WOLFCHASE HONDA-NISSAN DENTAL PLAN

2016 DENTAL PLAN OPTIONS

DEARBORN NATIONAL

Website: www.dearbornnational.com

BENEFIT PROVISIONS	**STANDARD OPTION - PPO, PLAN #1**	**ENHANCED OPTION - PPO, PLAN #2**
TYPE PLAN	**Can Choose Any Dentist, however,** claim payments are based on the PPO Fee Schedule. PPO Dentists adhere to PPO Fee Schedule and do not "balance bill".	**Can Choose Any Dentist, however,** claim payments are based on the PPO Fee Schedule. PPO Dentists adhere to PPO Fee Schedule and do not "balance bill".
CALENDAR YR DEDUCTIBLE	$50	$50
WAIVED FOR TYPE 1 (PREVENTIVE)?	Yes	Yes
TYPE 1/PREVENTIVE SERVICES	100%	100%
TYPE 2/BASIC SERVICES	80%, After Deductible	80%, After Deductible
TYPE 3/MAJOR SERVICES	10%, After Deductible	50%, After Deductible
TYPE 4/ORTHODONTIA SERVICES	No Coverage	50%, After Deductible
...MAXIMUM BENEFIT	N/A	$1,000/Lifetime
...ELIGIBILITY	N/A	Children Only (up to age 19)
EXAMPLES OF COVERAGE		
...CLEANINGS	100%	100%
...BITEWING X-RAYS	100%	100%
...PANOREX (360°) X-RAYS	100%	100%
...EMERGENCY TREATMENT	100%	100%
...FILLINGS	80%	80%
...ORAL SURGERY	80%	80%
...ROOT CANALS	80%	80%
...GUM DISEASE	80%	80%
...CROWNS	10%	50%
...DENTURES	10%	50%
...BRIDGES	10%	50%
CALENDAR YEAR MAXIMUM BENEFIT	$1,000	$1,000
EMPLOYEE PAYROLL DEDUCTIONS		
EMPLOYEE ONLY	$ 4.23 Per Week	$ 6.04 Per Week
EMPLOYEE + ONE DEPENDENT	$ 7.69 Per Week	$12.03 Per Week
EMPLOYEE + TWO & MORE DEPENDENTS	$10.98 Per Week	$22.01 Per Week

02/01/16

MUST ENROLL NOW OR WAIT UNTIL OPEN ENROLLMENT (FEBRUARY 1ST) OR QUALIFYING SPECIAL ENROLLMENT

THIS IS AN OVERVIEW ONLY. REFER TO THE COVERAGE BOOKLET OR CERTIFICATE FOR COMPLETE INFORMATION, INCLUDING BENEFIT DESCRIPTIONS, RESTRICTIONS AND LIMITATIONS.

Dearborn National

Dearborn National

A Strong Parent Company
The parent company of Dearborn National, Health Care Service Corporation (HCSC), is the largest non-investor owned health care insurance provider in the United States and the 4th largest overall. To learn more about the family of companies that make up HCSC, visit www.hcsc.com These companies include BlueCross BlueShield of Illinois, BlueCross BlueShield of Texas, BlueCross BlueShield of Montana, BlueCross BlueShield of New Mexico and BlueCross BlueShield of Oklahoma.

The Dearborn National Dental Network

Network Advantage
Dearborn National offers access to the largest[1] dental network nationally, with more than 230,000 dental offices.

- When utilizing a network provider, out-of-pocket expenses may be lower
- Network dentists have agreed to accept discounted fees for their services at 25-40% below usual charges
- Plan members will not be balance billed for these discounts

Freedom of Choice

- Receive care from any network dentist without a referral
- Change dentists at any time
- Benefit level determines the amount of out-of-pocket expenses

Exceptional Savings

- National average discount of 28.9%

A complete list of Dearborn National Dental Network dentists can be accessed using the online Provider Finder tool at www.dearbornnational.com

[1]Largest Network in the United States in terms of access points

www.dearbornnational.com

STANDARD OPTION PLAN #1

Dearborn National

The following is a listing of common services available through the Dearborn National Dental Network. The member's share of the costs depends on whether care is received from a participating or non-participating provider.

