ERIE INDEMNITY COMPANY GROUP DENTAL ASSISTANCE PLAN

SUMMARY PLAN DESCRIPTION

deltadentalins.com

Group No: 09343

Effective Date: January 1, 2025

Erie Indemnity Company Group Dental Assistance Plan

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INTRODUCTION

The Erie Indemnity Company Group Dental Assistance Plan is a welfare plan that provides eligible Employees of Erie Indemnity Company and their covered dependents with certain dental benefits. This is a summary plan description of the Dental Assistance Plan as of January 1, 2025. The Group Dental Assistance Plan also provides benefits to Employees (and their covered dependents) of affiliates of Erie Indemnity Company that have adopted the Plan. Affiliates that have adopted the Plan are listed in the General Provisions section. Erie Indemnity Company and its affiliates that have adopted the Group Dental Assistance Plan are referred to as "ERIE". The Plan is self-funded by Erie Indemnity Company and your claims are administered by Delta Dental. The goal is to provide you with the highest quality dental care and to help you maintain good dental health. You are encouraged not to wait until you have a problem, but to see your dentist on a regular basis.

This Summary Plan Description is a summary of the Group Dental Assistance Plan. Please read it carefully. You may obtain a copy of the Plan document for the Group Dental Assistance Plan from the Benefits Operations & Planning Section of ERIE. If there is a conflict between this summary plan description and the Plan document, the Plan document will govern.

Using This Summary Plan Description

This Summary Plan Description (SPD), which includes Attachment A, Deductibles, Maximums and Benefit Levels (Attachment A) and Attachment B, Services, Limitations and Exclusions (Attachment B), discloses the terms and conditions of your coverage and is designed to help you make the most of the Group Dental Assistance Plan. It will help you understand how the plan works and how to obtain dental care. Please read this SPD completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Plan.

Contact Information

For more information, please visit Delta Dental's website at deltadentalins.com or call Delta Dental's Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access Delta Dental's automated information line at 800-932-0783 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental

300 Corporate Center Drive, Suite 600

Camp Hill, PA 17011

You can also contact the Plan Sponsor, Erie Indemnity Company, or Plan Administrator, the Erie Indemnity Company Employee Benefits Administration Committee, as identified in the Plan Information section below.

DEFINITIONS

Terms when capitalized in this SPD have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: The amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: The covered dental services provided under the terms of the Plan.

Calendar Year: The 12 months of the year from January 1 through December 31.

Claim Form: The standard form used to file a claim or request a Pre-Treatment Estimate.

Claims Administrator: Delta Dental. As Claims Administrator, Delta Dental only provides administrative claims payment services. Delta Dental does not insure Benefits or assume any financial risk or obligation with respect to claims.

Coinsurance: Your share of the costs of a covered service after any applicable Deductible and subject to any Maximum and/or Maximum Contract Allowance as shown in Attachment A.

Days: Any mention of "days" in this Summary Plan Description shall be calendar days unless defined otherwise.

Deductible: A dollar amount that an Enrollee and/or the Enrollee's family (for any coverage other than individual coverage) must pay for certain covered services before the Plan begins paying Benefits. There is no Deductible for services in-network.

Delta Dental: Delta Dental of Pennsylvania, the claims administrator for the Plan.

Delta Dental Premier Provider (Premier **Provider**): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier Contracted Fee: the fee for a Single Procedure covered under the Plan that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental PPO℠ Provider (PPO Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee as payment in full for covered services provided under a PPO dental plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental PPO Contracted Fee: the fee for a Single Procedure covered under the contract that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: the effective date of this summary plan description, which is January 1, 2025.

Eligible Dependent: A dependent of an Eligible Employee eligible for Benefits. See Eligibility and Enrollment to see who qualifies as a dependent.

Eligible Employee: an employee that is eligible to enroll for coverage under the Plan.

Employee: An employee of Erie Indemnity Company or an affiliate of Erie Indemnity Company that has adopted the Group Dental Assistance Plan for the benefits of its employees.

Enrollee: An Eligible Employee ("**Primary Enrollee**") or an Eligible Dependent ("**Dependent Enrollee**") enrolled to receive Benefits.

Enrollee Pays: An Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

Enrollee's Effective Date of Coverage: the date the Enrollee becomes covered for Benefits under the Plan.

Maximum: The maximum dollar amount ("**Maximum Amount**" or "**Maximum**") the Plan will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. The Plan will pay up to the applicable Maximum Amount in Attachment A for Benefits under the Plan.

Maximum Contract Allowance: The reimbursement under the Plan against which Delta Dental calculates the Plan's payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee.

Non-Delta Dental Provider: A Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period: The period of the year during which employees may change coverage for the next Plan Year.

Plan: The Erie Indemnity Company Group Dental Assistance Plan.

Plan Year: The Calendar Year.

Pre-Treatment Estimate: An estimation of the allowable Benefits under the Plan for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee: An Eligible Employee enrolled in the Plan to receive Benefits; may also be referred to as "Enrollee".

Procedure Code: The Current Dental Terminology© (CDT) number assigned to a Single Procedure by the American Dental Association.

Provider: A person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Single Procedure: A dental procedure that is assigned a separate Procedure Code.

Spouse: The spouse of the Primary Enrollee:

Submitted Fee: The amount that the Provider bills and enters on a claim for a specific procedure.

COST OF COVERAGE

While ERIE pays the majority of the cost of coverage for you and your enrolled dependents, you pay a portion of the cost of coverage through payroll deduction. ERIE periodically determines the portion of the cost of coverage you will pay under each type of coverage. Each year ERIE notifies Eligible Employees of the cost of coverage under each option.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

If you are a full-time Employee of Erie Indemnity Company or any affiliate of Erie Indemnity Company that has adopted the Dental Assistance Plan, you are eligible to enroll in the Dental Assistance Plan on your date of hire or the date you become a full-time Employee. A complete list of ERIE affiliates that have adopted the Dental Assistance Plan is set forth in the General Provisions section of this SPD. You are a full-time Employee if you are a common law Employee of ERIE (or any affiliate of ERIE that has adopted the Plan) and you are either (i) a salaried Employee; or (ii) an hourly Employee and are regularly scheduled to work at least 37-1/2 hours in a normal workweek. However, any person who is a temporary employee, who is a leased employee, who is on another company's payroll or who is treated as an independent contractor for payroll tax purposes is not eligible to participate in the Plans.

