step 1: Determine Age + Eligible Credited Service Cost-Share Tier as of 12/31/2013**

61 (Age) + 26 (eligible credited service) = 87 [85 or more tier]

**Step 2: Determine Eligible Credited Service as of Date of Termination**

11/30/2017 (date of termination) - 11/30/1987 (date of hire) = 30 years

**Step 3: Calculate Annual Company Contribution Amount**

$7.00 (85 or more tier) X 30 (eligible credited service from Step 2) = $210

**Step 4: Calculate Annual Retiree Contribution Amount**

\[
\text{Annual Basic/Plus Dental Cost (Retiree Only)} = 366/601 \\
\text{- Annual Company Contribution Amount} = 210 \\
\text{Annual Basic Retiree Cost} = 156/391 \\
\text{Monthly Retiree Cost} = 13/33
\]
Retirement on or before December 1, 2013

For participants enrolled in the Plan who retired after 1992 and before January 1, 2014, the Company capped contributions. The annual “cap” of 3% is in addition to the scheduled cost-sharing percentage, as described in this section. The annual cap limits the Company’s contribution increase to the lower of 3% or the actual cost increase.

For detailed cost-sharing information, contact Benefits Express at 1-800-758-4460. Please note that rates and contribution levels for all retirees are subject to change at any time at the Company’s discretion.

If you retired on or after January 1, 1993 and before December 31, 2013, your contribution will be a percentage of the full cost for coverage based on your continuous eligible years of service at retirement, plus any applicable cost-sharing contribution. The following chart is the percentage contribution schedule for employees who qualify for retirement coverage and who retired on or after January 1, 1993 but before December 31, 2013.

<table>
<thead>
<tr>
<th>Continuous Eligible Years of Service at Retirement</th>
<th>Percent of the Price Paid by Retiree (Formerly Full-Time)</th>
<th>Percent of the Price Paid by Retiree (Formerly Part-Time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or more but less than 15</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>15 or more but less than 20</td>
<td>70%</td>
<td>80%</td>
</tr>
<tr>
<td>20 or more but less than 25</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>25 or more but less than 30</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td>30 or more but less than 35</td>
<td>40%</td>
<td>65%</td>
</tr>
<tr>
<td>35 or more</td>
<td>30%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Note: As stated above, only continuous service with your employer during the period your employer is part of a Participating Employer counts for determining eligibility and/or cost-sharing for post-retirement dental coverage. In some cases, however, service with your employer prior to its entry into the Company controlled group or service with a previous employer, may count towards eligibility and/or cost-sharing:

- Former CIGNA Bond Services employees who were employed as of January 24, 1994 receive credit for prior employment service with ICNA for purposes of eligibility and cost-sharing.
- Former CUMIS General Insurance Co. and CUNA Mutual General Agency of Texas employees who transferred to a Participating Employer in conjunction with the acquisition of CUMIS General on July 1, 1998 receive credit for prior employment service with CUNA Mutual Insurance Co. for purposes of eligibility and cost-sharing.
- Golden Eagle Insurance Corporation employees who were employed as of October 1, 1997 receive credit for prior employment service with Golden Eagle Insurance Co. for purposes of eligibility only.
- Liberty Real Estate Management, Inc. employees who were employed on January 1, 1997 receive credit for prior employment service with Liberty Real Estate Group, Inc. and Liberty Sanibel II Limited Partnership for purposes of eligibility and cost-sharing.
• Wausau Service Corporation and former Nationwide Trial Division employees who were employed as of the acquisition date of December 31, 1998, receive credit for prior employment service with Wausau Service Corporation and Nationwide Trial Division for purposes of eligibility and cost-sharing.

• Atlantic Health Group employees who were employed as of March 31, 1997, receive credit for prior employment service with New England Health Group from the later of January 2, 1996 or the employee’s date of hire for purposes of eligibility and cost-sharing.

• ACE employees who were employed as of January 1, 2000 receive credit for prior continuous service from their last full-time hire date with CIGNA (if they transferred from CIGNA to ACE on July 2, 1999) or from their last full-time hire date with ACE (if hired by ACE after July 2, 1999) for purposes of eligibility and cost-sharing.

• RAM employees who were former employees of The Netherlands Insurance Company (TNIC) who lost or retained post-retirement coverages under the TNIC welfare benefit plans as of December 31, 1998, and who are employed by TNIC on December 31, 2000, will receive prior service credit for purposes of eligibility and cost-sharing.

• RAM employees who were not former employees of TNIC referenced above are granted past service credit toward eligibility, but not cost-sharing for pre-65 post-retirement benefit purposes. However, in the case of post-65 coverage, such employees who have less than 10 years of service for cost-sharing, but at least 10 years of service for eligibility will be eligible for the minimum Company contribution to the cost of the post-retirement dental plan.

• RAM and Liberty Mutual employees who were former employees of OneBeacon Insurance Company on December 31, 2001, and who are employed by Participating Employers on January 1, 2002, receive credit for prior employment service with OneBeacon companies for purposes of eligibility and cost-sharing.

• Former employees of Merchants Holding Corporation who transferred and became employees of The Netherlands Insurance Company on April 1, 2002 receive credit for prior employment service with Merchants Holding Corporation for eligibility purposes only.

• Cascade Disability Management, Inc. (Cascade) employees employed with Cascade, as of January 1, 2003, receive credit for prior employment service with Cascade for eligibility purposes only.

• Former employees of Liberty Financial Companies, Inc. (LFC) who are employed by Participating Employers on or after January 1, 2003 receive credit for prior employment service with LFC for eligibility purposes only.

• Former employees of Prudential Commercial Insurance Company, Inc., Prudential General Insurance Company, and Prudential Property and Casualty Insurance Company (collectively referred to as “Prudential”) who transferred to Participating Employers on November 1, 2003 receive credit for prior employment service with Prudential, for eligibility purposes only.

• Liberty Northwest employees employed with Liberty Northwest, as of January 1, 2004, receive credit for prior employment service with Liberty Northwest for purposes of determining years of service for eligibility and cost-sharing for post-retirement coverage.

• Former Ohio Casualty Corporation (OCAS) employees who were employed by a Participating Employer as of January 1, 2008 and retire after December 31, 2013, will receive credit for purposes of eligibility and cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Employees with 25 years of continuous eligible service as of July 1, 2004:</th>
<th>Employees with less than 25 years of continuous eligible service as of July 1, 2004 and</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Retiree Dental SPD

<table>
<thead>
<tr>
<th>Age</th>
<th>Cost sharing based on actual years of eligible credited service with Ohio Casualty and Liberty Mutual (up to a maximum of 35 years).</th>
<th>Eligibility based on total years of eligible credited service. Cost sharing based on eligible credited service from July 1, 2004 forward.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than Age 65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 65 or Older</td>
<td>Company contribution category: 75 to 79 Years of eligible credited service: 25</td>
<td>Company Contribution Category: &lt; 60 Years of eligible credited service: Service from July 1, 2004 forward.</td>
</tr>
</tbody>
</table>

- Former employees of Ohio Casualty Corporation (OCAS) who transitioned to a Participating Employer as of January 1, 2008 and retired before December 31, 2013, will receive credit for purposes of eligibility and/or cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Employees with 25 years of service as of July 1, 2004.</th>
<th>Cost-sharing based on actual years of service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees with less than 25 years of service as of July 1, 2004 and more than 10 years of total service.</td>
<td>Eligibility based on total years of service. Cost-sharing based on service from July 1, 2004 forward.</td>
</tr>
</tbody>
</table>

- Former employees of Safeco Corporation and subsidiaries who transitioned to Participating Employers on January 1, 2009, will receive credit for prior employment service with Safeco for eligibility purposes only.

