



Voluntary Dental Insurance

HIGH PLAN - FOR EMPLOYEES OF ST. FRANCIS HEALTH SERVICES OF MORRIS, INC.

With this dental plan, you have a choice in coverage levels, either the High Plan or the Low Plan. The High Plan offers a higher level of coverage (ex. a larger benefit percentage is available for covered services), with more costly premiums than the Low Plan. The Low Plan offers a lower level of coverage, with more affordable premiums than the High Plan. You have the flexibility to enroll for the plan that best meets you and your dependents dental health needs.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES

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|--|--|
| Eligibility Requirement | You must be actively working a minimum of 30 hours per week to be eligible for coverage. |
| Dependent Eligibility Requirement | A child must meet the eligibility requirements of the Policy and be under age 26 if eligible as defined by Policy. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself. |
| Premium Payment | The premiums for this insurance are paid in full by you. |

| PLAN YEAR DEDUCTIBLES AND MAXIMUMS | IN-NETWORK | OUT-NETWORK |
|-------------------------------------|--------------------|--------------------|
| Type A | Waived | Waived |
| Type B & C Deductible | | |
| Individual | \$50 | \$50 |
| Family | 3 times Individual | 3 times Individual |
| Annual Maximum | \$1,250 | \$1,250 |
| Orthodontia Lifetime Maximum | \$1,000 | \$1,000 |

The same expenses may be used to satisfy both the In-Network and Out-Network deductible.

| COVERED SERVICES | IN-NETWORK | OUT-NETWORK |
|--|------------|-------------|
| Type A Services | 100% | 100% |
| <ul style="list-style-type: none"> • Examinations/Evaluations • Bitewing X-rays • All Other X-Rays • Fluoride Treatments • Cleaning/Prophylaxis • Sealants • Space Maintainers • Full Mouth X-rays, Panoramic Film | | |

| COVERED SERVICES | IN-NETWORK | OUT-NETWORK |
|--|-------------------|--------------------|
| Type B Services <ul style="list-style-type: none"> • Palliative Treatment • Brush Biopsy/Cancer Screening • Fillings • Stainless Steel Crowns • Simple Extractions • General Anesthesia or I.V. Sedation | 80% | 80% |
| Type C Services <ul style="list-style-type: none"> • Periodontal Maintenance • Oral Surgery • Endodontics • Full or Partial Removable Dentures • Repair of Full or Partial Removable Dentures • Adjustments, Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures • Bridges • Repair/Recementation of Bridges • Cast Crowns, Inlays, Onlays, Labial Veneers • Repair/Recementation of Cast Crowns/Inlays/Onlays/Labial Veneers • Temporomandibular Joint Disorder - TMD • Surgical Extractions • Surgical Periodontics • Non-Surgical Periodontics | 50% | 50% |
| Child Orthodontia <ul style="list-style-type: none"> • Harmful Habit Appliances | 50% | 50% |

The plan pays the percentage shown after the deductible is satisfied up to the maximum. Additional information about the benefits and covered services of this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have questions prior to enrolling.

The plan provides the same coverage levels for both In-Network and Out-Network services. However, because In-Network providers offer their services at predetermined fees, out-of-pocket expenses may be lower for plan members when receiving covered services from an In-Network provider.

The Maximum Allowance for Out-Network Services is based on the 90th Percentile as determined by Mutual of Omaha. Charges that exceed the Maximum Allowance (as defined in the certificate booklet) for any covered dental service are not considered.

PREVENTIVE EDGE

Benefits for Type A services listed above will not be applied to the insured person's Annual Maximum.

ANNUAL OPEN ENROLLMENT PERIOD

The plan has an Annual Open Enrollment Period. Any Benefit Waiting Periods or Late Entrant Waiting Periods will be waived during this time period.

LIMITATIONS

Information about the limitations and exclusions for this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or Benefits Administrator if you have any questions prior to enrolling.

- Exams – 1 service in a 6 month period.
- Bitewing X-rays – 4 films in a 12 month period.
- Full Mouth X-rays or Panoramic Film – 1 in any 60 month period.
- Fluoride – For dependent children up to age 14. 1 service in a 6 month period.
- Harmful Habit Appliance – For dependent children up to age 14.
- Cleaning/Prophylaxis – 1 service in a 6 month period.
- Sealants – For dependent children up to age 14; one per permanent bicuspid or molar tooth in any 36 month period.
- Brush Biopsy/Cancer Screen – 1 service in a 6 month period.
- Space Maintainers – For dependent children up to age 19, includes recementations and removal.
- Fillings – Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement once in a 24 month period.
- Stainless Steel Crowns – For dependent children up to age 19; one per tooth per lifetime. Not for temporary restoration.
- Periodontal Maintenance – 1 service in a 6 month period in addition to routine cleaning. Following active periodontal treatment only.
- Cast Crowns, Inlays, Onlays, Labial Veneers – Replacement allowed once in 10 years.
- Bridges – Replacement allowed once in 10 years.
- Dentures – Replacement allowed once in 10 years.
- TMD – Non-surgical treatment only.
- Orthodontia – Includes case workup, all appliances and one set of retainers. Braces/Appliances must be placed prior to the dependent child turning age 26 for orthodontic benefits to be payable.

SERVICES

Hearing Discount Program

The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

PREMIUM AMOUNTS AND ENROLLING FOR COVERAGE

| Coverage Tier | Premium Amount (12 Payroll Deductions Per Year) |
|-----------------------------|--|
| Employee/Member | \$36.40 |
| Employee/Member + 1 | \$78.10 |
| Employee/Member + 2 or more | \$137.12 |

To enroll for dental coverage:

- 1) Using the table above, first identify the tier of coverage you wish to enroll for. Options are available that provide coverage for you (the employee) only, or for you and your family. The amount listed in the Premium Amount column is the cost per paycheck for each tier of coverage.
- 2) Locate the Voluntary Dental Coverage election section on your enrollment form. Place a \checkmark or an x in the Yes box next to the tier of coverage you wish to enroll for, then insert the Premium Amount for the tier you select into the Premium Amount column (if the premium amount is not already available on the form).
- 3) If you are enrolling for coverage for your dependents, complete the Dependent Information section of the enrollment form.

> Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

When does my coverage begin?

Complete enrollment information must be submitted to us through your Benefits Administrator *prior* to the requested effective date. Enrollment will be accepted within 31 days following the day you become eligible; however your effective date will then be the first of the following month.

When does my coverage begin for my dependents?

A Dependent child is considered eligible for insurance at birth and may be added to your policy at any time up to the child's third birthday. If we do not receive notification of the child's enrollment by age 3, you will be required to wait until the next Subsequent Enrollment Period to enroll the child.

If I enroll now, can I change or drop my coverage at any time?

Your enrollment in this coverage is for a 12 month Policy Year. During the Policy Year, you may drop coverage, or add or remove dependents, or terminate coverage within 31 days of a qualifying Life Change Event (as defined in the Certificate). These events include the birth of a child, pending adoption, marriage, divorce or loss of other coverage.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Availability of benefits is subject to final acceptance and approval of the group application by the underwriting company. Dental insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Insurance Company is licensed nationwide, except in New York Policy form number: G2018MP or state equivalent (In NC: G2018MP NC).

VOLUNTARY DENTAL INSURANCE