If you participate in the Dental Assistance Plan, you may also enroll your Eligible Dependents for coverage under the Plan.

Your Eligible Dependents include:

- Your Spouse.
- Your child who is under age 26. This includes not only your natural child, but also your stepchild and any child you have adopted.
- A child who is under age 26 and who is solely supported by you and is either related by blood or you are the child's legal guardian. If the child is your foster child, you will be treated as solely supporting the child.
- An unmarried child who is described above except that the child has attained age 26, provided the child is fully disabled and the child depends chiefly on you for maintenance and support. The disability must have commenced prior to the child attaining age 26.

Your child includes not only your natural child, but also:

- A legally adopted child or a child placed with you for adoption
- A stepchild
- A child for whom coverage is required pursuant to a qualified medical child support order (see the section entitled Qualified Medical Child Support Orders).
- Note: ERIE reserves the right to require proof that a dependent satisfies the above requirements. In addition, you may be asked periodically to furnish current information about your dependent's continuing eligibility, such as support or disability status.

Qualified Medical Child Support Orders

- A qualified medical child support order is a judgment, decree or order issued by a court or a National Medical Support Notice issued by a state agency, which provides for child support or health benefit coverage, including coverage relating to benefits under the Group Dental Assistance Plan and which meets certain requirements as to form and substance. In accordance with ERISA, the Group Dental Assistance Plan will provide coverage to a child of an Employee in accordance with the terms of any medical child support order that the Plan Administrator determines to be a qualified medical child support order. If you receive a medical child support order it should be submitted to the Benefits Operations & Planning Section. The Plan Administrator will promptly notify the involved individuals of the receipt of the order and of the Plan's procedure for determining whether the order is a qualified order. You may request a copy of the procedure for determining whether an order is a qualified medical child support order from the Benefits Operations & Planning Section.

Enrollment Requirements

Under the Dental Assistance Plan, there are the following four types of coverage:

- Employee only coverage—Provides coverage only for you.
- Employee and child(ren) coverage—Provides coverage for you and your dependent children that you have enrolled but does not provide coverage for your spouse.
- Employee and spouse coverage—Provides coverage for you and your spouse.
- Family coverage—Provides coverage for you and all your dependents that you have enrolled, including your spouse.

If you do not enroll a dependent, then coverage will not be provided for that dependent.

Coverage will be effective for you on your first day of employment if you are a full-time Employee (provided you don't opt out of coverage). Otherwise, coverage will be effective on the date on which you become a full-time Employee (provided you don't opt out of coverage). If you have dependents, coverage of your dependents will be effective on the date on which you become covered provided that you elect Employee and spouse coverage, Employee and child(ren) coverage or Family coverage. However, coverage will only be provided for a dependent that you actually enroll in the Group Dental Assistance Plan.

If you do not become covered under the Dental Assistance Plan when first eligible, then you must generally wait until the next open enrollment period to become covered beginning in the next year. Similarly, if you do not obtain coverage for your dependents when they are first eligible for coverage, then you must generally wait until the next open enrollment period to obtain coverage beginning in the next year.

In certain instances, you may obtain coverage for yourself or for your dependents during the year. For example, in the event you become married or you acquire a dependent during the year, you may obtain coverage for them provided that you enroll them in the Group Dental Assistance Plan within 31 days of the event (birth, adoption or placement for adoption, or marriage). If you have a newborn child or adopt a child and enroll them within 31 days of their birth or placement for adoption, coverage will be provided from the child's date of birth or placement for adoption.

You may also obtain coverage for yourself or your dependents if you declined coverage for yourself or did not obtain coverage for your dependents because you were covered under another group dental plan (such as the group dental plan of your spouse's employer) and (i) the maximum COBRA continuation

coverage period under the other plan was exhausted; (ii) coverage was lost under the other plan due to divorce, legal separation, termination of employment or reduction in hours; or (iii) the other employer terminates the plan or ceases making any employer contributions for coverage. To obtain coverage, you must enroll within 31 days of when coverage was lost under the other plan. Documentation is required from the other plan confirming the cancellation date.

Finally, coverage may be obtained for your child during the year if such coverage is required under a qualified medical child support order (see the above section entitled Qualified Medical Child Support Orders).

If both spouses are Eligible Employees, either one may cover the other as a dependent, or each may receive coverage as an Employee. If a parent and a child under age 26 are both full-time Employees, the parent may cover the child as a dependent or the child may have coverage as an Employee. No Employee may have coverage both as an Employee and as a dependent at the same time.

Annual Open Enrollment Period

In the fall of each year, ERIE conducts an annual open enrollment period. At this time, you will have the opportunity to make changes to your coverage that will be effective on January 1st of the following year. For example, you can:

- Change coverage from Employee Only Coverage to Employee and Spouse, Employee and Child(ren) or Family Coverage or vice versa.
- Enroll in the Group Dental Assistance Plan if you previously opted out of the Dental Assistance Plan.

Coverage While on Approved Leave of Absence

Coverage under the Group Dental Assistance Plan will continue while an Employee is on an approved leave of absence. Eligible types of leave are:

- Short Term Disability Leave
- Long Term Disability Leave
- Work Injury Leave
- Family Medical Leave Act Leave
- Military Leave
- Other leaves approved by ERIE
- Coverage will continue for the length of the leave provided the Employee pays the Employee portion of the cost of coverage under the Group Dental Assistance Plan. You may make arrangements for paying the Employee portion while on leave by contacting the Benefits Operations & Planning Section.
- Note that if you are on a leave protected by the Family and Medical Leave Act, you may drop coverage under the Group Dental Assistance Plan while on leave and reacquire coverage when you return from the leave. For more information contact the Benefits Operations & Planning Section

Termination of Coverage

Employee coverage will terminate under the Group Dental Assistance Plan when:

- The Employee terminates employment with ERIE.
- The Employee's hours are reduced so that the Employee is no longer full-time.
- The Employee drops coverage.