Eligible participants who were retired at the time of the acquisition and transitioned to the Company’s plans may have a different cost-sharing arrangement based on the agreement in place at the time of acquisition. Price Tags and contribution levels are subject to change at the Company’s discretion.

After retirement, dependents may include your spouse or domestic partner and children who were covered dependents under the Plan on the day immediately preceding your retirement.

If a retiree is enrolled for dependent coverage at the time of his or her death, the spouse or domestic partner and dependent children of the deceased retiree may continue their coverage upon payment of the applicable cost. This is contingent upon the spouse or the domestic partner remaining unmarried and not entering into a new domestic partner relationship and the children remain dependents as defined in this Plan. Coverage terminates automatically on the date of the surviving spouse's remarriage or entering into a domestic partnership or children cease to be dependents under the Plan.

Break in Service

- Employees and/or retirees rehired on or after January 1, 2018 will not be eligible for retiree dental benefits under the Plan. However, benefits for certain retired employees and/or retirees in certain situations will be administered as shown in the chart below. Prior to January 1, 2018, different break in service provisions applied.
Retiree Dental SPD

1/2018

<table>
<thead>
<tr>
<th>Rehired Employees</th>
<th>With a break in service greater than 30 days</th>
<th>Not eligible for retiree benefits under the Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehired Retirees</td>
<td>Enrolled in retiree coverage prior to a break in service</td>
<td>Age + Svc as of December 31, 2013 - or - Determined based on Age + Eligible credited service prior to break</td>
</tr>
<tr>
<td></td>
<td>Not previously enrolled in retiree coverage prior to a break in service where the break is 30 days or less</td>
<td>Age + Svc as of December 31, 2013 - or - Determined based on Age + Eligible credited service prior to break</td>
</tr>
<tr>
<td></td>
<td>Not previously enrolled in retiree coverage prior to a break in service where the break is greater than 30 days</td>
<td>Not eligible for retiree benefits under the Plan</td>
</tr>
</tbody>
</table>

Dependants: Continuation of Coverage under Special Circumstances

Disabled Dependent Children
A covered retiree may continue coverage for certain dependent children who are 26 or older if they meet certain conditions. The retiree must provide proof that the child is unable to earn his or her own living for reasons of physical disability or mental illness. The covered retiree must be covered for dependent coverage for the child under the Plan on the date the child reaches age 26, and medical proof of the disability must be received by the appropriate claims administrator within thirty (30) days after the last day of the month he/she turns age 26. After reviewing the medical proof submitted, the appropriate claims administrator must approve the child’s status as mentally or physically disabled in order for coverage to continue.

The covered retiree's or domestic partner’s child will be considered a covered dependent as long as the covered retiree submits due proof upon request by the claims administrator that the child remains physically or mentally unable to earn his or her own living.

The Company, at its own expense, may have a physician of its choice examine the child during the time his or her coverage is continued. An exam will not be required more than once a year.

A covered retiree's coverage for such child will end according to the provisions under “Termination of Coverage” or on the earliest of:

- the date the child is able to earn his own living;
- failure to provide due proof that the child is unable to earn his own living; or
- failure of the child to submit to an exam by a physician.
Dependents of Deceased Retirees
If a retiree’s spouse or domestic partner and dependent children are enrolled in coverage at the time of the retiree’s death, the spouse or domestic partner and dependent children of the deceased retiree may continue their coverage upon payment of the applicable cost. The coverage can continue as long as the spouse remains unmarried and does not enter into a new domestic partner relationship or the domestic partner remains unmarried and does not enter into a new domestic partner relationship, and the children are dependents as defined in the Plan. Coverage terminates automatically on the date of the surviving spouse's remarriage, entry into a new domestic partnership or the domestic partner's marriage or entry into a new domestic partnership. See “Dependents of Deceased Retirees” in the “Right to Continue Coverage” section.

Please note that once a surviving spouse or domestic partner attains age 65 or becomes eligible for Medicare, the survivor and any dependents that he or she is covering under the Plan will continue their coverage in the Retiree Dental Plan.

Deductible and Co-Insurance Percentages
No benefit is payable up to the deductible amount of covered dental expenses incurred by any individual in any calendar year. The deductible does not apply to covered charges for orthodontic services. Co-insurance percentages vary with the coverage option selected, as follows:

<table>
<thead>
<tr>
<th>Coverage Option</th>
<th>Annual Deductible</th>
<th>Co-Insurance Percentage</th>
<th>Orthodontia Co-Insurance</th>
<th>Individual Maximum Annual Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual/Family</td>
<td>Part I Preventive</td>
<td>Part II Standard</td>
<td>Part III Major</td>
</tr>
<tr>
<td>Basic</td>
<td>$100/$200</td>
<td>100%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(No deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plus</td>
<td>$100/$200</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(No deductible)</td>
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</tr>
</tbody>
</table>

*Part I benefits paid by the Plan apply to the individual maximum annual benefit.
**$1,500 lifetime Orthodontia maximum

If you are enrolled in family coverage and the sum of covered dental expenses used toward you and your covered dependents' individual deductibles in a calendar year equals $200, the dental deductible will be met for the rest of that calendar year. For example, if you incur $100 in covered expenses in January and your spouse or domestic partner and children incur a total of $100 in covered expenses in February, the family annual deductible will be satisfied for that year.

Deductible Carryover
If you do not meet your annual deductible, covered dental expenses applied toward the family annual deductible during the last three months of that calendar year will be used toward the deductible for the following year. For example, the first expense that you incur during the year occurs in December and amounts to $75. If you incur no additional covered expenses during December, the $75 will be applied to satisfy the following year's deductible and, you will only need to incur $25 in covered expenses to satisfy your following year's deductible, and $125 to satisfy the Family deductible.
**Maximum Benefit**

The maximum benefit applicable to covered dental expenses, including preventive care, incurred by each individual in any calendar year is $1,000 in the Basic Plan and $2,000 in the Plus Plan, excluding orthodontia. The lifetime benefit maximum applicable to covered charges for orthodontic expenses is $1,500 in the Plus Plan, per eligible individual up to age 18 and includes amounts paid previously toward orthodontic coverage in the Plus Plan. There is no orthodontic coverage in the Basic Plan.

**Covered Dental Expenses**

"Covered dental expense" means the Maximum Fee Allowance that is set for services that may be provided under this contract for a dental service. This amount will not exceed the actual submitted charge. Covered dental expenses must be incurred while the person is covered. "Dental service" means any dental service

1. required for the treatment or management of the dental condition;
2. the most cost-efficient procedure for the treatment or management of the dental condition, taking into account alternate courses of treatment;
3. commonly and customarily recognized by dentists as appropriate in the treatment or management of the dental condition (as determined by the ADA or other nationally recognized dental boards);
4. other than educational or experimental;
5. not primarily for the comfort or convenience of the dentist or covered person; and
6. given in the most cost-efficient setting consistent with maintaining high quality care.

