DELTACARE DHMO DENTAL PLAN

SUMMARY PLAN DESCRIPTION

As of January 1, 2018

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This summary plan description (SPD) outlines the major features of the Andeavor DeltaCare DHMO Dental Plan. If you have questions regarding your coverage under the DeltaCare DHMO Dental Plan, contact the Andeavor Benefits Department.

This document describes the Andeavor DeltaCare DHMO Dental Plan as of January 1, 2018. This Plan is available to eligible Andeavor employees on the U.S. payroll. This information comprises the SPD of this Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

This description doesn't cover every provision of the Plan. Some complex concepts may have been simplified or omitted in order to present a more understandable plan description. If this plan description is incomplete, or if there's any inconsistency between the information provided here and the official plan texts, the provisions of the official plan texts will prevail.

WHO IS ELIGIBLE

Employee Eligibility

You are eligible to participate in the Plan as of your employment commencement date if you:

- are an employee of Andeavor or one of its participating subsidiaries who is scheduled to work at least 30 hours per week (regular full-time employee);
- are not classified as a Retail Store, Hourly Bakery Production or Bakery Driver employee; and
- are on a U.S. payroll.

You are eligible to participate in the Plan on the first day of the month coincident with or following your completion of sixty (60) days of continuous employment if you:

- are an employee of Andeavor or one of its participating subsidiaries who is scheduled to work at least 30 hours per week (regular full-time employee);
- are classified as a Retail Store, Hourly Bakery Production or Bakery Driver employee; and
- are on a U.S. payroll.

You are **not** eligible to participate in the Plan if you:

- are not a regular full-time employee (e.g., are a part-time, temporary or seasonal employee);
- are covered by a collective bargaining agreement unless it provides, or is deemed to provide, for participation in the Plan;
- are not on a U.S. payroll;
- are a leased employee, non-employee director, or independent contractor; or
- are employed by a company that is not a participating subsidiary.

Dependent Eligibility

If you enroll for Plan coverage, you may also enroll your eligible Dependents, which are defined as follows:

- your spouse (if you are not legally separated);
- your Child under age 26. For these purposes, a Child includes the following:
  - biological child;
  - stepchild;
  - grandchild who resides with you;
  - foster child or legally adopted child, including a child placed with you for adoption for whom legal adoption proceedings have started even if not final;
  - child for which there is a court order establishing your legal guardianship or conservatorship, which has not been terminated by the parties or operation of law;
- your mentally or physically disabled Child of any age (see special rules below); and
- your Domestic Partner and your Domestic Partner's Child(ren) (see special rules below).

*Dependents who are in active military are not eligible to participate in the Plan.

Eligibility Rules for a Disabled Child

Coverage for a Child who is Disabled at age 26 will not terminate merely because such Child has attained age 26. Such coverage may continue during the period the Child is both:

1. Disabled, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means the Child suffers from any medically determinable physical or mental condition that prevents the Child from engaging in self-sustaining employment. The disability must begin before the Child attains age 26. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claim Administrator within 31 days following the Child's attainment of age 26. For new employees, such proof must be submitted in connection with your initial enrollment.

As a condition to the continued coverage of a Child as a Disabled Dependent beyond age 26, the Claim Administrator may require periodic certification of the Child's physical or mental condition after the two-year period following the Child's attainment of age 26. Any such certification shall not be requested more frequently than once each plan year.

Eligibility Rules for Domestic Partner Coverage

An individual is eligible for domestic partner coverage if he or she meets the eligibility criteria listed on Andeavor’s Affidavit of Domestic Partnership. To qualify for domestic partner coverage, you must register your domestic partnership with Andeavor’s Benefits Administrator by submitting an executed Affidavit of Domestic Partnership and completing the Dependent verification process (see **Proof of Dependent Status**). Andeavor’s Affidavit of Domestic Partnership is available through your benefits administrator or may be downloaded from Andeavor’s intranet site (see **Contacts**). In event your Domestic Partnership ends, you must submit a signed Benefits Change Form to your benefits administrator.

Proof of Dependent Status

When you add any Dependent, you may be required to submit the appropriate documents (marriage certificate, birth certificate, etc.) to provide proof of Dependent status. This process will apply whether the Dependent is being added during your initial eligibility period, annual open enrollment or due to a life event.

Enrollment of your Dependents in the Plan will be pended until proof of Dependent status has been received by your benefits administrator. Such documentation generally must be received within 31 days of enrollment; otherwise, your Dependents will *not* be added to the Plan. Please contact your benefits administrator with any questions.

Ineligible Dependents

The following persons are **not** eligible for Dependent coverage under the Plan

- your legally separated spouse;
- a Child who is employed by Andeavor or an affiliate;
- an individual who no longer qualifies as a Dependent Child; or
- an individual who no longer qualifies as a Domestic Partner or a Dependent Child of a Domestic Partner.

If Your Spouse is Also an Eligible Employee

If both you and your spouse are eligible to enroll in the Plan, you may elect Plan coverage as an employee and as a Dependent spouse. Your coverage as a Dependent spouse will be Secondary to your coverage as an employee. See Coordination of Benefits (COB) section for more information on Primary coverage and Secondary coverage. However, you may not receive coverage as both an employee and Dependent Child. Rather, your Dependent Child can only enroll in his or her capacity as an employee.

Service Area

In order to receive coverage under the Plan, the eligible Employee must live or work in the “Service Area” as defined by DeltaCare.

The “Service Area” includes specified locations in Alabama, Alaska, Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Hawaii, Idaho, Illinois, Louisiana, Missouri, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, Virginia, Washington, Wisconsin, Wyoming.