- The Employee dies.
- The Group Dental Assistance Plan is terminated or is amended to exclude the class of employees to which the Employee belongs.
- The Employee ceases to make any required contributions for coverage.

Dependent coverage will terminate under the Group Dental Assistance Plan when:

- Coverage ends for the Employee.
- The dependent no longer qualifies as a dependent under the Group Dental Assistance Plan. If the dependent loses coverage because he/she attains age 26, coverage will be provided until the end of the month in which the dependent attains age 26.
- The Employee drops coverage for the dependent.
- The Employee ceases to make any required contributions for the dependent coverage.

If an Employee dies, coverage for the Employee's covered dependents will automatically continue to be provided for 31 days after the date of the Employee's death.

Extension of Coverage Upon Termination

The Plan will not pay for any services/treatment received after your coverage ends. However, coverage will be extended for charges incurred in the 90 days after the date you cease to be covered under the Dental Assistance Plan, but only for the following dental services:

An appliance or alteration of an appliance for which an impression was made while you were a covered person under the plan.

A crown, bridge or gold restoration, for which the tooth was prepared while you were a covered person under the Plan.

Root canal therapy for which the pulp chamber was opened while you were a covered person under the Plan.

During this extension this coverage will apply to charges for these dental services as if you were still a covered person under the Plan.

If you are rehired within the same Calendar Year, Deductibles and maximums will resume as if you were never gone.

Continuation of Coverage Rights

The Group Dental Assistance Plan provides continuation of coverage rights as described below to extend temporary coverage to covered Employees and dependents in certain circumstances when they would otherwise lose their coverage under the Group Dental Assistance Plan. These continuation of coverage rights are intended to comply with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If an Employee or dependent who is a "Qualified Beneficiary" loses coverage under the Group Dental Assistance Plan as a result of a "Qualifying Event," the Employee or dependent will have the right to elect continuation coverage under the Group Dental Assistance Plan.

A Qualified Beneficiary is:

1. A covered Employee, but only if the Qualifying Event is the Employee's termination of employment (other than for gross misconduct) or the reduction of the Employee's hours so that the Employee is no longer a full-time Employee.

2. A Spouse (including a same-sex Spouse) of a covered Employee provided the Spouse has coverage in effect at the time of the Qualifying Event.

3. Any other dependent of a covered Employee provided the dependent has coverage in effect at the time of the Qualifying Event.

Note: A child born to, or placed for adoption with, the covered Employee or the Employee's Spouse or former spouse while such person is on continuation coverage under the Group Dental Assistance Plan is a Qualified Beneficiary, provided the child is enrolled for coverage within 31 days following the date of birth or placement for adoption.

The following are Qualifying Events:

1. **Termination of Employment/Reduction in Hours**—One Qualifying Event is the termination of a covered Employee's employment (other than for gross misconduct) or the reduction in the covered Employee's hours so that the Employee is no longer a full-time Employee. If this Qualifying Event occurs, the Employee may elect to continue the coverage that he or she had in effect under the Dental Assistance Plan for up to 18 months following the date on which the Qualifying Event occurred. If the Employee's spouse or dependents have coverage, the spouse or dependents will have the right to purchase continuation coverage individually. However, if the form of coverage elected by the Employee provides coverage for the spouse or dependents, the spouse or dependents need not elect to continue coverage individually. The 18-month period may be extended for up to an additional 11 months in the event that an Employee, a spouse or dependent receiving continuation coverage is determined to be disabled for purposes of Social Security at any time during the first 60 days of continuation coverage. However, in order for the Employee or any dependent to obtain the additional 11 months of continuation coverage the Employee or dependent must notify the COBRA Administrator for the Dental Assistance Plan, UnitedHealthcare, in writing within 60 days of when Social Security makes its determination, but in no case later than the last day of the 18-month continuation coverage period. A copy of the Social Security Administration's disability award notice must also be provided to the COBRA Administrator, UnitedHealthcare.

2. **Death of Employee**—If a covered Employee has a form of coverage that provides coverage for his or her spouse or dependents at the time of his or her death, any covered spouse or covered dependents will have the right to purchase up to 36 months of continuation coverage from the date of the Employee's death. Coverage will automatically be provided to any covered spouse or covered dependents for the 31-day period following the date of the Employee's death.

3. **Divorce**—If a covered Employee has a form of coverage that provides coverage for his or her spouse and the Employee becomes divorced from his or her spouse, the spouse and

any other dependent that will lose coverage as a result of the divorce will have the right to purchase up to 36 months of continuation coverage from the date of the divorce.

4. **Entitlement to Medicare**—If a covered Employee has a form of coverage that provides coverage to his or her spouse or dependents and the Employee becomes entitled to Medicare and elects Medicare as his or her primary coverage, the Dental Assistance Plan is prohibited from providing coverage to the Employee. The Employee's spouse and dependents who lose coverage as a result of the Employee's election will have the right to purchase up to 36 months of continuation coverage from the date on which the Employee's election is effective.

5. **Child Ceases to be Dependent**—If a child is covered as a dependent and the child ceases to qualify as a dependent of the covered Employee, the child can purchase up to 36 months of continuation coverage from the date the child ceases to qualify as a dependent.

6. **Multiple Qualifying Events**—If an Employee lost coverage because of termination of employment or reduction in hours and the Employee's spouse or dependents are receiving continuation coverage and then one of the events listed in paragraphs 2 through 5 occurs, the spouse or dependents may elect to continue coverage for an additional period of time not to exceed the date that is 36 months from the date of the Employee's termination of employment or reduction in hours.

Each individual who is eligible to elect continuation coverage must make a written election for continuation coverage no later than the day that is 60 days after the later of the date coverage would otherwise end or the date on which written notice of the right to purchase continuation coverage is provided to the individual. The written election must either be hand-delivered to the COBRA Administrator, UnitedHealthcare, or postmarked on or before the 60th day or the individual will not be permitted to elect continuation coverage.

A covered Employee or the Employee's spouse or dependents must notify the Benefits Operations & Planning Section as soon as possible (but not later than 60 days) after the Employee and his or her covered spouse are divorced or a covered dependent child ceases to qualify as a dependent. The notice must be provided in writing.