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Dental Highlight Sheet

Benefits	Participating Provider	Non-Participating Provider
Calendar Year Maximum	$1,000	$1,000
Deductible	$50 per person per Calendar Year. $150 maximum per family. *(Deductible does not apply to Diagnostic, Preventive, and Miscellaneous Services)*	$50 per person per Calendar Year. $150 maximum per family. *(Deductible does not apply to Diagnostic, Preventive, and Miscellaneous Services)*
Dependent Coverage	To age 26, and to age 26 if a full-time student.	
	Maximum Allowance*	Maximum Allowance*
Diagnostic and Preventive Services Oral Exams, X-rays, Professional Cleanings, Fluoride Treatment	100%	100%
Miscellaneous Services Sealants (per tooth), Space Maintainers, Pulp Vitality Tests, Palliative Treatment to relieve dental pain	100%	100%
Restorative Services Amalgam filling, Pin Retention (per tooth), Composite Restorations, Tooth Extraction	80%	80%
General Services Intravenous Sedation, General Anesthesia, Stainless Steel Crowns, House Call, Injection of Antibiotic Drugs	80%	80%
Endodontic Services Molar Root Canal Therapy, Bicuspid Root Canal Therapy	80%	80%
Periodontal Services Scaling & Root Planing (per quadrant), Osseous Surgery (per quadrant)	80%	80%
Periodontal Maintenance Periodontal Maintenance Cleanings	80%	80%
Oral Surgery Services Surgical Tooth Extractions, Other dentally necessary surgical procedures	80%	80%
Crown/Inlay/Onlay Services Prefabricated Post and Cores, Crown, inlays/ onlays Repairs	10%	10%
Prosthodontic Services Bridgework, Dentures	10%	10%
Implant Services	10%	10%

Open enrollment will be allowed at initial effective date and once a year as designated by the employer. New hires can enroll within 31 days of their eligibility date. All others (excluding changes in family status) must enroll during the next annual open enrollment period.

Find a dentist at
www.dearbornnational.com

Please note: This information is only a product highlight. Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.

* Maximum Allowance means the amount determined by Dearborn National which providers have agreed to accept a payment in full for a particular service.
** For services received from a non-participating provider, you will be liable for any difference between the dentist's charge and your covered benefits.

ENHANCED OPTION PLAN #2

Dearborn National®

The following is a listing of common services available through the Dearborn National Dental Network. The member's share of the costs depends on whether care is received from a participating or non-participating provider.

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Dental Highlight Sheet

Benefits	Participating Provider	Non-Participating Provider
Calendar Year Maximum	$1,000	$1,000
Deductible	$50 per person per Calendar Year. $150 maximum per family. *(Deductible does not apply to Diagnostic, Preventive, and Miscellaneous Services)*	$50 per person per Calendar Year. $150 maximum per family. *(Deductible does not apply to Diagnostic, Preventive, and Miscellaneous Services)*
Dependent Coverage	To age 26, and to age 26 if a full-time student.	
	Maximum Allowance*	Maximum Allowance*
Diagnostic and Preventive Services Oral Exams, X-rays, Professional Cleanings, Fluoride Treatment	100%	100%
Miscellaneous Services Sealants (per tooth), Space Maintainers, Pulp Vitality Tests, Palliative Treatment to relieve dental pain	100%	100%
Restorative Services Amalgam filling, Pin Retention (per tooth), Composite Restorations, Tooth Extraction	80%	80%
General Services Intravenous Sedation, General Anesthesia, Stainless Steel Crowns, House Call, Injection of Antibiotic Drugs	80%	80%
Endodontic Services Molar Root Canal Therapy, Bicuspid Root Canal Therapy	80%	80%
Periodontal Services Scaling & Root Planing (per quadrant), Osseous Surgery (per quadrant)	80%	80%
Periodontal Maintenance Periodontal Maintenance Cleanings	80%	80%
Oral Surgery Services Surgical Tooth Extractions, Other dentally necessary surgical procedures	80%	80%
Crown/Inlay/Onlay Services Prefabricated Post and Cores, Crown, inlays/ onlays Repairs	50%	50%
Prosthodontic Services Bridgework, Dentures	50%	50%
Orthodontic Services (To age 19)	50% up to Lifetime Maximum of $1,000	50% up to Lifetime Maximum of $1,000
Implant Services	50%	50%