**Date Incurred**

The date a covered dental expense is incurred will be:

1. for full or partial dentures, on the date the final impression is taken;
2. for fixed bridges, crowns, inlays and onlays, on the date the teeth are first prepared;
3. for root canal therapy, on the later of the date the pulp chamber is opened, or the date the canals are explored to the apex;
4. for periodontal surgery, on the date the surgery is actually performed;
5. for all other services, on the date the service is performed.

**Definitions**

"Active employee" means any full-time or part-time employee of a Participating Employer.

"Ambulatory surgical center" (or free-standing emergency center) means a facility that:

1. is established, equipped and operated mainly to perform surgical procedures;
2. is operated under the supervision of a staff of physicians and provides the full-time services of at least one RN;
3. is licensed by the jurisdiction in which it is located;
4. has at least two operating rooms and at least one post-anesthesia recovery room;
5. has a written transfer agreement with one or more hospitals and does not provide its own place for patients to stay overnight;
6. is not an establishment that is operated by one or more physicians solely for their own patients; and
(7) maintains medical records for each patient.

"Annual Benefits Enrollment period" means the period each fall during which eligible employees/retirees may enroll for or change coverage under this Plan for the next Plan Year.

"Calendar year" means the period starting January 1 of any year and continuing through December 31 of that same year.

"Coverage category" means retiree only, retiree plus spouse/domestic partner, retiree plus child(ren), or family.

"Coverage option" means no coverage, Plus Plan, or Basic Plan.

"Covered dental injury" means a chewing injury only.

"Covered dependent" means a dependent whose coverage is in effect. It does not include a dependent whose coverage has ended.

"Covered employee" means an active employee regularly scheduled for a minimum of 20 hours per week, or a retired employee whose coverage is in effect. It does not include an employee or retiree whose coverage has ended.

"Covered person" means a covered employee, retiree, or dependent.

"Dental treatment plan" means the dentist's report of recommended treatment on a form accepted by Delta Dental, the claims administrator that: (a) itemizes the dental procedures and charges required for the necessary care of the mouth; (b) lists the charges for each procedure; and (c) is accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials required by the Company.

"Dentist" means a person other than a covered person who: (a) is licensed to practice dentistry; and (b) practices within the scope of his license. A dental hygienist, dentist, or physician will be considered a dentist when he performs any dental services that are within the scope of his license.

"Dependent" means: (a) an employee's/retiree's spouse, (b) a domestic partner provided he or she meets the eligibility criteria and requirements detailed under “Eligible Dependents,” and (c) an employee's/retiree's child (including any stepchild, foster child, legally adopted child, or a child for whom a court order of custody or guardianship has been obtained) under age 26. This does not include a child for whom your parental rights have been legally terminated.

Coverage for an adult child who is age 26 or older may only be continued under the Plan if the adult child is unable to earn his own living because of a physical disability, mental illness, or developmental disability. Coverage will be continued in accordance with “Dependents: Continuation of Coverage under Special Circumstances”

"Dependent" does not include a person who is: (a) covered under this Plan as an employee; or (b) a legally divorced spouse.

"Dependent coverage" means coverage of a covered employee or retiree with respect to his dependents.

"Eligible dependent" means a dependent of an employee or retiree who is eligible for coverage.

"Employee" means an employee of a Participating Employer who is eligible for coverage.
"Functioning tooth" means a tooth that holds space and aids in mastication of food.

"Immediate family" means a covered person's spouse, domestic partner, child, domestic partner's child, brother, sister, parent, or in-laws.

"Maximum Fee Allowance" means the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the fee allowance used by the claim administrator. Such charge will be determined from within the range of charges made for the service or procedure by providers in the general geographic area where the provider maintains his usual place of business. The maximum fee allowance will not exceed the fee allowance schedule used by the claims administrator.

"Natural teeth" are teeth or parts of teeth that are organic and formed by the natural development of the body (not manufactured).

"Orthodontic treatment" is the corrective movement of the teeth through the bone by means of an active appliance to correct a malocclusion of the mouth.

"Orthodontic treatment plan" means the dentist's report of recommended treatment on a form accepted by the claims administrator that: (a) itemizes the procedures required to correct the malocclusion and (b) shows the total charge for the recommended treatment.

"Personal coverage" means coverage of a covered employee/retiree with respect to himself.

"Physician" means only:
(1) a medical practitioner who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures;
(2) a licensed dentist practicing within the terms of his license;
(3) a psychologist practicing in conformity with applicable state law;
(4) any other licensed practitioner of the healing arts in a category specifically favored under the health insurance laws of the state where the service for which claim is made is performed, practicing within the terms of his license; or
(5) a practitioner currently authorized to act as such by the Mother Church, The First Church of Christ Scientist.

"Retired employee or retiree" means one who is so classified by the Participating Employer.

"Sound teeth" means teeth that are fully restored to function, do not have any decay, are not more susceptible to injury than virgin teeth, or do not have significant periodontal disease.

"Temporary Dental Prosthesis" includes bridges, partial dentures, full dentures, and crowns that are inserted for a period of less than 12 months.

Schedule of Covered Dental Services

The following is a list of covered dental services. A temporary dental service is considered part of the final dental service.

<table>
<thead>
<tr>
<th>Diagnostic</th>
<th>Procedure</th>
<th>Time Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td>Time Limitation</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Evaluation Exam</td>
<td>Once every 60 months, per dentist.</td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Exams</td>
<td>Twice per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td>As needed.</td>
<td></td>
</tr>
<tr>
<td>Bitewing – X-rays</td>
<td>Twice per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Full Mouth X-rays or Panoramic X-rays</td>
<td>One every 60 months.</td>
<td></td>
</tr>
<tr>
<td>Single Tooth X-Rays</td>
<td>As needed.</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Casts</td>
<td>Only allowed in conjunction with orthodontic services.</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive

#### Procedure | Time Limitation
--- | ---
Teeth Cleaning | Twice per calendar year.
Periodontal (Maintenance) Cleaning | Four per calendar year following active periodontal treatment. Not to be combined with preventative cleanings.
Full Mouth Debridement | Once per lifetime to enable a comprehensive evaluation.
Fluoride Treatment | Twice per calendar year, limited to children under the age of 19.
Space Maintainers | Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.
Sealants | Unrestored permanent molars, every 24 months per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who had a recent cavity and are at risk for decay.
Chlorhexidine Mouth Rinse | Covered benefit only when administered and dispensed in a dental office following active periodontal therapy.
Fluoride Toothpaste | Covered benefit only when administered and dispensed in a dental office following active periodontal therapy.
Emergency Dental Care/Palliative Treatment | Three occurrences in 12 months.