A part-time Employee or former Employee who is on continuation coverage must notify the COBRA Administrator, UnitedHealthcare, as soon as possible, but not later than 60 days, after the part-time Employee or former Employee and his or her covered spouse are divorced, a covered dependent child ceases to qualify as a dependent or the part-time Employee or former Employee or covered spouse, or dependent receives a Social Security disability determination. The notice must be provided in writing. In the case of a Social Security Administration determination of disability, a copy of the Social Security Administration disability award notice must be provided to the COBRA Administrator, UnitedHealthcare. Further, the COBRA Administrator or Plan Administrator may request that documentation or additional information be provided in the case of one of these Qualifying Events (for example, if the Qualifying Event is divorce, a copy of the divorce decree may be requested). If notice is not timely provided after one of these events occurs or documentation or additional information requested is not timely provided, continuation coverage will not be available (in the case of a disabled individual, extended continuation coverage will not be available).

If the Qualifying Event is termination of employment (other than for gross misconduct) or reduction in hours of employment, the COBRA Administrator will notify the Employee and any covered dependents of the right to purchase continuation coverage. Notice will be provided within 44 days of the date of the Employee's termination or reduction in hours.

If the Qualifying Event is the Employee's death or entitlement to Medicare (and the election of Medicare as the Employee's primary coverage) and the Employee's spouse and/or dependents have coverage, the COBRA Administrator will notify the Employee's spouse and/or dependents of their right to purchase continuation coverage. Notice will be provided within 44 days of the Employee's death or the effective date of the Employee's Medicare coverage.

If the Qualifying Event is divorce or loss of dependent child status and the Employee or dependent has provided proper notification on a timely basis and provided any additional information or documentation requested, the COBRA Administrator will provide a written notice of the right to purchase continuation coverage to the affected dependent(s) within 14 days of when the notice is provided.

The monthly amount you will pay for continuation coverage under the Dental Assistance Plan will be no more than 102 percent of the applicable premium (as determined in accordance with COBRA and regulations issued pursuant to COBRA) for coverage under the Dental Assistance Plan, and 150 percent of the applicable premium for coverage for the 19th through 29th months of coverage for disabled individuals who are eligible for 11 additional months of continuation coverage. Payment of the monthly amount is due by the first day of each month of continuation coverage, provided that the initial payment of the monthly amount(s) must be made within 45 days after the election of continuation coverage.

Continuation coverage under the Group Dental Assistance Plan will end as of the date any of the following occur:

1. The required payment is not paid on a timely basis. Except for the initial payment (which is due within 45 days of when the election is made), a monthly payment will be treated as timely made if it is made within 30 days of its due date (the grace period).

2. The maximum (18-month, 29-month or 36-month) continuation coverage period ends.

3. ERIE terminates the Dental Assistance Plan.

4. The date that the individual becomes covered under another dental plan that does not contain any exclusion or limitation with respect to a pre-existing condition of the person who becomes covered or the date on which the exclusion period ends under the plan. Continuation coverage only ends for the person who becomes covered by the other dental plan.

5. The date that the individual becomes enrolled in Medicare. Continuation coverage only ends for the person who becomes enrolled in Medicare.

6. If extended coverage is being provided due to a Social Security disability determination, continuation coverage will end at the beginning of the month that begins after 30 days have passed from a final determination that the individual is no longer disabled for purposes of Social Security.

USERRA Continuation Coverage. A covered Employee who is absent from work to serve in the military service may elect to continue coverage under the Dental Assistance Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA") under certain circumstances. These

rights only apply to an Employee and his or her dependents that have coverage under the Dental Assistance Plan before the military service begins. These rights are in addition to any other rights the Employee and dependents may have for continuation coverage. For more information about your rights under USERRA contact the Benefits Operations & Planning Section.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

The Plan will pay Benefits for the dental services described in Attachment A and subject to the limitations and exclusions in Attachment B. The Plan will pay Benefits only for covered services. The Plan covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed in accordance with Delta Dental's standard processing policies. Those processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards.

Delta Dental will use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

If you receive dental services from a Provider outside the Commonwealth of Pennsylvania, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Plan. If a Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance

The Plan pays a percentage of the Maximum Contract Allowance for covered services, as shown in Attachment A and you are responsible for paying the remaining percentage which is your Coinsurance. Your Coinsurance is part of your out-of-pocket cost which you pay after any applicable Deductible has been met.

The amount of your Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Coinsurance for covered services. Coinsurances is a method of sharing the costs of providing dental Benefits between the Plan and Enrollees. If a Provider discounts, waives or rebates any portion of the Coinsurance to you, the Plan will provide Benefits based upon the Provider's fees or allowances after reduction by the amount of the fees or allowances that are discounted, waived or rebated.

It is to your advantage to select a PPO Provider or A Premier Provider because dental services provided by them typically result in lower out-of- pocket costs for you. Please refer to the section titled "Selecting Your Provider" for more information.

Deductible

The Plan includes a Deductible if you receive services from a Provider that is not a PPO Provider or a Premier Provider. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible

amounts are listed in Attachment A. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

The Group Dental Assistance Plan has Maximum Amounts it will pay toward the cost of dental care each year. There is a one Maximum Amount for dental services with PPO Providers and Premier Providers and a second lower Maximum Amount for dental services with non-Delta Dental Providers. There is also a lifetime Maximum Amount for orthodontic services. You are responsible for paying costs above a Maximum Amount.

The Maximum Amounts payable are shown in Attachment A.

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of Benefits payable under the Plan for the listed services. By asking your Provider for a Pre-Treatment Estimate from Delta Dental before you agree to receive any prescribed treatment, you will have an estimate up front of what the Plan will pay and the difference you will need to pay. Benefits will be processed according to the terms of the Plan when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Plan terminates;
- the date Benefits under the Plan are amended if the services in the Pre-Treatment Estimate are affected by the amendment;
- the date your coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Coordination of Benefits

When you are covered under the Group Dental Assistance Plan and you also have coverage under another plan or policy that provides dental benefits, Delta Dental will coordinate benefit payments under the Group Dental Assistance Plan with any benefit payments made under the other plan or policy. One plan or policy will pay the benefit as a primary benefit. The other plan or policy will pay secondary benefits, to the level covered by the plan or policy, if necessary to cover your expenses. If the other plan or policy is primary, covered services which are allowable charges under the other plan or policy will first be reduced by the amount that plan or policy pays or would have paid on your behalf. Any remaining covered services are subject to any applicable deductible, coinsurance and out-of-pocket limit under the Group Dental Assistance Plan. To the extent that a covered service is not an allowable charge under the primary plan or policy, the Group Dental Assistance Plan will pay the claim in accordance with the Plan's applicable cost sharing provisions.