The permanent legal residence of any enrolled Dependent must be the same as the Employee's, or the eligible Employee must live or work in the Service Area and the residence of any enrolled Dependent must be:

1. in the Service Area with the Employee having temporary or permanent conservatorship or guardianship of such Dependents, where the Employee has legal responsibility for the health care of such Dependents; or
2. in the Service Area under other circumstances where the Employee is legally responsible for the health care of such Dependents; or
3. in the Service Area with the Employee's spouse; or
4. anywhere in the United States for a Child whose coverage under the Plan is required by a medical support order.

***Applicable state laws may require different or additional benefits or processes than are described under this SPD. Such laws are controlling unless preempted by federal law. You should refer to the underlying policy for more information regarding the specific requirements applicable to coverage in your state.**

ENROLLING IN THE PLAN

You must enroll yourself and your eligible Dependents in the Plan (or waive coverage) within 31 days of your employment date, or within 31 days of the date you or, as applicable, your Dependent(s) first become eligible for the Plan (if later). If you enroll within such 31-day period, your coverage will be effective as of your employment date or, if applicable, your subsequent eligibility date.

To complete your Plan election, you'll need to:

- choose the Andeavor DeltaCare DHMO Dental Plan; and
- decide which of your eligible Dependents you wish to cover, if any.
- submit verification documents for enrolled Dependents, if any.

Generally, the coverage levels available under the Plan are:

- Employee Only;
- Employee + Child(ren);
- Employee + Spouse/Domestic Partner;
- Employee + Family (including Domestic Partner plus Child(ren) &/or Domestic Partner Child(ren); or
- Waive Coverage.

If you do not wish to participate, you may affirmatively decline coverage by selecting the "Waive" option. If you do not enroll within 31 days after you first become eligible, you will be treated as if you had waived coverage. If you decline (waive) coverage, or do not enroll within 31 days after you were first eligible, you must wait until the next open enrollment period to change your elections, unless you become eligible to make an election change under the Plan as a result of a qualifying status change.

Coverage for your Dependents will not be completed until you submit required documentation verifying eligibility (see **Proof of Dependent Status**).

Each person enrolled for coverage under the Plan is referred to herein as an "Enrollee."

After you have completed your enrollment, you should print a Confirmation Form verifying your elections. It is important for you to keep a copy of your enrollment elections to show proof of your elections should an issue later arise. Your dental coverage will begin as of your eligibility date and any payroll deductions covering your elections will be made retroactively.

Annual Enrollment Period

During an annual open enrollment period designated by the Company (normally in October/November of each year for coverage beginning the following January 1), you may make an election to enroll, re-enroll or decline (waive) participation for the coming year. You may change your Plan coverage levels and add/re-add Dependents to your coverage. If you waive coverage, you will not have coverage under the Plan for the following year. If you do not make an election at annual enrollment, your current coverage will continue into the next year.

You will not be allowed to change your election before the next open enrollment period, unless you experience a qualifying status change during the year. Coverage elections (and deemed elections) made during open enrollment become effective on January 1 of the immediately following year.

After you have completed your enrollment, you should print a Confirmation Form verifying your elections. It is important for you to keep a copy of your enrollment elections to show proof of your elections should an issue later arise. Your dental coverage will begin as of the first payroll period of the immediately following year.

Special Enrollment

Certain events may occur which allow for mid-year enrollment as a Special Enrollee. If you are applying for coverage as a Special Enrollee, you must do so within 31 days of the applicable event. A person will be considered to be a Special Enrollee if all of the following apply:

- you did not elect dental coverage for that person within 31 days of the date the person first became eligible (or during an open enrollment period), because the person had dental coverage from another source; and
- the person loses such coverage because:
  - of the person’s termination of employment,
  - of reduction in hours of employment,
  - your spouse dies,
  - you and your spouse divorce or become legally separated,
  - your Dependent ceases to be eligible for coverage under such plan,
  - the dental coverage was COBRA continuation and the continuation is exhausted, or
  - the other plan terminates due to the employer’s failure to pay the premium or any other reason; and
  - you elect coverage under this Plan within 31 days of the date the person loses coverage for one of the above reasons.

In addition, you will be a Special Enrollee if you obtain a new Dependent through birth, adoption or marriage, and you elect coverage for that person within 31 days of the date you obtain the new Dependent.

WHEN COVERAGE BEGINS

If you enroll ...	Coverage for you and your enrolled Dependents begins ...
Within 31 days of your eligibility date	On your eligibility date
During the open enrollment period	On January 1 of the following year
Within 31 days of an eligible status change (see **Changing Your Coverage**)	On the effective date of the status change (unless otherwise prohibited by applicable law)

*Note, however, claims for Dependents will be pended until adequate documentation is submitted.

CHANGING YOUR COVERAGE

After your initial enrollment, you can make changes to your coverage only during the open enrollment period or as the result of a qualifying status change or other permissible event.

A qualifying status change includes a change during the Plan Year in the following:

- your family status; or
- your or your spouse's employment status.

A qualifying status change allows you to:

- change your level of coverage (for example, from "Employee Only" to "Employee + Spouse" coverage);
- elect coverage if you previously waived coverage; or
- terminate coverage.

You must request any changes to your coverage within 31 days of the qualifying status change or other permissible event. You may complete the change event online via the respective legacy Tesoro or legacy Western benefits enrollment websites or by calling the benefits administrator.

Changes in your Plan coverage must be consistent with the status change. For example, you may change your level of coverage from "Employee + Spouse" to "Employee" if your status changes as a result of your divorce during the Plan Year.

Changes to your coverage and any change in your required contributions will take effect as of the date of the event (unless otherwise prohibited by applicable law.)