### Fillings

#### Procedure | Time Limitation
--- | ---
Amalgam (silver) and Composite (white) | Amalgam (silver) fillings – once every 24 months per surface per tooth.
Composite (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface composites on posterior teeth will be processed as a silver filling and the patient is responsible for the difference between the discounted fee for a silver filling and the discounted fee for a white filling.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite Fillings</td>
<td></td>
</tr>
<tr>
<td>Stainless Steel Crowns</td>
<td>Once per primary tooth per 24 months.</td>
</tr>
<tr>
<td>Protective Restoration</td>
<td>Once per tooth per 60 months. Disallowed in conjunction with definitive restoration or endodontic procedures.</td>
</tr>
</tbody>
</table>

### Oral Surgery

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extractions</td>
<td>Includes local anesthesia and routine post-operative care.</td>
</tr>
<tr>
<td>General Anesthesia &amp; IV Sedation</td>
<td>Allowed with covered surgical procedures, up to one hour.</td>
</tr>
</tbody>
</table>

### Periodontics (on natural teeth only)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodontal Surgery</td>
<td>One surgical procedure in 36 months, per quadrant.</td>
</tr>
<tr>
<td>Scaling and Root Planning</td>
<td>Once in 24 months per quadrant. Only two quadrants are allowed on the same date of service.</td>
</tr>
<tr>
<td>Crown Lengthening</td>
<td>Once per tooth per 60 months, if tooth meets crown requirements.</td>
</tr>
<tr>
<td>Mucogingival Surgery</td>
<td>Two teeth per quadrant per 36 months.</td>
</tr>
<tr>
<td>Bone grafts/Guided Tissue Regeneration</td>
<td>No more than 2 teeth per quadrant per 36 months. Not covered when done in conjunction with an implant.</td>
</tr>
<tr>
<td>Occlusal Guard</td>
<td>Once per 60 months, after active periodontal therapy or due to bruxism.</td>
</tr>
</tbody>
</table>

### Endodontics

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root Canal Treatment</td>
<td>Once per tooth per lifetime.</td>
</tr>
<tr>
<td>Root Canal Retreatment</td>
<td>Once per tooth, after 24 months have elapsed from initial treatment.</td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>Covered as a separate benefit on primary teeth only.</td>
</tr>
</tbody>
</table>
### Prosthetic Maintenance

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridge or Denture Repair</td>
<td>Limited to repairs or adjustments performed more than 12 months after the initial insertion.</td>
</tr>
<tr>
<td>Rebase or Reline of Dentures</td>
<td>Limited to relining done more than 6 months after the initial insertion, and then not more than once in a 36 consecutive month period.</td>
</tr>
<tr>
<td>Crown or onlays repairs</td>
<td>Once per tooth per 12 months, after 24 months of initial treatment.</td>
</tr>
<tr>
<td>Recement of Crowns, Bridges &amp; Onlays</td>
<td>Once in 12 months per crown, bridge or onlay.</td>
</tr>
</tbody>
</table>

### Prosthodontics

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures, Partial and Fixed Bridges</td>
<td>Once per arch per 60 months, for members age 16 and older. No additional benefit for over dentures, customized dentures, precision or semi-precision attachments.</td>
</tr>
<tr>
<td>Inlays</td>
<td>Covered as an alternative benefit; an amalgam (silver filling) benefit is provided.</td>
</tr>
<tr>
<td>Crowns or Onlays</td>
<td>Once per tooth per 60 months, for members age 12 and older, when the tooth cannot be restored with a regular filling. Anterior crowns subject to consultant review.</td>
</tr>
<tr>
<td>Surgical Implant Placement</td>
<td>Once per tooth in lieu of a three unit bridge when adjacent teeth do not require immediate restoration. Subject to consultant review.</td>
</tr>
<tr>
<td>Implant Abutments</td>
<td>Once per tooth per 60 months, only when surgical implant is benefitted.</td>
</tr>
<tr>
<td>Crown Build-up / Post and Core</td>
<td>Once per tooth per 60 months, only benefitted to retain a crown.</td>
</tr>
</tbody>
</table>

### Orthodontia (Braces)

Traditional braces or invisible aligner therapy.

Diagnostic casts only allowed in conjunction with orthodontic services.

Orthodontia is only covered for members under the age of 19, when administered and supervised by a licensed dentist.
Orthodontia Benefits

Orthodontia Benefits are payable for covered orthodontic expenses incurred by a covered person who is under age 18.

Orthodontia Benefits are paid at 50% of the covered orthodontic expense. The lifetime benefit for covered orthodontic expenses in the Plus Plan is $1,500 per covered person. The Basic Plan does not cover orthodontic expenses. See the “Maximum Benefit.”

Covered Orthodontic Expense

"Covered orthodontic expense" means the maximum fee allowance charge for the following services:

- cephalometric x-rays
- orthodontic treatment

The maximum fee allowance charge will not exceed the actual charge.

Covered orthodontic expenses must be incurred while covered by the Plus Plan. These expenses do not include orthodontic expenses if the appliance or bands are inserted before the covered person is covered under the Plus Plan.

Date Incurred

The date all covered orthodontic expenses are incurred will be:

1. the date the bands are inserted;
2. the date the appliance is inserted; or
3. the date a procedure is performed, if it is completed on the same day it was started.

Benefit Payments

An orthodontic treatment plan must be submitted to Delta Dental, the claims administrator, before benefits are payable for covered orthodontic expenses. Total benefits for the orthodontia treatment will then be determined and divided into 12-monthly payment installments:

Delta Dental will notify the covered person and his dentist of the benefits payable. Orthodontic benefits will be paid on a monthly basis over 12-months until the lifetime maximum benefit has been reached, provided the covered person remains eligible for coverage. Orthodontic benefit payments will cease in the month that the covered person’s eligibility under the plan is terminated.

Delta Dental has the right to require additional information to determine whether benefits are payable. This includes, but is not limited to:

- full mouth dental x-rays;
- cephalometric x-rays and analysis;
- study models; and
- completion of a questionnaire that will specify: the degree of overjet, overbite, crowding, or open bite, if teeth are impacted, in crossbite, or congenitally missing, the length of treatment, and the total charge for the treatment.
Exclusions

Dental Benefits will not be payable for the following charges:

- Services, supplies, procedure or appliance that is not described as a covered service;
- A Service or procedure that is not generally accepted as determined by Delta Dental;
- Charges for missed appointments;
- Charges by the dentist for completing dental forms;
- Incomplete procedures;
- Nitrous Oxide;
- Any service or supply furnished along with, in preparation for, or as a result of a non-covered service;
- Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn dependent child;
- Adjustment of a denture or bridgework that is made within six months after installation by the same dentist who installed it;
- Any duplicate appliance or prosthetic device;
- Services or supplies that are covered by any employers’ liability laws;
- Services or supplies that are deemed experimental in terms of generally accepted dental standards;
- Home health aides used to prevent decay, such as toothpaste and fluoride gels;
- Instruction for oral care, such as hygiene or diet;
- Office visits after regular office hours;
- Silver Fluoride;
- Cleaning and inspection of removable appliances;
- Replacement of a lost, missing or stolen crown, bridge or denture;
- Services or supplies received through a medical department or similar facility that is maintained by the covered person’s employer;
- Charges and treatment for Myofunctional therapy, athletic mouth guards, precision or semi-precision attachments, acid etch in conjunction with fillings, and orthognathic surgery;
- Services or supplies received by a covered person for which no charge would have been made in the absence of dental coverage for the covered person;
- Services not performed by a licensed dentist, except for the services of a licensed hygienist whose services are supervised and billed by a dentist and that are for: Cleaning and scaling of teeth, or Fluoride treatments;
- Services or supplies for which a covered person is not required to pay;
- Repair or replacement of an orthodontic appliance;
- Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan sponsored or contributed to by the company;
- Periodontal splinting;
- Services or supplies that any employer is required by law to furnish in whole or in part;
• Sterilization supplies;
• Charges for care or treatment of any sickness or injury that results from war, declared or undeclared, or any act of war, or committing or attempting to commit an assault or felony or from any intentionally self-inflicted injury, except to the extent that such injury results from an act of domestic violence or a medical condition;
• Services or supplies that are covered by any workers’ compensation law or occupational disease law;
• Charges for treatment of TMJ therapy;
• Caries susceptibility tests;
• Prescription drugs;
• Restorations for reasons other than decay or fracture, such as to increase height of teeth;
• Services that are cosmetic (meant to change or improve appearances);
• Tooth bleaching;
• Photographs;
• Localized delivery of chemotherapeutic agents;
• Nitrous Oxide;
• Therapeutic Drug Injections;
• Temporary crown, fixed bridges and dentures that are placed as part of the procedure of placing a permanent crown, fixed bridge or denture will be disallowed and is included in the fee for the permanent restoration;
• Ridge augmentation, ridge preservation, sinus lifts, and bone grafts in conjunction with extractions, apicoectomies, root amps, and implants;
• Debridement and osseous surgery around an implant;
• Cone Beam images, CT (computerized tomography) scans, surgical stents, surgical guides for implants;
• Transitional implants and interim abutments;
• Treatment of dental implant failures including surgical debridement and bone grafts to repair implant; and
• Travel time and related expenses