In order to determine which plan or policy is primary, Delta Dental will coordinate benefits with the other plan, insurance carrier or HMO in accordance with rules in the plans. In order to properly coordinate benefits, you may be asked by Delta Dental to furnish information and to take necessary actions. For

more information on the coordination of benefits provisions of the Group Dental Assistance Plan, contact the Benefits Operations & Planning Section of ERIE.

SELECTING YOUR PROVIDER

Free Choice of Provider

You may see any Provider for your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. This plan is a PPO plan and the greatest benefits – including out-of-pocket savings – occur when you choose a PPO Provider. To take full advantage of your Benefits, we highly recommend you verify a Provider's participation status within a Delta Dental network with your dental office before each appointment. Review this section for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a PPO Provider

You may access information through Delta Dental's website at deltadentalins.com. You may also call Delta Dental's Customer Service Center and a representative will assist you. Delta Dental can provide you with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider

A PPO Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider who has not agreed to the features of the Delta Dental's PPO plan. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance. The amount charged by a Premier Provider may be above that accepted by PPO Providers but will be no more than the Delta Dental Premier Contracted Fee.

Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO Providers or Premier Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.

Additional Obligations of PPO and Premier Providers

- A PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental, as claims administrator of the Group Dental Assistance Plan, after satisfaction of the Deductible and Enrollee Coinsurance. The Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement from the Plan.
- PPO and Premier Providers accept contracted fees as payment in full for covered services and will not balance bill if the Submitted Fee is greater than the contracted fee.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. In addition, Claim Forms are available on ERIEweb (Forms & Tools—Benefits Forms—Delta Dental Claim Form). You can also obtain a claim form from the Benefits Operations & Planning Section of ERIE. You or your Provider may also download a Claim Form from Delta Dental's website (deltadentalins.com). PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to Delta Dental. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Delta Dental

P.O. Box 2105

Mechanicsburg, PA 17055

Payment Guidelines

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO Provider or Premier Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO Provider or Premier Provider that you were covered under a Delta Dental administered plan at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact Delta Dental.

CLAIMS AND APPEALS

Claims Review Procedure

As claims administrator, Delta Dental will undertake the initial claims review, as well as reviewing any appeals of denied claims, to determine whether you are entitled to Plan benefits and what benefits you are entitled to.

Delta Dental will make a decision on your claim within 30 days of when it receives your claim. However, if for reasons beyond its control, Delta Dental cannot decide the claim within 30 days, it may extend the period to decide the claim by up to 15 additional days. If an extension of time is necessary, Delta Dental will provide you with a written notice of the extension before the end of the initial 30-day period. This notice will explain why the extension is necessary and provide you with the date by which Delta Dental expects to decide your claim.

If the reason why Delta Dental needs an extension is because it did not receive all of the documentation necessary to make a decision, the notice of extension will explain what information and documentation it needs to decide the claim. You will be given at least 45 days to provide the information or documentation to Delta Dental. During this time, the 15-day extension period for deciding your claim is suspended.

If your claim for benefits is approved by Delta Dental, it will either reimburse you or will pay the dental provider directly. If Delta Dental denies your claim, in whole or in part, it will notify you in writing. The notice will include:

- The specific reason or reasons for the denial of all or any part of your claim.
- The specific provision of the Group Dental Assistance Plan and any other document on which the denial is based. If the decision to deny the claim is based, in whole or in part, on a specific internal rule, guideline, protocol or similar criteria, either a copy of that document will be provided to you or you will be advised that you may obtain a copy of the document upon request and free of charge from Delta Dental. If the decision to deny benefits is based, in whole or in part, on an exclusion or limitation that the benefit claimed is not medically necessary, is experimental or there is a lack of a clinical judgment, either an explanation that applies the appropriate terms to your circumstances and which details the scientific or clinical judgment that led to the decision to deny benefits will be provided to you or you will be advised that you may obtain it upon request and free of charge from Delta Dental.
- A description of any additional material or information necessary for you to complete the claim and an explanation as to why such material or information is necessary.
- Information on how you may appeal the denial and the applicable time limits.
- A statement regarding your right to bring a suit under federal law should you appeal the denial and the denial is upheld on both levels of appeal.

Personal Representative - You may designate a representative to act on your behalf in pursuing a claim or appealing the denial of a claim. You should contact Delta Dental directly to find out how to designate a representative for your claim or the appeal of your claim. In addition, in order for Delta Dental or the Plan to disclose any “protected health information” (as such term is defined in privacy regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA) to the designated representative, the individual to whom the protected health information relates may need to provide

the Plan with a written authorization allowing such disclosure. Delta Dental will treat your dentist as your representative unless you direct otherwise.

You may appeal a claim denial by following the appeal procedure below.

Appealing A Denied Claim

If you wish to appeal a denied claim, you must file a written request for an official review of your claim. The appeal request must be filed within 180 days of the date on which you receive the notice from Delta Dental denying your claim. The appeal request must be filed with Delta Dental. You should follow the instructions for appealing a claim that are set forth in the notice Delta Dental sends to you in which it denied your claim.

In your appeal, you must state that you are requesting an official review of your claim and the reasons why you do not agree with the denial or partial denial of the claim. You should also include any additional information pertinent to the claim. You and your designated representative have the right to review and obtain copies of all documents, records and information relating to your claim. If you wish, you or your representative may submit written issues, comments and additional justification of why your claim should be allowed. You will be provided with the name of any dental, medical or vocational expert whose advice was obtained in connection with your claim regardless of whether the advice was relied upon.