Changes in Family Status

An eligible change in family status includes:

- marriage;
- divorce or legal separation from your spouse;
- completion of six months in a Domestic Partnership;
- termination of a Domestic Partnership;
- birth, adoption or placement for adoption of a Dependent Child;
- establishment or termination of Dependent Child status during the Plan Year; or
- death of a spouse, Domestic Partner, or a Dependent Child.

Changes in Employment Status

An eligible change in employment status includes the following for you, your spouse or your Dependent Child if the change affects the person's eligibility for coverage under the Plan:

- a Company-authorized transfer or relocation requiring a change in work location and relocation of your residence;
- employment or unemployment (i.e., new job or loss of a job); or
- a change in work schedule (i.e., a reduction or increase in hours, a switch between part-time and full-time, strike or lockout, commencement or return from unpaid leave of absence).

Other Permissible Events

You may make certain changes to your coverage during the Plan Year upon the occurrence of the following additional events:

- the receipt of a qualified medical child support order (QMCSO) with respect to your Child;
- a significant increase in the cost of the benefit option;
- a significant curtailment of coverage under the benefit option; or
- loss of coverage under another employer plan or coverage sponsored by a governmental or educational institution

Qualified Medical Child Support Orders (QMCSOs)

The Plan will provide coverage for your eligible Child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), even if:

- you do not have legal custody of the Child; or
- the Child is not dependent on you for support (where applicable).

A QMCSO is an order from a state court or other state agency, usually issued as a part of a settlement agreement or divorce decree that provides for health care coverage for the Child of a group health plan participant. A QMCSO must meet certain legal requirements to be considered "qualified."

You are required to be enrolled in the Plan in order to enroll your eligible Child pursuant to the terms of a QMCSO.

If the Plan receives a valid QMCSO and you do not enroll the Dependent Child, the custodial parent or state agency may enroll the affected Child. Andeavor may withhold the contributions required for the Child's coverage from your pay.

A copy of the Plan's QMCSO procedures is available, free of charge, upon request to your benefits administrator.

COST OF COVERAGE

You and the Company share the cost of dental coverage for you and your eligible Dependents. Your cost is based on the level of coverage you choose. The contribution amount for each coverage option and level of coverage is subject to change and is announced in advance.

You generally pay for coverage on a pre-tax basis. However, Dependent coverage for eligible Domestic Partners (and their Children) generally requires that the value of that coverage be reported as taxable income to you and that the cost of such coverage be remitted on an after-tax basis.

SELECTING YOUR PROVIDER

Services Limited to Contract Providers

All services which are Benefits shall be rendered at the Contract Dentist's facility selected by the Enrollee, and the Plan shall have no obligation or liability with respect to services rendered by out-of- network Dentists, with the exception of Emergency Dental Services, or Specialized Services recommended by a Contract Dentist, and preauthorized by the Claims Administrator. If an Enrollee requires Specialized Services and there is no Contract Specialty Care Dentist to provide these services within 35 miles of their home address, the assigned Contract Dentist must receive Preauthorization from the Claims Administrator to refer the Enrollee to an out-of-network Dentist to provide the Specialized Services. Specialized Services which are not preauthorized by ALPHA may not be covered. All approved claims for Specialized Services will be paid by the Plan less any applicable Copayments.

Locating a DeltaCare DHMO Provider

You may access information through our website at www.deltadentalins.com. You may also call Delta Dental's Customer Service Center and one of their representatives will assist you.

BENEFITS[1]

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Plan. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered. If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by the Insurer.

CODE	DESCRIPTION	COPAY
D0100 - D0999	**Diagnostic**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office	$5.00
D0180	Comprehensive periodontal evaluation - new or established	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - limited to 1 series every 24 months	No Cost
D0220	Intraoral - periapical first radiographic	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	D0601 Caries risk assessment and documentation, with a finding of low risk - 1 every 3 years	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - 1 every 3 years	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - 1 every 3 years	No Cost

[1] Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.

D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)	No Cost
D1000 - D1999	**Preventive**	
D1110	Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period	$5.00
D1110	Additional prophylaxis cleaning - adult (within the 6 month period)1	$45.00
D1120	Prophylaxis cleaning - child - 1 D1110, D1120 or D4346 per 6 month period	$5.00
D1120	Additional prophylaxis cleaning - child (within the 6 month period)	$35.00
D1206	Topical application of fluoride varnish - child to age 19; 1 D1206 or D1208 per 6 month period	No Cost
D1208	Topical application of fluoride - excluding varnish - child to age 19; 1 D1206 or D1208 per 6 month period	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - limited to permanent molars through age 15	$15.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - limited to permanent molars through age 15	$15.00
D1353	Sealant repair - per tooth - limited to permanent molars through age 15	$15.00
D1354	Interim caries arresting medicament application - per tooth – child to age 19; 1 per 6 month period	No Cost
D1510	Space maintainer - fixed – unilateral	$70.00
D1515	Space maintainer - fixed – bilateral	$70.00
D1520	Space maintainer - removable – unilateral	$80.00
D1525	Space maintainer - removable – bilateral	$80.00
D1550	Re-cement or re-bond space maintainer	$15.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral - child to age 9	$70.00
D2000 - D2999	**Restorative** • Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures. • When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit. • Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.	
D2140	Amalgam - one surface, primary or permanent	$8.00
D2150	Amalgam - two surfaces, primary or permanent	$12.00
D2160	Amalgam - three surfaces, primary or permanent	$18.00
D2161	Amalgam - four or more surfaces, primary or permanent	$22.00
D2330	Resin-based composite - one surface, anterior	$22.00
D2331	Resin-based composite - two surfaces, anterior	$26.00
D2332	Resin-based composite - three surfaces, anterior	$30.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55.00
D2390	D2390 Resin-based composite crown, anterior	$65.00
D2391	D2391 Resin-based composite - one surface, posterior	$65.00
D2392	D2392 Resin-based composite - two surfaces, posterior	$75.00
D2393	D2393 Resin-based composite - three surfaces, posterior	$85.00
D2394	D2394 Resin-based composite - four or more surfaces, posterior	$95.00
D2510	Inlay - metallic - one surface	$185.00
D2520	Inlay - metallic - two surfaces	$195.00
D2530	Inlay - metallic - three or more surfaces	$205.00
D2542	Onlay - metallic - two surfaces	$200.00
D2543	Onlay - metallic - three surfaces	$210.00
D2544	Onlay - metallic - four or more surfaces	$230.00
D2610	Inlay - porcelain/ceramic - one surface	$310.00
D2620	Inlay - porcelain/ceramic - two surfaces	$345.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$365.00
D2642	Onlay - porcelain/ceramic - two surfaces	$340.00