Predetermination of Benefits

If the total estimated charges for a recommended dental treatment plan are expected to exceed $300, the dental treatment plan should be submitted to Delta Dental for review before treatment begins. You can use the claim form to submit the treatment plan. This predetermination will itemize for you what benefits are payable under the Plan. Delta Dental will notify you and your dentist of the benefits payable. Delta Dental will make its determination by taking into account alternate courses of treatment based on professional standards of dental care. If you and your dentist agree to a more expensive method of treatment than that agreed to by Delta Dental, the excess amount will not be considered a covered dental expense. If treatment is given without obtaining an estimate of benefits, benefits payable will be the same as if an estimate had been requested. The Predetermination of Benefits will become invalid with any coverage changes or changes in the treatment plan.

Delta Dental has the right to require additional information to determine benefits payable. This includes but is not limited to:
(a) complete dental charting showing: (1) extractions; (2) missing teeth; (3) fillings; (4) prosthesis; (5) periodontal pocket depths; (6) orthodontic relationships; (7) the date of any work previously performed;
(b) an itemized bill for all dental care;
(c) preoperative x-rays, study models, laboratory and/or hospital reports; and/or
(d) a physical examination of the covered person at the Plan's expense

Coordination of Benefits

This provision applies to all benefits provided under the Plan.

If a member of your family is covered by another employer's dental plan, there may be some duplication of benefit coverage between the Plan and the other plan. This coordination of benefits (or COB) provision describes how benefits are paid in such cases. Its purpose is to ensure that, when benefits are payable under both the Plan and another group plan or plans, the total benefits paid do not exceed the total that would be payable under the Plan in the absence of other coverage.

To determine how plans coordinate benefits, one plan is considered primary and the other is considered secondary. The primary plan pays benefits first, up to that plan’s limits. The secondary plan will not pay benefits until the primary plan pays a portion of the claim or denies it. The “Non-Duplication of Benefits” section below describes how a plan is determined to be primary.

The word "plan" as used in this provision applies to any of the following that provides benefits or services for dental care:

- group insurance or group prepayment coverage;
- coverage for persons in a group (whether or not on an insured basis); or
- governmental programs and coverage required or provided by statute including, but not limited to Medicare

The word "plan" applies separately to:

- each policy or other arrangement for benefits or services; and
- the portion of such policy or other arrangement that reserves the right to consider other plans in determining its benefits

The term "this Plan" means the group dental benefits provided by the Company and described in this section.

"Allowable Expense" means any necessary, reasonable, and customary item of expense, at least a part of which is covered by one of the plans that covers the person for whom claim is made (claimant). When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed an allowable expense and a benefit paid.

In applying this provision, it will be presumed conclusively that all affected employees and dependents have chosen to assert their rights under other plans of benefits, including automobile no-fault laws.

Non-Duplication of Benefits
A plan without a COB provision is always the primary plan. The primary plan is the plan that pays its benefits first. If all plans have COB provisions, the following rules apply:

- The Plan is primary for covered employees of Participating Employers. Any other plan covering a
dependent as an employee is the primary plan for that person. For example, if your spouse or domestic partner is covered by a plan offered by his or her employer, then that plan will be primary for that dependent.

- If your child is covered by this Plan and your spouse or domestic partner’s plan as a dependent, then the birthday rule determines which plan is primary. Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is your child’s primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If your spouse or domestic partner’s plan does not have the birthday rule, then your spouse or domestic partner’s plan is primary.

- If parents are divorced or separated and a court decree establishes financial responsibility for dental care of a child, then the plan of the parent assigned that responsibility will be that child’s primary plan. In the absence of a court decree and when not remarried, the plan of the parent with custody will pay benefits before the plan of the other parent. If the parent with custody has remarried or entered into a domestic partnership and the stepparent’s or domestic partner’s plan also covers the child, the plan of the parent with custody will pay first, then the plan of the stepparent or domestic partner will pay next, and the plan of the parent without custody will pay last.

There are two other rules to keep in mind regarding non-duplication of benefits. When an individual has coverage from two employers, one a current employer, and the other, a previous employer, the current employer’s plan is primary. When the preceding rules do not resolve which plan is primary, the plan covering the individual the longest is primary.

When the Plan is primary, the Plan pays benefits as if it were the only plan. After the Plan pays its benefits, or denies a claim, you may file a claim for any unpaid amounts with the secondary plan.

When the Plan is the secondary plan, it coordinates benefits by:

- determining the benefit that would be paid if it were the only plan. This includes applying the appropriate co-pay, deductible, and all other benefit limitations.
- subtracting, or “carving out,” the amount of benefits paid by the primary plan from any benefit that would be paid by the Plan. This means that when the Plan is secondary, it will only pay the difference, if any, between its usual benefit and the benefit paid by the primary plan.

Coverage under the Plan, as well as another plan, will not likely result in receiving reimbursement greater than the total that would have been payable under the Plan in the absence of other coverage for dental care expenses.

When the preceding rules do not resolve which plan is primary, the plan covering the individual the longest defaults as the primary plan.

**Right to Receive and Release Necessary Information**
The Plan has the right, without obtaining consent or serving notice, to release or obtain benefit information needed in order to implement this provision.

**Optional Payment of Benefits**
If payments should have been made under this Plan, but were made under any other plan(s), the Plan may make payments to such other plan(s) to satisfy the intent of the provision, and benefits under this Plan will be considered paid. The Plan will no longer be liable for the payments.

**Right of Recovery**
If payments were made under this Plan that should have been made under any other plan, the Plan has the right
to recover such payments. This right may be exercised against any persons to, for, or with respect to whom the payments were made, and any insurance companies or other organizations.