When Delta Dental reviews the denied claim it cannot provide any deference to the initial decision. The review of your appeal will be done by a person or persons at Delta Dental who were not involved in the original decision of your claim, and who are not subordinate to the person at Delta Dental who initially denied your claim. If the benefit denial is based in whole or in part on a medical judgment, such as whether the service is medically necessary or experimental or there is a lack of clinical judgment, Delta Dental will consult with a health care professional who has appropriate training and experience in the particular field of dentistry relating to your claim. The health care professional will not be someone who was previously consulted on the claim.

Delta Dental will decide the appeal within 30 days of receiving your appeal request. You will be provided with a written notice of the decision on appeal. If the denial of your claim is upheld, in whole or in part, the notice will include the following information:

- The specific reason or reasons for the adverse determination.
- The specific provision of the Group Dental Assistance Plan and any other document on which the denial is based.
- A statement that you may obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. If any internal rule, guideline, protocol or similar criteria was relied upon in making the adverse determination, either a copy of that document will be provided to you or you will be advised that you may obtain a copy of the document upon request and free of charge from Delta Dental. If the adverse determination is based, in whole or in part, on an exclusion or limitation that the benefit claimed is not medically necessary, is experimental or there is a lack of clinical judgment, you will be provided with an explanation of the scientific or clinical judgment for the adverse determination or advised that you may obtain it upon request and free of charge from Delta Dental.
- A statement regarding your right to bring a suit under federal law if you further appeal the decision and the claim was again denied.

The Group Dental Assistance Plan does not offer voluntary dispute resolution options.

If an Enrollee believes they need further review of their appeal, they may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Medical Privacy Rights

Information that is provided to the Group Dental Assistance Plan regarding your dental care and payment for that care is subject to privacy rules issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You can obtain more information about your medical privacy rights from the Plan's Notice of Privacy Practices. You may obtain a copy of the Notice of Privacy Practices from ERIEweb (Info Center—Benefits Information—Privacy Practices) or from the Benefits Operations & Planning Section.

Non-Discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Delta Dental's Customer Service Center at 800-471-0275.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

Delta Dental

P.O. Box 997100

Sacramento, CA 95899

Telephone Number: 800-471-0275

Website Address: deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Clinical Examination

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at Delta Dental's expense, in or near your community or residence. Delta Dental will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

You must provide written proof of loss within 12 months after the date on which the service was provided. If it is not reasonably possible to give written proof in the time required because the claimant was legally incapacitated, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible.

Time of Payment

Claims payable under the Plan will be processed no later than 30 days after written proof of loss is received. Delta Dental will notify you and your Provider of any additional information needed to process the claim within this 30-day period.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO Provider or Premier Provider will be made directly to the Provider. Unless a Non-Delta Dental Provider accepts direct payment, payment will be made to you.

Neither you, the Primary Enrollee, nor a Dependent Enrollee, nor your dependents, nor any beneficiaries may assign, sell, transfer, pledge, charge, or encumber any Benefits under the Plan without the written consent of Delta Dental. Any assignment by you will be void. To the extent allowed by law, the Plan will not accept an assignment to a Non-Delta Dental Provider or facility for any reason, including but not limited to, an assignment of the right to receive payments. Any payments made by Delta Dental as claims administrator of the Plan to a Non- Delta Dental Provider or facility does not create a waiver of this section nor grant a Non-Delta Dental Provider rights under the Group Dental Assistance Plan or ERISA.

Discretionary Authority

The Employee Benefits Administration Committee of ERIE is the Plan Administrator of the Dental Assistance Plan under the Employee Retirement Income Security Act (ERISA). As Plan Administrator, the committee has the discretionary authority to interpret and construe the terms of the Group Dental Assistance Plan. In addition, Delta Dental has been provided with the discretionary authority to interpret and construe the terms of the Group Dental Assistance Plan for the purpose of administering claims and deciding appeals of denied claims

Plan Termination

Erie Indemnity Company may terminate the Group Dental Assistance Plan at any time and for any reason. Except as otherwise required by applicable law and regulations, any plan termination may be done without prior notice to plan participants. Any plan termination shall be done by resolution of the Board of Directors of Erie Indemnity Company, and the plan termination shall be effective as of the date specified in the enabling resolution. A copy of the resolution shall be provided to the Plan Administrator of the Group Dental Assistance Plan and, to the extent necessary or appropriate, to any outside service provider of the Plan. The Plan Administrator of the Plan shall notify plan participants and beneficiaries of the plan termination in accordance with applicable law and regulations.

ERISA Rights

You are entitled to certain rights and protections. ERISA provides that all plan participants of plans covered by ERISA are entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge at the Plan Administrator's office and at other specific locations, such as worksites, all documents governing the plan including a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain upon request to the Plan Administrators copies of documents governing the operation of the plan, including copies of the latest annual report (Form 5500 series) and 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 Plan Administrator is required by law to furnish you with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents if there is a loss of dental 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the 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 fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from a plan and do not receive them within 30 days, you may file a suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a Federal or state court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance With Your Questions

If you have questions about the plan, contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area 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.

Plan Information

Plan Name - Erie Indemnity Company Group Dental Assistance Plan

Plan Number – 505

Plan Type - Welfare Plan (Dental)

Source of Contributions - Employer and Employee

Payment of Benefits - Self funded by Employer – Claims paid by Claims Administrator.

Plan Sponsor:

Erie Indemnity Company

100 Erie Insurance Place

Erie, PA 16530

814-870-2000

Employer Identification Number: 25-0466020

Plan Administrator:

Erie Indemnity Company Employee Benefits Administration Committee

100 Erie Insurance Place

Erie, PA 16530

814-870-2000

Service of Legal Process:

Erie Indemnity Company

Law Division

100 Erie Insurance Place

Erie, PA 16530

814-870-2000

Claims Administrator:

Delta Dental of Pennsylvania

P.O. Box 2105

Mechanicsburg, PA 17055

Adopting ERIE Affiliates:

Erie Insurance Company of New York

Erie Resources Management Corp.

Plan Year - January 1st to December 31st

Attachment A

Description of Dental Benefits, Deductibles, Maximums and Contract Benefit Levels

Deductible and maximum amounts will be determined on a Calendar Year basis per Enrollee unless otherwise stated and are subject to *Attachment B - Limitations and Exclusions*.