D2643	Onlay - porcelain/ceramic - three surfaces	$375.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$395.00
D2650	Inlay - resin-based composite - one surface	$210.00
D2651	Inlay - resin-based composite - two surfaces	$235.00
D2652	Inlay - resin-based composite - three or more surfaces	$270.00
D2662	Onlay - resin-based composite - two surfaces	$265.00
D2663	Onlay - resin-based composite - three surfaces	$290.00
D2664	Onlay - resin-based composite - four or more surfaces	$335.00
D2710	Crown - resin-based composite (indirect)	$185.00
D2712	Crown - 3/4 resin-based composite (indirect)	$185.00
D2720	Crown - resin with high noble metal	$335.00
D2721	Crown - resin with predominantly base metal	$235.00
D2722	Crown - resin with noble metal	$275.00
D2740	Crown - porcelain/ceramic	$395.00
D2750	Crown - porcelain fused to high noble metal	$395.00
D2751	Crown - porcelain fused to predominantly base metal	$295.00
D2752	Crown - porcelain fused to noble metal	$335.00
D2780	Crown - 3/4 cast high noble metal	$395.00
D2781	Crown - 3/4 cast predominantly base metal	$295.00
D2782	Crown - 3/4 cast noble metal	$335.00
D2783	Crown - 3/4 porcelain/ceramic	$395.00
D2790	Crown - full cast high noble metal	$395.00
D2791	Crown - full cast predominantly base metal	$295.00
D2792	Crown - full cast noble metal	$335.00
D2794	Crown - titanium	$395.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$20.00
D2920	Re-cement or re-bond crown	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp - anterior	$55.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - anterior	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$75.00
D2931	Prefabricated stainless steel crown - permanent tooth	$75.00
D2932	Prefabricated resin crown - anterior primary tooth	$85.00
D2933	Prefabricated stainless steel crown with resin window - anterior primary tooth	$75.00
D2940	Protective restoration	$20.00
D2941	Interim therapeutic restoration - primary dentition	$20.00
D2949	Restorative foundation for an indirect restoration	$80.00
D2950	Core buildup, including any pins when required	$80.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Post and core in addition to crown, indirectly fabricated - includes canal preparation	$110.00
D2953	Each additional indirectly fabricated post - same tooth - includes canal preparation	$80.00
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	$95.00
D2957	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	$70.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$60.00
D2980	Crown repair necessitated by restorative material failure	$30.00
D2981	Inlay repair necessitated by restorative material failure	$30.00
D2982	Onlay repair necessitated by restorative material failure	$30.00
D2983	Veneer repair necessitated by restorative material failure	$30.00
D2990	Resin infiltration of incipient smooth surface lesions - limited to permanent molars through age 15	$15.00

D3000 - D3999	**Endodontics**	
D3110	Pulp cap - direct (excluding final restoration)	$5.00
D3120	Pulp cap - indirect (excluding final restoration)	$5.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$45.00
D3221	Pulpal debridement, primary and permanent teeth	$50.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$60.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$60.00
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	$125.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	$215.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	$365.00
D3331	Treatment of root canal obstruction; non-surgical access	$80.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$80.00
D3333	Internal root repair of perforation defects	$80.00
D3346	Retreatment of previous root canal therapy - anterior	$155.00
D3347	Retreatment of previous root canal therapy - premolar	$245.00
D3348	Retreatment of previous root canal therapy - molar	$395.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$80.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$55.00
D3410	Apicoectomy - anterior	$155.00
D3421	Apicoectomy - premolar (first root)	$165.00
D3425	Apicoectomy - molar (first root)	$175.00
D3426	Apicoectomy (each additional root)	$100.00
D3427	Periradicular surgery without apicoectomy	$155.00
D3430	Retrograde filling - per root	$75.00
D3450	Root amputation - per root	$85.00
D3920	Hemisection (including any root removal), not including root canal therapy	$75.00
	D3110 Pulp cap - direct (excluding final restoration)	$5.00
	D3120 Pulp cap - indirect (excluding final restoration)	$5.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$45.00
D3221	Pulpal debridement, primary and permanent teeth	$50.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$60.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$60.00
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	$125.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	$215.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	$365.00
D3331	Treatment of root canal obstruction; non-surgical access	$80.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$80.00
D3333	Internal root repair of perforation defects	$80.00
D3346	Retreatment of previous root canal therapy - anterior	$155.00
D3347	Retreatment of previous root canal therapy - premolar	$245.00