Subrogation and Reimbursement

If your illness or injury appears to be someone else’s fault, benefits otherwise payable under the Plan as a result of that illness or injury will not be paid unless you or your legal representative agree:

- to repay the Plan for such benefits to the extent that they are for losses for which payment is made to you by or on behalf of the person at fault;
- to allow the Plan a lien on such payments and to hold such payments in trust for the insurer; and
- to execute and give to the Plan any instruments needed to secure the rights set forth above.

Failure to hold or forward to the Plan any such payments shall constitute unjust enrichment and shall create a constructive trust over any such payments and subject you, your attorney or any other constructive trustee to an equitable action seeking an equitable lien or constructive trust, in addition to other remedies.

Additionally, when benefits have been paid on your behalf under the Plan, the Plan will be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount the Plan has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Plan.

Termination of Coverage

The personal coverage of a covered retiree will end on the date that any of the following events first occurs, subject to any applicable Continuation of Coverage Provisions in the section entitled “Right to Continue Coverage”:

- the Plan terminates; or
- the end of the last period for which a covered retiree makes a required contribution or otherwise failed to pay any required portion of the cost of personal coverage.

The retiree's coverage of a covered dependent will end on the date that any of the following events first occurs, subject to any applicable Continuation of Coverage Provisions:

- status as a dependent ends;
- the covered retiree's personal coverage ends;
- dependent coverage is deleted from the Plan; or
- the end of the last period for which a covered retiree makes a required contribution, if he has canceled his pension deduction authorization or otherwise failed to pay any required portion of the cost of dependent coverage.

Please refer to the section entitled “Right to Continue Coverage.”

Extension of Benefits

In certain situations, expenses are considered covered expenses, and eligible for reimbursement, after the date your coverage ends. These situations are:
• for fixed bridgework and full or partial dentures, the first impressions are taken while you are a member of the Plan and the device is installed or delivered to you within the 31-day period after your coverage ends.

• for a crown, inlay, or onlay, the tooth is prepared while you are a member of the Plan and the crown, inlay, or onlay is installed within the 31-day period after your coverage ends.

• for root canal therapy, the pulp chamber of the tooth is opened while you are a member of the Plan and the treatment is completed within the 31-day period after your coverage ends.

These are the only situations in which dental benefits can extend beyond the date your coverage ends.

How to Claim Your Dental Benefits

Dentists who participate in the Delta Dental PPO or Delta Dental Premier networks, will file claims directly with Delta Dental for the services covered under the contract. For dentists who do not participate in the network, you may be asked to file a claim.

Claim Form
This form initiates your claim and serves as the dentist's bill for actual services rendered, or an estimate for proposed treatment. In both cases, it is important that you answer all relevant questions in Part I and sign all the appropriate sections. Be sure the question on "other coverage" is answered. Failure to answer relevant questions will delay the payment of benefits. All claims must be submitted within one year of the date that charges are incurred.

The treating dentist completes Part II of the form. This becomes the bill or estimate. Orthodontia claims should indicate the entire agreement with the practitioner. The $1,500 lifetime Orthodontia Benefit for dependent children under 18 is not payable in full at the onset of treatment. Claims must be submitted within two years from the date the charges are incurred.

Claim forms are available on Delta Dental’s website (www.deltadentalma.com) or by calling Delta Dental at 1-888-43-DELTA.

Direct Payment of Benefits

If a dentist or dental office participates in the Delta Dental PPO network or Delta Dental Premier, the Plan allows for direct payment of benefits to the dentist or dental office. If a dentist or dental office does not participate in the Delta Dental PPO or Delta Dental Premier network, payment will be made directly to you.

Explanation of Benefits

An "Explanation of Benefits (EOB)" form is issued after each claim is processed. It lists the dates of service, dental providers, amounts considered, co-payment level, and amounts applied toward maximum benefit levels. If you have any questions regarding payments, you may call or write Delta Dental at the telephone and address on the EOB. Your questions can be answered more quickly by stating your claim ID number that is located on the EOB.
Qualified Medical Child Support Order (QMCSO)

A "Qualified Medical Child Support Order" may require benefits for a dependent child under the Plan. Generally, this is a judgment, decree, or order that pertains to divorce. You can obtain a copy of the Plan’s QMCSO procedures, without charge, by calling Benefits Express at 1-800-758-4460.

Right to Continue Coverage (COBRA)

It is important that both you and your spouse read this summary. These provisions generally explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The federal law known as COBRA requires most employers sponsoring group health plans to offer retirees and their dependents who would otherwise lose group health plan coverage a temporary extension of coverage under the employer’s group health plan. COBRA continuation coverage is continuation of plan coverage when coverage would otherwise end because of a qualifying event, specified below. COBRA continuation coverage must be offered to each person who is a qualified beneficiary, defined as a person who will lose plan coverage because of a qualifying event.

COBRA continuation coverage for the Plan is administered by Benefits Express, 4 Overlook Point, Lincolnshire, IL, 60069-1490, telephone number 1-800-758-4460.

Spouse and Dependent Children

Dependent spouses and children covered by this Plan will become qualified beneficiaries and can elect COBRA continuation coverage if Plan coverage is lost because of any of the following qualifying events:

- death of a retiree (see “Dependents of Deceased Retirees.”)
- termination of an employee's employment (for other than gross misconduct), including retirement, reduction in hours of employment, or movement to benefits ineligibility status;
- divorce or legal separation of the spouse from an employee; or
- loss of "dependent" status of a child as defined under the Plan.

Newborns and children placed for adoption with a covered retiree during a period of COBRA continuation coverage will be eligible for coverage immediately under a parent’s COBRA coverage as qualified beneficiaries.

Notification

If the qualifying event that will cause a loss of Plan coverage is divorce, legal separation, or a child's loss of dependent status under the Plan, the retiree or a family member must inform Benefits Express at 1-800-758-4660 within sixty (60) days of such a qualifying event. Supporting documentation may be required. For such qualifying events, and the other qualifying events listed under “Spouse and Dependent Children,” Benefits Express, as COBRA administrator, will then notify the person whose coverage would otherwise end because of such qualifying events that he or she has sixty (60) days to inform Benefits Express of his or her intent to elect COBRA continuation coverage. The qualified beneficiary must elect COBRA continuation coverage following such qualifying events within sixty (60) days of receiving notice of his or her COBRA election rights from Benefits Express. If a qualified beneficiary does not elect COBRA continuation coverage within sixty (60) days of receiving the COBRA Enrollment Notice from Benefits Express, Group dental coverage will end on the date of the qualifying event. To elect continuation of coverage, retirees may call Benefits Express at 1-800-758-4460.
Period of COBRA Continuation Coverage
COBRA continuation coverage, if chosen, is identical to Plan coverage provided to similarly situated employees, retirees, or family members. COBRA continuation coverage, if chosen, will begin as of the date of the qualifying event.

If the qualifying event is the retiree’s death, entitlement to Medicare, divorce or legal separation, or a child losing dependent status, COBRA continuation coverage may last for up to 36 months. If the qualifying event is termination of employment (for other than gross misconduct) or reduction in hours, the COBRA continuation coverage may last for up to 18 months. There are two ways in which this 18-month COBRA continuation coverage can be extended.