Open enrollment will be allowed at initial effective date and once a year as designated by the employer. New hires can enroll within 31 days of their eligibility date. All others (excluding changes in family status) must enroll during the next annual open enrollment period.

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* Maximum Allowance means the amount determined by Dearborn National which providers have agreed to accept a payment in full for a particular service.
** For services received from a non-participating provider, you will be liable for any difference between the dentist's charge and your covered benefits.

DIGITAL BENEFIT ADVISORS
JON CAMERON

Prepared for:
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Benefit Highlights

PPO DENTAL INSURANCE

Employee Eligibility

Employee and covered dependents are eligible for coverage under the Plan if they are in an eligible class and have completed the applicable waiting period, if any. Employees must be legally working in the United States in order to be eligible for coverage.

Dependent Eligibility

- An eligible Employee's lawful spouse, including a spouse or former spouse for whom the Employee has received a court order to maintain financial responsibility for providing health insurance; and/or

- any married/unmarried (as allowed by issued state) child of an eligible Employee who is within the age limits set forth in the Dental rate and Cost Summary, and is not in active military service, including:
  - the Employee's natural child; or
  - the Employee's legally adopted child;
  - the Employee's stepchild; or
  - a child for whom the Employee has received a court order to maintain financial responsibility for providing health insurance.

Eligibility will continue past the limiting age for eligible Dependent children who are primarily dependent upon the Employee for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to us upon request.

Group Dental Insurance Benefits Provided

Diagnostic and Preventive Care

Dental Services that are used to prevent dental disease or to determine the nature or cause of a dental disease:

- Routine oral evaluations (limited to once per 6 months).
- X-rays (dental radiographs):
  - full mouth or panorex x-ray limited to once every 60 months;
  - bitewing limited to 4 horizontal films or 8 vertical films once per Calendar Year; and
  - other x-rays as necessary for diagnosis (except in connection with a program of orthodontics).
- Professional cleaning, scaling and polishing teeth (prophylaxis) limited to once per 6 months.

- Fluoride treatment (topical application), limited to one per Calendar Year for Participants up to age 14.

Miscellaneous Services

- Sealants, limited to one per unrestored permanent molar for Participants up to age 16.
- Space maintainers for Participants up to age 19.
- Pulp vitality tests.
- Palliative (emergency) treatment to relieve dental pain except when performed in conjunction with definitive dental treatment.

Restorative Services

Dental Services used to restore, by artificial means, a part of a tooth that has been damaged by disease (e.g. cavities). Tooth preparation, all adhesive (including amalgam bonding agents), liners and bases are included as part of the restoration.

- Amalgam restorations limited to once per surface per tooth in any Calendar Year.
- Pin retention, per tooth, in conjunction with the restoration.
- Composite restorations limited to once per surface per tooth per Calendar Year.
- Simple tooth extraction.

General Services

- Intravenous sedation.
- General Anesthesia.
- House call.
- Injection of Antibiotic drugs.
- Stainless steel crowns limited to one per tooth in a 60 month period and not to be used as a temporary crown.

Endodontic Services

Dental Services used for prevention, diagnosis and treatment of diseases and injuries affecting the tooth and dental pulp.