Description of Dental Benefits	
Dental Benefit Category	Dental Benefit Description
Exams	evaluation to assess oral health
Diagnostic and Preventive	
X-Rays	radiographic imaging services to aid diagnosis
Diagnostic and Preventive	
Prophylaxis	services to remove plaque, tartar and stains from the tooth surface
Diagnostic and Preventive	
Fluoride	topical application of fluoride in the dental office
Diagnostic and Preventive	
Space Maintainers	oral appliance made to "maintain" the space created by the loss of a tooth
Diagnostic and Preventive	
Sealants	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay
Diagnostic and Preventive	

Minor Restorative	amalgam (silver filling) and resin-based composite (tooth-colored filling) for treatment of decay, failing restorations or fractures
Basic	
Stainless Steel Crowns	prefabricated crowns used to repair teeth
Major	
Endodontics	treatment of diseases and injuries of the tooth pulp
Basic	
Periodontics; Surgical	surgical treatment of gums and bones supporting teeth
Basic	
Periodontics; Non-Surgical	non-surgical treatment of gums and bones supporting teeth
Basic	
Periodontal Maintenance	a cleaning performed to maintain periodontal health after periodontal treatment
Diagnostic and Preventive	
Denture Repair/Rebase/Reline	repair to partial or complete dentures, including rebase procedures and relining
Basic	

Extractions	removal of teeth
Basic	
Surgical Extractions	removal of teeth by opening the gums and removing bone
Basic	
Other Oral Surgery	oral surgery services with the exception of surgical and non-surgical extractions
Basic	
Palliative Treatment	treatment to relieve pain
Diagnostic and Preventive	
IV Sedation & General Anesthesia	when administered by a Dentist for Oral Surgery or selected endodontic and periodontal surgical procedures
Basic	
Consultation	opinion or advice requested by a Dentist
Diagnostic and Preventive	
Major Restorative	treatment of decay and fracture when teeth cannot be restored with amalgam (silver filling) or resin-based composites (tooth-colored filling)
Major	
Prosthodontics; Removable	procedures for construction, modification and repair of partial or complete dentures
Major	
Prosthodontics; Fixed	procedures for construction, modification and repair of fixed bridges
Major	
Implants	procedures for the surgical placement and removal of endosteal, eposteal and transosteal implants and for implant supported prosthetics, including implant connecting bars, implant repairs and recementation. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain implant supported dental prosthesis
Major	

Orthodontic	procedures using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function
Orthodontic	
Cone Beam CT	x-ray technique that captures multiple images of the head and neck from a variety of angles
Major	
Resin-based Composites - Posterior	resin-based composite (tooth-colored fillings) in the rear of the mouth for treatment of decay, failing restorations or fractures
Basic	

Additional Benefits During Pregnancy

The Plan will pay for additional Benefits to help improve oral health during pregnancy. The additional Benefits include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided when the claim is submitted.

Deductibles	
Annual Deductible	PPO and Premier Dentists None Non-Delta Dental Dentists $25 per Enrollee $75 per family
Deductibles waived for	Diagnostic & Preventive and Orthodontic Benefits provided by a Non-Delta Dental Dentist

Maximums
If You obtain Benefits from any combination of PPO, Premier or Non-Delta Dental Dentists during a Calendar Year, the amount the Plan will pay each year for all Benefits received from all Dentists will not exceed the maximum amount payable for PPO Dentists. You enjoy the greatest Benefits - including out-of-pocket savings—when You choose a PPO Dentist.

Annual Maximum	PPO and Premier Dentists $2,000 Non-Delta Dental Dentists $1,000
Orthodontic Maximum	PPO, Premier and Non-Delta Dental Dentists $3,000 per Enrollee per lifetime

Contract Benefit Levels
The Plan's reimbursement to Dentists is based on PPO Maximum Contract Allowance for PPO Dentists, Premier Maximum Contract Allowance for Premier Dentists, and Premier Maximum Contract Allowance for Non-Delta Dental Dentists.

The Plan will pay the Contract Benefit Level for the following Benefits.

Dental Benefit Category	PPO and Premier Dentists	Non-Delta Dental Dentists
Diagnostic and Preventive	100%	100%
Basic	100%	75%
Major	50%	50%
Orthodontic	50%	50%

Attachment B

Limitations and Exclusions

Limitations

- Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. The Plan does not cover Optional Services.

  Examples of Optional Services:

  - a crown where a filling would restore the tooth;
  - an inlay/onlay instead of an amalgam restoration;
  - porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
  - an overdenture instead of a denture.

- Exam and cleaning limitations:
  - The Plan will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) no more than twice in a 12-month period.
  - The Plan will pay for periodontal maintenance in the presence of inflamed gums or any combination thereof no more than twice in a 12-month period.
  - Full mouth debridement is not allowed when performed by the same Dentist/Dentist office on the same day as evaluation procedures.
  - A full mouth debridement is allowed once in a lifetime when You have no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
  - Note that full mouth debridement is covered as a Basic Benefit and that periodontal maintenance, Procedure Codes that include periodontal maintenance and routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
  - Caries risk assessments are allowed once in 36 months.

- Image limitations:
  - The Plan will limit the total reimbursable amount to the Dentist's Submitted Fee for a comprehensive series of radiographic images when the fees for any combination of

intraoral images in a single treatment series meet or exceed the Submitted Fee for a comprehensive intraoral series.

- If a panoramic image is taken in conjunction with a comprehensive intraoral series, The Plan will limit reimbursement to the Dentist's Submitted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be Your responsibility. Panoramic images are not considered part of a comprehensive intraoral series.
- Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 36 months.
- Bitewing images are limited to two (2) times in a 12-month period for each Enrollee. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
- Bitewing images of any type are included in the fee of a comprehensive series when taken within six (6) months of the comprehensive images.
- Bitewing images are limited to two (2) images for Dependent Enrollee children under age 10.
- Image capture procedures are not separately billable services.