First, if a second qualifying event occurs during this 18-month period which would entitle the qualified beneficiary to continue coverage for a longer period (e.g., termination of employment followed by retiree’s death, entitlement to Medicare, divorce or legal separation, or a child losing dependent status), coverage may be extended up to 36 months from termination or reduction in hours. The qualified beneficiary must inform Benefits Express at 1-800-758-4460 within 60 days of the second qualifying event. In no event will COBRA continuation coverage last beyond 36 months from the event that originally made the qualified beneficiary eligible to elect COBRA continuation coverage.

Second, the 18-month continuation period may be extended to 29 months for individuals who qualified for COBRA continuation coverage because of termination of employment or reduction in hours and later are determined to be disabled by the Social Security Administration (“SSA”) during the first 60 days of COBRA continuation coverage. This 11-month extension is available provided the individual notifies Benefits Express at 1-800-758-4460 within 60 days after the SSA issued its determination of disability and before the end of the original 18-month COBRA continuation coverage period. You should include a copy of the SSA determination.

Non-disabled family members of disabled qualified beneficiaries are also entitled to this extension. The affected individual must also notify Benefits Express at 1-800-758-4460 within 30 days of any final SSA determination that the individual is no longer disabled. You should include a copy of the SSA determination.

Termination of COBRA Continuation Coverage
COBRA continuation coverage may be terminated before the end of the maximum period of COBRA continuation coverage if:

- provision of group dental coverage to employees ceases;
- the charge for COBRA coverage continuation is not paid when due;
- the qualified beneficiary extends coverage for up to twenty-nine (29) months based on a SSA determination of disability and there has been a final SSA determination that the individual is no longer disabled; or
- otherwise becomes ineligible under the terms of the Plan.

Cost
In most cases, the charge for continuation of coverage will be 102% of the full cost under the Plan. In cases where the 11-month extension is available based on an SSA determination of disability as described above, the charge for the additional eleven (11) months of COBRA continuation coverage will be increased from 102% to 150% of the full cost under the Plan. There is a grace period of at least 30 days for payment of the regularly scheduled charges.
Trade Act of 2002
Special COBRA rights apply to employees who have been terminated or experienced a reduction in hours and who qualify for trade adjustment assistance under the Federal Trade Act of 1974 (“Eligible Individuals”). Eligible Individuals may be entitled to a second 60-day COBRA election period. The Trade Act of 2002 created a new tax credit under which Eligible Individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you qualify or may qualify for assistance under the Trade Act of 1974, please contact Benefits Express at 1-800-758-4460 for additional information. You must contact Benefits Express promptly or you may lose your special COBRA rights.

COBRA-Like Continuation Coverage for Domestic Partners
Although there is no legal obligation to offer COBRA continuation rights to covered domestic partners and their children, the Company has elected to provide the opportunity for such persons to continue their dental coverage if coverage otherwise ends, upon the occurrence of certain events. Specifically, covered domestic partners and their dependent children will generally be allowed to continue coverage similar to coverage provided to COBRA qualified beneficiaries under the same terms as described above upon the:

- termination of Domestic Partnership within thirty (30) days of the termination of domestic partnership of the domestic partner from a retiree;
- surviving domestic partner of a deceased retiree remarries; or
- domestic partner’s child loses "dependent" status as defined under the Plan.

Address Changes, Correspondence, and Questions
To protect your family’s rights when you change your address, notify, in writing, Benefits Express at 1-800-758-4460, about any changes in the addresses of you and your family members. You should keep a copy for your records of any such notices. If you have questions about COBRA continuation coverage, contact Benefits Express at the address above, or contact the nearest Regional or District Office of the US Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at http://www.dol.gov/ebsa/.

USERRA: Continuation of Coverage during Military Leave
If you are away from work due to military leave, different rules pertain to the continuation of your benefits, depending on the length of your leave.

If your aggregate military leave during your employment with the Company is two (2) years or less, Plan coverage will remain effective and you be responsible for the employee share of the benefits cost unless you submit a written request to Benefits Express to suspend your benefits before your leave begins. All Plan provisions will apply, including any exclusion for “acts of war.”

If, and when, your aggregate military leave exceeds two years, you may elect to continue your Plan coverage for up to twenty-four (24) additional months, or the time period required under USERRA as amended from time to time; however, you will be required to pay 102% of the full cost to continue coverage. If your military leave ends prior to the expiration of this 24-month period and you are reinstated with the Company, your benefits under the Plan will be reinstated without exclusions or waiting periods.

For enrollment and billing information, contact Benefits Express.
Rights of Plan Participants (ERISA)

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

- Examine, without charge, at the Plan Administrator's office and at other locations, all documents governing the Plan including the Plan documents and a copy of the latest annual report.
- Obtain copies upon written request to the Plan Administrator of Plan documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The law requires the Plan Administrator to furnish each participant with a copy of this Summary Annual Report; and
- Continue dental coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights, if any. Please note domestic partners and their dependents are not entitled to COBRA continuation coverage under federal law.

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 employer or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce your rights. For example, you may file suit in a federal court if:

- you have a claim for benefits that is denied or ignored, in whole or in part;
- you request materials from the Plan Administrator and do not receive them within thirty (30) days. The court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator; or
- the Plan fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim to be frivolous.

If you have any questions about this plan, you should contact the Plan Administrator. If you have any questions about this statement or about 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.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
 HIPAA Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information and to inform you periodically about:

- the Plan’s uses and disclosures of Protected Health Information (PHI);
- your privacy rights and the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS); and
- the person to contact for further information about the Plan’s privacy practices.

A description of HIPAA Privacy rights is in the HIPAA Notice provided to participants covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by law.

If you have a complaint, question, or concern, or require a copy of the Privacy Notice, please contact the Manager - Benefits Administration, Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, MA 02116, Attention: Benefits Department - Mailstop M03E, telephone: 1-847-224-4767.

This language intends to satisfy the notice requirements regarding HIPAA Privacy rights with regard to the Plan.

 HIPAA Portability

A notice of the special enrollment rights under HIPAA must be provided to all employees at the time the employee is initially offered a chance to enroll in the Plan. This notice is provided to all newly eligible employees within their new hire materials. Members may also request this notice by contacting their claims administrator at the address or telephone number provided at the end of this document.

 Administration of the Plan

 Interpretation of the Plan
The benefit plan Summary Plan Description summarizes the important features of the plan document. While the Summary Plan Description attempts to accurately describe benefits available as of the date of publication, it does not cover every provision of each policy or plan. In the event of a question of interpretation or conflict, the plan document will govern.

 Authority of Plan Administrator
The Plan Administrator has the authority, in its sole discretion, to construe the terms of the Plan regarding eligibility to participate in the Plan and any other matters relating to the administration or operation of the Plan, except for claim determinations. Any such interpretations or decisions of the Plan Administrator shall be conclusive and binding.

 Authority of Claims Administrator
The Plan Administrator shall designate a claims administrator for purposes of responding to claims filed in accordance with the claim and appeal procedures below.
Claim and Appeal Procedures

All claims by participants, beneficiaries, and others based on a purported failure to follow the Plan's terms, including, but not limited to, an alleged failure to follow any direction from a participant pursuant to Plan terms, an alleged administrative error or omission, or other alleged misconduct, are subject to the Plan's claims procedures.