- Root canal therapy including treatment plan, clinical procedures, pre and post-operative radiographs and follow-up care.
- Direct pulp cap.
- Apicoectomy/periradicular services.
- Apexification/recalcification.
- Retrograde filling.

- Root amputation/hemisection.
- Therapeutic pulpotomy.
- Gross pulpal debridement.

Periodontal Services

Dental Services that treat diseases of the tissues that surround and support the teeth (e.g. gums and supporting bone). Periodontal Maintenance visits are limited to one exam per 6 months. Periodontal Services include the following:

- Periodontal scaling and root planing limited to one time per quadrant per 36 months;
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to one time per 36 months;
- Gingivectomy or gingivoplasty limited to one time per quadrant per 36 months;
- Gingival flap procedure (includes root planing) limited to one time per quadrant per 36 months;
- Osseous surgery, including flap entry with closure limited to one time per quadrant per 36 months;
- Osseous grafts limited to one time per site per 36 months; and
- Soft tissue grafts (includes donor site).

Oral Surgery Services

Dental Services used for the treatment of certain dental conditions by operative or cutting procedures.

- Surgical tooth extractions.
- Alveoloplasty.
- Vestibuloplasty.
- Other Dentally Necessary surgical procedures.

Crowns and Inlays/Onlays Services

Dental Services used as a result of extensive disease or fracture limited to one per tooth in a 60 month period.

- Prefabricated post and cores.
- Cast post and cores.
- Crown, inlays/onlays repairs.
- Recementation of inlays/onlays, crowns.
- Benefits include the replacement of a lost or defective crown whether placement was under this Plan or under any prior dental coverage and even if the original crown was stainless steel.

- Benefits will not be provided for replacement of dentures, crowns, inlays/onlays, removable or fixed prostheses, and dental restorations due to theft, misplacement, or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within 60 months after receiving such dentures, prostheses, or restorations.

Prosthodontic Services

Dental Services used to restore and maintain the oral function, comfort and health of a patient by replacing missing teeth and surrounding tissue with artificial substitute. Covered Services include bridges, partial dentures and complete dentures.

- Initial installation of bridgework (including inlays and crowns as abutments) limited to once per tooth in any 60 month period, whether placement was under this Plan or under any prior dental coverage.
    - Bridge repair.
    - Recementing a bridge.
    - Post and core buildup.
- Initial installation of removable complete, immediate or partial dentures (including any adjustments, relines or rebases during the 6 month period following installation) limited to once in any 60 month period, whether placement was under this Plan or under any prior dental coverage.
- Benefits are available for the replacement of complete or partial dentures, but only if the appliance is 60 months old or older and cannot be made serviceable.
- Adjustments limited to 3 times per appliance in any Calendar Year.
- Repairs.
- Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures) limited to a lifetime maximum of once per tooth.
- Denture rebasing and reline procedures limited to one in any 36 month period.

Orthodontic Services

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Participants covered for Orthodontics as shown on Schedule of Benefits provided in the Group Certificate.

Orthodontic services are paid over the course of treatment, up to the maximum lifetime orthodontic benefit and are not subject to the Calendar Year benefit limit.

Orthodontic lifetime benefits will be reduced by the amount paid by the previous Dental carrier if the Policyholder elects to provide the dollar maximum used while covered under the previous carrier's Plan.

Orthodontic services include:

- Diagnostic orthodontic records limited to a lifetime maximum of once per Participant;
- Limited, interceptive and comprehensive orthodontic treatment;
- Minor treatment to control harmful habits;
- Orthodontic retention limited to a lifetime maximum of one appliance per Participant.

Orthodontic treatment is started on the date the bands or appliances are inserted. A Covered Dental Service for orthodontic evaluation will be considered started and completed on the date the service is actually performed.

Implant Services

An artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth.