- Cone Beam CT capture and interpretation are covered not more than once in any 12 month period. Interpretation of a diagnostic image only is covered for cone beam services. Cone beam interpretation is a covered Benefit when provided by a different Dentist/Dentist office than the Dentist/Dentist office who provided the cone beam capture only services.
- Topical application of fluoride solutions is limited to Enrollees under age 19 and no more than twice in a 12-month period.
- Application of caries arresting medicament is limited to twice per tooth per Calendar Year.
- Space maintainer limitations:
  - Space maintainers are limited to the initial appliance. A distal shoe space maintainer-fixed- unilateral is limited to Dependent Enrollee children eight (8) and younger. A separate/ additional space maintainer can be allowed after the removal of a unilateral distal shoe.
  - Recementation of space maintainer is limited to once in a 12-month period.
  - The removal of a fixed space maintainer is included in the fee. An exception is made if the removal is performed by a different Dentist/Dentist office.
- Pulp vitality tests are allowed once every 30 days when definitive treatment is not performed.
- Cephalometric images are covered once every 36 months and oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services and are subject to the lifetime maximum on Orthodontic Services. 3D images are not a covered Benefit.

- Sealants are limited as follows:
  - for Dependent Enrollee children younger than age 14 on permanent first and second molars if the molars are without caries (decay) or restorations on the occlusal surface.
  - repair or replacement of a Sealant on any tooth within 36 months of its application is included in the fee for the original placement.
- Specialist Consultations are limited to three (3) times per Dentist in a 12-month period. Screenings or assessments reported individually when covered are limited to only one (1) in a 12-month period and included if reported with any other examination on the same date of service and Dentist office.
- The Plan will not cover replacement of an amalgam or resin-based composite restoration (filling) or prefabricated crowns within 24 months of treatment if the service is provided by the same Dentist/Dentist office. Replacement restorations within 24 months are included in the fee for the original restoration.
- Protective restorations (sedative fillings) are allowed once per tooth every 90 days when definitive treatment is not performed on the same date of service.
- Therapeutic pulpotomy is limited to once in a 24-month period for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Dentist/Dentist office within 24 months is considered part of the original procedure.
- Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, one (1) interim visit and one (1) final visit.
- Retreatment of apical surgery by the same Dentist/Dentist office within 24 months is considered part of the original procedure.
- Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.
- Periodontal limitations:
  - Benefits for periodontal scaling and root planing in the same quadrant are limited to once every 12-month period. See note on additional Benefits during pregnancy. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be covered on the same date of service.
  - Periodontal surgery in the same quadrant is limited to once in every 60-month period and includes any surgical re-entry or scaling and root planing performed within 60 months by the same Dentist/Dentist office.
  - Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration

are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.

- o Periodontal surgery is subject to a 30 day waiting period following periodontal scaling and root planing in the same quadrant.
- o Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Dentist office.
- o When implant procedures are a covered Benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces,

  without flap entry and closure is covered as a Basic Service and are limited to once in a 24- month period.

- The following Oral Surgery procedure is limited for Dependent Enrollees under age 19 (or Orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.
- The following Oral Surgery procedures are limited for Dependent Enrollees under age 19 (or Orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or the frenum is contributing to the presence of a large diastema(s).
- Crowns are covered not more often than once in any 60-month period except when Delta Dental determines the existing crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Inlays/onlays are limited for Dependent Enrollee children to age 12 and older and are covered not more often than once in any 60-month period except when Delta Dental determines the existing inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Core buildup, including any pins, are covered not more than once in any 60-month period.
- Post and core services are covered not more than once in any 60-month period.
- Crown repairs are covered not more than once in any 12-month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- Denture Repairs are covered not more than four (4) times in any 12-month period except for fixed Denture Repairs which are covered not more than once in any 60-month period.

- Prosthodontic appliances, implants and/or implant supported prosthetics that were previously covered under the Plan will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prothesis that was not previously covered under the Plan will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Payment for implant removal is limited to one (1) for implant site per lifetime whether provided under this Plan or any other dental care plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Dentist/Dentist office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Dentist/Dentist office.
- The Plan limits payment for dentures to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.
    - Denture rebase is limited to two (2) times per arch in a 12-month period and includes any relining and adjustments for six (6) months following placement.
    - Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a 12-month period and relining is limited to two (2) per arch in a 12-month period.

      Immediate dentures and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a 12-month period and relining is limited to two (2) per arch in a 12-month period.
    - Tissue conditioning is limited to two (2) per arch in a 36-month period. Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
    - Recementation of fixed partial dentures is limited to once in a 12-month period.
- Orthodontic limitations:
    - Benefits for Orthodontic Services will be provided in periodic payments based on Your continuing eligibility.
    - Benefits are not paid to repair or replace any Orthodontic appliance received.
    - Benefits are not paid for Orthodontic retreatment procedures.

- Orthodontic treatment must be provided by a licensed Dentist.
- The removal of fixed Orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

- All Orthodontic services, including direct to consumer Orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for Benefits that are not provided by a Dentist are not eligible for reimbursement.
- The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

Exclusions

The Plan does not pay Benefits for:

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for Dependent Enrollee children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for the completed service.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn Dependent Enrollee children for medically diagnosed congenital defects or birth abnormalities.
- Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, Night Guards/Occlusal Guards and abfraction.
- Any Single Procedure provided prior to the date the Enrollee became eligible for Benefits under this Plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- Charges for anesthesia, other than General Anesthesia and IV Sedation in connection with Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

- Extra oral grafts (grafts of tissues obtained from extraoral sites of the Enrollee's own body to their oral tissues).
- Interim implants, endodontic endosseous implant and extraoral implants.
- Indirectly fabricated resin-based inlays/onlays.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening or tobacco counseling.
- Dental practice administrative services including, but not limited to, preparation of claims, any non- treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Any tax imposed by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- Deductibles, amounts over plan maximums and/or any service not covered under the Plan.
- Services covered but which exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section.
- Services for any disturbance of TMJ or associated musculature, nerves and other tissues except as provided under the TMJ Benefit section.
- Missed and/or cancelled appointments.
- Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management, motivational interviewing and patient education to improve oral health literacy.
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

- Extra-oral – 2d projection radiographic image and extra-oral posterior dental radiographic image.
- Diabetes testing.
- Corticotomy (specialized Oral Surgery procedure associated with Orthodontics).
- Antigen or antibody testing.
- Counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.
- Services or supplies for sleep apnea.
- Cone beam image capture only is not a covered Benefit.