Claim Procedures
You may file claims for benefits and appeal adverse claim decisions, yourself or through an authorized representative, who may be a spouse, domestic partner, parent, or designated health care agent. In the case of a claim involving emergency or urgent care, a health care professional with knowledge of your condition may act as your authorized representative. An urgent care claim is any claim where application of the pre-service claim time periods described below could seriously jeopardize your life, health, or ability to regain maximum function or would in the opinion of a physician with knowledge of your condition subject you to severe pain that cannot be adequately managed without care or treatment.

Urgent Care Claims
If the claims administrator or your physician determines that you have an emergency or urgent care claim, you will be notified of the decision no later than seventy-two (72) hours after the claim is received. If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but no later than twenty-four (24) hours after receipt of the claim. You will be given a reasonable additional amount of time, but no less than forty-eight (48) hours, to provide the information. You will be notified of the decision no later than forty-eight (48) hours after the end of that additional time period or after receipt of the information, if earlier. The time frames described above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

Pre-Service and Post-Service Claims
If a service, supply, or procedure requires advance approval before a benefit will be payable, it is considered a pre-service claim. You will be notified of the decision no later than fifteen (15) days after receipt of the pre-service claim. For other claims, such as post-service claims, you will be notified of the decision no later than thirty (30) days after receipt of the claim. The time frames above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

For either a pre-service or a post-service claim, the time frames above may be extended up to an additional fifteen (15) days due to circumstances outside the Plan’s control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period. If the extension is necessary because of failure to submit sufficient information, you will be notified of the specific information necessary and given an additional period of at least forty-five (45) days to furnish that information. In such case, the decision making period is tolled or suspended from the date the extension notice is sent until the earlier of the date the additional information is received or the end of the 45-day period. You will be notified of the claim decision no later than fifteen (15) days after the end of that additional 45-day period or after receipt of the information, if earlier.

If you do not follow the pre-service claim procedures, you will be notified of the failure and the proper procedures no later than five (5) days following the decision or within 24 hours for an emergency or urgent care claim. The notice may be oral unless you request written notice.

Concurrent Care: Ongoing Course of Treatment
If you are receiving an ongoing course of treatment, you will be notified in advance if the claims administrator intends to terminate or reduce benefits for this treatment, so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves emergency or urgent care and you request an extension of the course of treatment at least twenty-four (24) hours before its expiration, you will be notified of the decision within twenty-four (24) hours after receipt of
the request. The time frames described above begin at the time a claim is filed, without regard to whether all
the information necessary to make a decision is included.

Claim Denial Notification
If your claim is denied in whole or in part, you will receive a written notice of the denial. The denial notification
will contain:

(1) the specific reason for the denial;
(2) reference to specific provisions on which the decision is based;

(3) a description of any additional information necessary to perfect the claim and the reason why such
information is necessary;
(4) a description of the appeal procedures and time frames, including a statement of the right to bring a civil
action under ERISA following an adverse decision on review;
(5) the specific rule, guideline, protocol, or other similar criterion relied upon in making the decision, if
applicable, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request;
and

(6) an explanation of the scientific or clinical judgment for the determination if the decision was based on a
medical necessity or experimental treatment or similar exclusion or limit, or a statement that such
explanation will be provided free upon request.

Appeal Procedures

Appeal Time Periods
If you wish to appeal an adverse benefit decision, you must do so in writing within one hundred eighty (180)
days following receipt of the adverse benefit decision. You will be notified of the decision no later than thirty
(30) days for pre-service claims or sixty (60) days for post-service claims after the appeal is received.

If the claim involves emergency or urgent care, you or your authorized representative may appeal the denial
either orally or in writing. All necessary information, including the appeal decision, will be communicated
between you or your authorized representative by telephone, facsimile, or a similar method. You will be notified
of the decision no later than seventy-two (72) hours after the appeal is received.

The appeal time periods begin at the time an appeal is filed, without regard to whether all the information
necessary to make a decision on appeal is included.

Appeal Rights
You may submit, and have a right to an appeal review that takes into account written comments, documents,
records, and other information relating to the claim, whether or not such information was submitted or
considered in the initial decision. You may request, free of charge, copies of all documents, records, and other
information relevant to your claim. You have a right to an appeal review that does not afford deference to the
initial denial, and that is conducted by a person who is neither the individual who made the initial denial, nor
that person’s subordinate. The Plan Administrator, in deciding an appeal based on a medical judgment, must
consult a health care professional who has appropriate training and experience in the field of dentistry and who
was neither consulted in connection with the denial, nor is the subordinate of any health care professional
consulted during the initial claim review. You have a right to the identification of dental or vocational experts
consulted in connection with a claim denial, without regard to whether the advice was relied upon in making
the decision.

Appeal Denial
The appeal denial letter will contain:
(1) the specific reasons for the adverse decision on appeal;
(2) reference to specific provisions on which the decision is based;
(3) a statement that the claimant is entitled to receive free copies of all documents, records, and other information relevant to the claimant’s claim;
(4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under ERISA section 502(a);
(5) the specific rule, guideline, protocol, or other similar criterion relied upon in making the decision if applicable, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request; and
(6) an explanation of the scientific or clinical judgment for the determination if the decision was based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free upon request.

Legal Proceedings

You will not be entitled to challenge a claim decision made by the Claims Administrator in federal or state court or in any other administrative proceeding until all of the Claim and Appeal procedures outlined above have been complied with and exhausted: No lawsuit shall be brought against the Plan, the Plan Sponsor, the Company, the Plan Administrator or the Claims Administrator by you or your authorized representative until:

• the date on which your appeals rights have been exhausted; and
• no more than (1) one year after the time proof of claim is required.

Legal actions are contingent upon first having followed the Claims and Appeals procedure outlined above.

Amendment or Termination of the Plan

The Company can adopt any amendment to the Plan or terminate the Plan at any time: Any action that may be taken by the Company to amend or terminate the Plan may also be taken by the Company’s Chief Executive Officer except as otherwise restricted under the Company’s Compensation Committee charter.

General Provisions

The Plan is a group health plan. Plan records are maintained on a calendar-year basis: January 1 through December 31.

The Plan Sponsor is Liberty Mutual Group Inc. The employer identification number assigned by the Internal Revenue Service to Liberty Mutual Group Inc. is 04-3583679. The Plan number assigned in accordance with instructions of the Internal Revenue Service is 505.

The Plan offers participation to employees of the Company and its subsidiaries that participate in the Plan, including, Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116. A list of participating subsidiaries is available on request.

The Plan is self-insured. Benefits are paid out of the Company’s general assets. The Company and employees share costs of coverage. Active employees make contributions on a before-tax basis through the Liberty Mutual Section 125 Plan. Retirees make contributions on an after-tax basis. Price tags and contribution levels are subject
to change at the Company’s discretion.

The Company has contracted with Delta Dental to provide administrative services only with respect to the Plan’s self-funded preferred provider organization coverage in accordance with the terms of the Plan. Claim administrator is Delta Dental, 465 Medford Street, Boston, Massachusetts 02129-1454.

Liberty Mutual Insurance Company is the Plan Administrator. Your rights under ERISA are described above. Melanie M. Foley, Executive Vice President, Chief Talent and Enterprise Services Officer, is designated as agent for service of legal process for the Plan Administrator. Process may be served on her at Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116, Attention: Benefits Department - Mailstop M03E phone number 1-617-357-9500.