D3348	Retreatment of previous root canal therapy – molar	$395.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$80.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$55.00
D3410	Apicoectomy - anterior	$155.00
D3421	Apicoectomy - premolar (first root)	$165.00
D3425	Apicoectomy - molar (first root)	$175.00
D3426	Apicoectomy (each additional root)	$100.00
D3427	Periradicular surgery without apicoectomy	$155.00
D3430	Retrograde filling - per root	$75.00
D3450	Root amputation - per root	$85.00
D3920	Hemisection (including any root removal), not including root canal therapy	$75.00
D4000 - D4999	**Periodontics** • Includes preoperative and postoperative evaluations and treatment under a local anesthetic.	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$160.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$95.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$95.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$160.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$95.00
D4245	Apically positioned flap	$175.00
D4249	Clinical crown lengthening - hard tissue	$150.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$385.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$308.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$235.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$85.00
D4270	Pedicle soft tissue graft procedure	$235.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$90.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$235.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$235.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$60.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	$5.00
D4355	Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$60.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$45.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000 - D5899	Prosthodontics - Removable • For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered. • Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months. • Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.	
D5110	Complete denture - maxillary	$365.00
D5120	Complete denture - mandibular	$365.00
D5130	Immediate denture - maxillary	$385.00
D5140	Immediate denture - mandibular	$385.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$325.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$325.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$325.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$325.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$445.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$445.00
D5410	Adjust complete denture – maxillary	$18.00
D5411	Adjust complete denture – mandibular	$18.00
D5421	Adjust partial denture – maxillary	$18.00
D5422	Adjust partial denture – mandibular	$18.00
D5511	Repair broken complete denture base, mandibular	$55.00
D5512	Repair broken complete denture base, maxillary	$55.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$35.00
D5611	Repair resin partial denture base, mandibular	$55.00
D5612	Repair resin partial denture base, maxillary	$55.00
D5621	Repair cast partial framework, mandibular	$55.00
D5622	Repair cast partial framework, maxillary	$55.00
D5630	Repair or replace broken clasp - per tooth	$55.00
D5640	Replace broken teeth - per tooth	$45.00
D5650	Add tooth to existing partial denture	$45.00
D5660	Add clasp to existing partial denture - per tooth	$55.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$180.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$180.00
D5710	Rebase complete maxillary denture	$105.00
D5711	Rebase complete mandibular denture	$105.00
D5720	Rebase maxillary partial denture	$105.00
D5721	Rebase mandibular partial denture	$105.00
D5730	Reline complete maxillary denture (chairside)	$60.00
D5731	Reline complete mandibular denture (chairside)	$60.00
D5740	Reline maxillary partial denture (chairside)	$60.00
D5741	Reline mandibular partial denture (chairside)	$60.00
D5750	Reline complete maxillary denture (laboratory)	$95.00
D5751	Reline complete mandibular denture (laboratory)	$95.00

D5760	Reline maxillary partial denture (laboratory)	$95.00
D5761	Reline mandibular partial denture (laboratory)	$95.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$125.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$125.00
D5850	Tissue conditioning, maxillary	$30.00
D5851	Tissue conditioning, mandibular	$30.00
D5900 - D5999	**Maxillofacial Prosthetics - Not Covered**	
D6000 - D6199	**Implant Services - Not Covered**	
D6200 - D6999	**Prosthodontics - Fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])** • When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit. • Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.	
6210	D Pontic - cast high noble metal	$395.00
D6211	Pontic - cast predominantly base metal	$295.00
D6212	Pontic - cast noble metal	$335.00
D6240	Pontic - porcelain fused to high noble metal	$395.00
D6241	Pontic - porcelain fused to predominantly base metal	$295.00
D6242	Pontic - porcelain fused to noble metal	$335.00
D6245	Pontic - porcelain/ceramic	$395.00
D6250	Pontic - resin with high noble metal	$335.00
D6251	Pontic - resin with predominantly base metal	$235.00
D6252	Pontic - resin with noble metal	$275.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$345.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$365.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$295.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$305.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$195.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$205.00
D6606	Retainer inlay - cast noble metal, two surfaces	$225.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$235.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$340.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$375.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$300.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$310.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$200.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$210.00
D6614	Retainer onlay - cast noble metal, two surfaces	$220.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$240.00
D6720	Retainer crown - resin with high noble metal	$335.00
D6721	Retainer crown - resin with predominantly base metal	$235.00
D6722	Retainer crown - resin with noble metal	$275.00
D6740	Retainer crown - porcelain/ceramic	$395.00
D6750	Retainer crown - porcelain fused to high noble metal	$395.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$295.00
D6752	Retainer crown - porcelain fused to noble metal	$335.00
D6780	Retainer crown - 3/4 cast high noble metal	$395.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$295.00
D6782	Retainer crown - 3/4 cast noble metal	$335.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$395.00
D6790	Retainer crown - full cast high noble metal	$395.00
D6791	Retainer crown - full cast predominantly base metal	$295.00
D6792	Retainer crown - full cast noble metal	$335.00
D6930	Re-cement or re-bond fixed partial denture	$25.00
D6940	Stress breaker	$50.00

D6980	Fixed partial denture repair necessitated by restorative material failure	$70.00
D7000 - D7999	**ORAL AND MAXILLOFACIAL SURGERY** • Includes preoperative and postoperative evaluations and treatment under a local anesthetic.	
D7111	Extraction, coronal remnants - primary tooth	$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$14.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$55.00
D7220	Removal of impacted tooth - soft tissue	$70.00
D7230	Removal of impacted tooth - partially bony	$95.00
D7240	Removal of impacted tooth - completely bony	$120.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$140.00
D7250	Removal of residual tooth roots (cutting procedure)	$45.00
D7251	Coronectomy - intentional partial tooth removal	$140.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$130.00
D7280	Exposure of an unerupted tooth	$120.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$120.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$40.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$100.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$120.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	$100.00
D7472	Removal of torus palatinus	$100.00
D7473	Removal of torus mandibularis	$100.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$25.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$20.00
D7970	Excision of hyperplastic tissue - per arch	$80.00
D7971	Excision of pericoronal gingiva	$80.00
D8000 - D8999	**Orthodontics** • The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply. • The Retention Copayment includes adjustments and/or office visits up to 24 months.	
The benefit for pre-treatment records and diagnostic services includes:		
D0210	Intraoral - complete series of radiographic images	$200.00
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
The benefit for post-treatment records includes:		