Benefits are based on the percentage shown on Your Schedule of Benefits

Group Dental Insurance Exclusions

In addition to those Group Dental Benefit maximums and limitations described above, the benefits of the Group Dental Plan are not available for any Covered Dental Services incurred:

- In connection with an occupational illness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- For which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for dental assistance (Medicaid); provided, however, this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- As a result of disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
- Primarily for cosmetic purposes, including but not limited to bleaching teeth, grafts to improve esthetics, except for:
  - Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan; or
  - Covered orthodontic diagnostic procedures and treatment; or
  - Services provided to a newborn child that are necessary for treatment or correction of congenital defects.
- For services or supplies which do not meet accepted standards of dental practices.
- For services provided or received for:
  - Behavior management; or
  - consultation purposes.
- For Benefits for an alternate Course of Treatment which exceeds the most economical procedures.
- For personalized complete or partial dentures, overdentures, and their related procedures, or other specialized techniques not normally taught in regular dental school classes; for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/ Investigational in nature or not fully approved by a Council of the America Dental Association; and for services or supplies not Dentally Necessary.

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- For treatment provided before the effective date of a Participant's coverage or after termination of coverage under this Plan.
- For appliances, materials, restorations, or special equipment used to increase vertical dimension, correct or restore the occlusion except as may be provided on the Schedule of Benefits.
- To correct temporomandibular joint (TMJ) dysfunction or pain syndromes except as may be provided on the Schedule of Benefits.
- For which benefits are otherwise provided under inpatient hospital expense or medical surgical expense coverage under the medical benefits of the health benefit plan.
- For treatment by other than a Dentist, except that x-rays, scaling, cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the Dentist.
- For replacement or repair of an orthodontic appliance.
- For services or supplies when:
  - no charge is made;
  - the Participant is not legally obligated to pay;
  - no charge would be made in the absence of this or similar dental coverage;
  - "discounts" or waiver of a Deductible or Coinsurance Amounts is offered;
  - treatment is received by a Dentist who is related to the Participant by blood or marriage; or
  - treatment is provided through a medical department, clinic, or similar facility furnished or maintained by the Policyholder.
- For a duplicate prosthetic device, other duplicate appliance or duplicate dental restoration.
- For:
  - dietary and oral hygiene instruction, a plaque control program and tobacco use counseling; and
  - prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- For any charge:
  - Resulting from the failure of a Participant to keep a scheduled visit with a Dentist; or
  - For completion of any insurance forms; or
  - For telephone consultations; or
  - For records or x-rays necessary for us to make a benefit determination.
- For a partial or full denture or fixed bridge which includes replacement of a tooth which was missing before the Participant was covered under this Plan with FDL, except this exclusion will not apply:

- If such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after coverage becomes effective under the Plan for such Participant; or
- If the Participant has been continuously covered under a group dental care policy, which includes prosthestic benefits held by the Policyholder with FDL for a period of 60 consecutive months following the Participant's effective date; or
- To Participants effective on the Policy Effective Date who were covered under a previous group dental care policy held by the Policyholder with another carrier immediately prior to the Policy Effective Date.

- For the splinting of teeth, including double abutments for prosthetic abutments.
- For Accidental Injuries including tooth transplantation.
- For pin retention not performed on the same date of service and in conjunction with a covered amalgam or composite restoration.
- For administration of any local anesthesia, and necessary infection control as required by OSHA, state and federal mandates billed separately.
- For palliative (emergency) treatment performed in conjunction with definitive dental treatment.
- For indirect pulp capping.
- For athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/ malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- For bacteriological studies for determination of pathologic agents and soft tissue allograft.
- For biologic materials, cytology sample collection and histopathological examinations.
- For canal preparation and fitting of prefabricated dowel and post if billed separately.
- For caries susceptibility tests.
- For chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy.
- For crowns to restore occlusion or incisal edges due to bruxism or harmful habits.
- For desensitizing medicaments and/or their application.