D0210	Intraoral - complete series of radiographic images	$70.00
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$1,150.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,150.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,150.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult*	$1,350.00
D8050	Interceptive orthodontic treatment of the primary dentition	$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,900.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,900.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$2,100.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00
D9000 - D9999	**ADJUNCTIVE GENERAL SERVICES**	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$20.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$25.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$35.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9940	Occlusal guard, by report - limited to 1 in 3 years	105.00
D9943	Occlusal guard adjustment	$10.00
D9951	Occlusal adjustment, limited	$55.00
D9952	Occlusal adjustment, complete	$105.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - limited to one bleaching tray and gel for two weeks of self-treatment	$125.00
D9986	Missed appointment - without 24 hour notice - per 15 minutes of appointment time	$10.00
D9987	Canceled appointment - without 24 hour notice - per 15 minutes of appointment time	$10.00
D9991	Dental case management - addressing appointment compliance barriers	No Cost

D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost

EXCLUSIONS AND LIMITATIONS

Exclusions

- Any procedure that is not specifically listed under the Benefits Section
- Any procedure that in the professional opinion of the Contract Dentist:
    - has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
    - is inconsistent with generally accepted standards for dentistry.
- Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
- Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
- Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
- Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
- Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
- Consultations for non-covered benefits.
- Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for Emergency Dental Services as described in Schedule A.
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
- Prescription drugs.
- Lost, stolen or broken orthodontic appliances.
- Changes in orthodontic treatment necessitated by accident of any kind.
- Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9940 (occlusal guard, by report).
- Composite or ceramic brackets, lingual adaption of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
- Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Limitations

- The frequency of certain Benefits is limited. All frequency limitations are listed in the Benefits section.
- If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
- General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
- Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
- The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
- Benefits for dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with this Program are limited as follows:
    - Upon request of a newly covered Enrollee, Alpha will provide Benefits for the completion of covered services begun prior to the time his or her coverage became effective. Alpha will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Contract.
    - Enrollees may request completion of treatment in progress by calling the Customer Service department at 800 422-4234 during normal business hours, or by sending a written request to Alpha.
    - Whenever possible, an Enrollee should complete treatment in progress with the Dentist who initiated the service. If such Dentist is an out-of-network Dentist, that Dentist must agree to the same terms and conditions that apply to an in-network Dentist in order for Alpha to provide Benefits. Copayments and other cost sharing components will apply. Benefits may be adjusted so that the total paid by the Enrollee and/or coverage provided by all plans is not more than 100% of total Allowable Expenses (as defined in the Coordination of Benefits section of the Contract).
    - Should the Enrollee be unable to complete treatment with the Dentist who initiated the service, Alpha will make reasonable and appropriate arrangements for completion of such treatment by a Contract Dentist.
- Orthodontic treatment in progress is limited to new Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under this Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

COORDINATION OF BENEFITS

Coordination of benefits (COB) applies when you or your Dependents have coverage under more than one plan or other program. In these situations, it's necessary to determine which plan has primary responsibility for the payment of benefits. If you or a covered Dependent are covered under more than one plan and you incur an expense that is covered — partially or in full — under this Plan and at least one other plan:

- benefits related to that expense will be paid under the Primary and Secondary Plans as determined under the COB provisions; and
- under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

How COB Works

The order of benefit determination rules determine which plan will pay as the Primary Plan.

When an individual is covered under more than one plan:

- one plan is determined to be the Primary Plan and the others are considered Secondary Plans;
- the Primary Plan pays or provides its benefits first as if the Secondary Plan(s) did not exist;
- when this Plan is secondary, it pays after the Primary Plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan; and
- when this Plan is secondary, it will credit to its Plan deductible any amounts that would have been credited in the absence of other coverage. In determining the amount to be paid when this Plan is secondary, this Plan will calculate the benefits that it would have paid on the claim in the absence of other plan(s) and apply that amount to any allowable expense under this Plan that was unpaid by the Primary Plan.

This Plan will not pay more than it would have paid without the COB provision. In order to pay claims, the Claims Administrator must determine the Primary Plan and the Secondary Plan(s).

Determination of Primary and Secondary Plans

A plan that does not contain a coordination of benefits provision that is consistent with this provision is always the Primary Plan, with two exceptions:

- Coverage that is designed to supplement a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan.
  - Examples of these types of coverages are:
    - **–** major medical coverages that are superimposed over base plan hospital and surgical benefits, and
    - **–** insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- Automobile insurance coverage that is mandatory under state law, whether or not the Participant is in compliance with such mandate.

Subject to the provisions of the underlying policy, the first of the following rules that describes which plan pays its benefits first will be the rule that applies:

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent — for example as an employee, member or subscriber — is **primary,** and the plan that covers the person as a Dependent is **secondary.** However, if the person is a Medicare beneficiary, and by federal law Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person other than as a Dependent, then the order of benefits is reversed, so that the plan covering the person as an employee, member or subscriber is secondary and the other plan is primary.
2. **Child Covered Under More than One Plan**. The order of benefits is:
   - The Primary Plan is the plan of the parent whose birthday (month and day of birth) is earlier in the year if:
     - The parents are married and are not legally separated; or
     - A court order awards joint custody without specifying that one party has responsibility to provide health care coverage, or states that both parents are responsible for health care coverage.

Note: If both parents have the same birthday, the plan that has covered a parent longer is primary.

   - If the terms of a court order state that one of the parents is responsible for health care coverage and the plan of that parent is aware of those terms, that plan is primary. If the parent with responsibility has no health care coverage but that parent's spouse does, the plan of the parent's spouse is primary.
   - If the parents are separated or divorced, or are not living together whether or not they have ever been married, and there is no court order assigning responsibility for health care coverage, the order of benefits is:
     - If the parent with custody has not remarried, the policy or program covering the Child as a Dependent of the parent with custody shall be primary over the policy or program covering the Child as a Dependent of the parent without custody.

- If the parent with custody has remarried, the policy or program covering the child as a Dependent of the parent with custody shall be primary over the policy or program covering the Child as a Dependent of the step-parent, and the policy or program covering the Child as a Dependent of the step-parent shall be primary over the policy or program covering the Child as a Dependent of the parent without custody.

Note: For a Dependent Child covered under more than one plan of individuals who are not the parents of the Child, the order of benefits should be determined as shown above as if the individuals were the parents.

3. **Longer or Shorter Length of Coverage.** The plan that has covered the person as an employee, member or subscriber longer is primary.

4. **If the preceding rules do not determine the Primary Plan**, allowable expenses (expenses covered at least in part by any of the plans covering the person) will be shared equally between the plans. However, this Plan will not pay more than it would have paid had it been primary.

Medicare Coordination

Your benefits under the Plan may be coordinated and, in some cases, reduced by benefits that you receive (or would have received) from other plans or under other coverage, including Medicare. To the extent required by federal law, however, this Plan will be considered Primary to Medicare. Accordingly, your benefits under the Plan as an active employee will not be reduced as a result of eligibility or entitlement to Medicare, regardless of whether such eligibility or entitlement is a result of your attainment of age 65 or due to a disability.

However, in the event that you become eligible for or entitled to Medicare as a result of end-stage renal disease (ESRD), the Plan will be considered Primary to Medicare only during the thirty (30) month period commencing on the earlier of such dates. Thereafter, the Plan becomes Secondary to Medicare and your benefits under the Plan will be reduced by the amounts payable by Medicare for such services or treatments.

Medicare will be Primary to benefits under this plan for inactive participants who are eligible for Medicare, including those in LTD or retirement status.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan may use and disclose protected health information without an authorization from the individual only to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the HIPAA Regulations, including for payment, treatment and health care operations of the Plan. You will be provided with a notice describing the Plan's privacy practices and other information regarding your privacy rights with respect to protected health information. This notice is provided at the time of enrollment to new Plan enrollees. In addition, an updated notice will be provided to all Plan participants within 60 days of any material revision of the notice. Copies of the notice are available at all times through the Andeavor Benefit Center.

EVENTS AFFECTING COVERAGE

Leave of Absence

Your Plan coverage will continue, and contributions will be deducted from your paycheck, during any Company-approved absences with full or adequate partial pay. Your coverage will also continue during the following leaves of absence, subject to the conditions described below:

Types of Leave

<u>Disability Leave</u>

If you are disabled and receiving Long-Term Disability (LTD) income benefits from a program to which the Company contributes, the Plan coverage that was in effect at the time your disability began will continue for up to twenty-four (24) months from the initial date of your receipt of LTD benefits. During the disability period, you are responsible for the payment of any required premiums.

Coverage will end upon the earlier of:

- the date any required contributions are not made,
- the date you stop receiving disability benefits under the Company's LTD program,
- the date you retire, or

- the expiration of the applicable twenty-four (24) month period described above.

Note, if, prior to January 1, 2018, you became disabled and were receiving LTD income benefits from a program to which the Company contributes, your benefit continuation period for this purpose will be governed by the terms of the Plan in effect on December 31, 2017.

Personal Leave of Absence

You may remain eligible for coverage under the Plan during an approved personal leave of absence. During the leave, you are responsible for arranging for the payment of premiums due.

Coverage will end upon the earlier of:

- the date any required contributions are not made, or
- the expiration of the leave or, if earlier, twenty-four months (unless you return to regular, full-time employment prior to such dates).

Family and Medical Leave

Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993, as amended. During any leave taken under the Family and Medical Leave Act, your coverage will continue under the same conditions as coverage would have been provided if you had been continuously employed during the entire leave period.

Military Leave

USERRA (Uniformed Services Employment and Reemployment Rights Act of 1994, as amended) provides a way for you and your eligible Dependents who would otherwise lose group health plan coverage as a result of a leave of absence for your duty in the uniformed services, to continue coverage for a period of time. If you are on a military leave of absence, the maximum period of coverage for you and your Dependents would extend from the date on which your leave of absence begins to the earlier of:

- twenty-four (24) months after that date, or
- the day after the date on which you fail to apply for or return to a position of employment with Andeavor, or as determined under Section 4312(3) of the Act.

If you elect to continue coverage, you may be required to pay the full cost of coverage (employer and employee portions) plus a 2% administration fee. Plan exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Under circumstances in which both COBRA and USERRA apply, an election for continuation coverage under USERRA will be an election to take concurrent COBRA and USERRA coverage for the employee and any covered Dependents who elect USERRA, unless the employee specifically elects COBRA-only or USERRA-only.

Terms of Coverage

Continued coverage during your leave of absence is subject to the same rules that would apply if you were an active employee. If benefits change under the Plan, such changes will apply equally to you. If coverage terminates during your leave of absence, you may be able to elect to continue coverage under COBRA (see **Continuation of Coverage**, below).

Payment of Contributions While on Leave

If you are not receiving a paycheck, you must make the required contributions at the time prescribed by the Plan Administrator. Contact your benefits administrator to set up payment arrangements.

If payments are not made at the time prescribed (or within the 30-day grace period), coverage may be terminated provide you have received written notice of such termination of coverage.

However, if coverage is terminated during your FMLA leave due to non-payment of contributions, all previously owed contributions for the period of active coverage will be deducted from your paycheck and you will not be eligible to enroll in the Plan until the next annual enrollment period.

TERMINATION OF COVERAGE

Unless you are eligible for COBRA continuation coverage, your coverage under the Plan will end upon the earliest to occur of the following:

- The date your employment is terminated (including as a result of a layoff or your failure to return to regular, full-time employment following expiration of a FMLA or USERRA leave of absence),
- The date your regularly scheduled hours are reduced to less than 30 hours per week,
- With respect to eligibility for coverage based on your receipt of LTD benefits, the date you stop receiving disability benefits under the Company's LTD program or, if earlier, the expiration of the applicable twenty-four (24) month period described above,
- Your death,
- The date you no longer meet the eligibility requirements under the Plan,
- The date you fail to pay the required premiums/contributions toward coverage under the Plan, and
- The date the Company discontinues the Plan.

**Note, dental care benefits are not included as part of Andeavor's Post-Retirement Group Health Plan coverage.

Unless your Dependent is eligible to continue coverage as explained under **Continuation of Coverage,** see below, coverage for your Dependent(s) ends if:

- you fail to make required contributions for your Dependent's coverage;
- your own coverage ends for any of the reasons above;
- your Dependent no longer meets the eligibility requirements for coverage under the Plan; or
- your Dependent becomes an employee eligible for benefits under the Plan.

If you are covering a Domestic Partner and your Domestic Partner's Children under the Plan, they will no longer be considered eligible Dependents and coverage will end on the earlier of:

- the date the Plan no longer provides for such coverage; or
- the date your Domestic Partnership ends.; or
- For the Domestic Partner's Child, the date such Child no longer meets the Plan's definition of "Dependent" with respect to the Domestic Partner.

However, your Domestic Partner and your Domestic Partner's Children may be eligible to elect continuation coverage.

COBRA COVERAGE CONTINUATION

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"), you and your eligible Dependents that lose group health plan coverage may continue coverage under the Plan for a period of time. COBRA continuation rights are available only if coverage is lost due to certain "qualifying events" (see **COBRA Qualifying Events** below). Your covered Domestic Partner and their covered Children will be eligible for a continuation of benefit provision similar to COBRA if they lose coverage under the Plan due to a qualifying event.

COBRA continuation coverage with respect to the Plan is the same coverage that the Plan gives to other participants or Dependents who are covered under the same option under the Plan and who are not receiving continuation coverage. Each person who elects COBRA continuation coverage will have the same rights under the Plan as other participants or Dependents covered under the Plan, including special enrollment rights and the right to add or change coverage during the open enrollment period.

COBRA Qualifying Events

Employees

As an employee, you will be eligible for COBRA continuation coverage if you lose coverage due to:

- termination of employment, for reasons other than gross misconduct; or

- a reduction in hours of employment that results in loss of coverage (including upon expiration of an applicable disability leave continuation period).

Covered Dependents

Your covered Dependents will be eligible for COBRA continuation coverage if they lose coverage due to:

- your death;
- your termination of employment, for reasons other than gross misconduct;
- a reduction in your hours of employment;
- your divorce or legal separation; or
- your Dependent Child no longer meeting the definition of a Dependent Child.

It is you or your covered Dependent's responsibility to notify your benefits administrator (see **Contacts**) within 60 days of a qualifying event if your covered spouse or Dependent Child(ren) lose coverage under this Plan due to:

- divorce or legal separation; or
- your Dependent's loss of eligibility under the Plan.

*Additional notifications are required in connection with extensions of COBRA continuation due to disability. See below for details.

If you notify your benefits administrator more than 60 days after the qualifying event, your covered Dependents may not be entitled to elect COBRA continuation coverage. Please note that you must provide notification in writing within 31 days (not 60) to comply with rules for changing your coverage elections during the Plan Year (see Changing Your Coverage).

Length of COBRA Coverage

COBRA is a temporary continuation of coverage. Depending on the qualifying event, coverage may be continued from the date coverage would otherwise end, as follows:

COBRA Qualifying Event	Maximum Amount of Time Coverage May Continue Under COBRA	
	For You	For Your Qualified Beneficiary
You terminate employment (other than for gross misconduct) **OR** **Your hours of employment are reduced, resulting in a loss of coverage**	18 months (may be extended due to disability — see below)	18 months (may be extended due to disability or for a second qualifying event — see below)
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (special rules apply)
You divorce or legally separate	N/A	36 months
Your Child no longer meets the definition of a Dependent Child	N/A	36 months

Concurrent USERRA Coverage

Under circumstances in which both COBRA and USERRA apply, an election for continuation coverage under COBRA will be an election to take concurrent COBRA and USERRA coverage for the employee and any covered Dependents who elect COBRA, unless the employee specifically elects COBRA-only or USERRA-only.

Extension of COBRA Coverage Due to Disability

You and each qualified beneficiary may be eligible to extend your 18-month COBRA period to a total of 29 months if a qualified beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage.

- To receive the extension, you must provide notice of the disability determination to your benefit administrator (see **Contacts**) within 60 days of the date of the Social Security Administration's determination and before the end of the initial 18-month continuation period.
- If the qualified beneficiary is later determined to not be disabled, you must notify your benefit administrator within 30 days of the Social Security Administration's determination. If the date of the determination is after the original 18-month COBRA period, your COBRA benefits will cease effective as of the date of determination.

Extension of Continuation Coverage Due to a Second Qualifying Event

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours of employment, up to an 18-month extension of coverage may be available to your qualified beneficiaries if a second qualifying event occurs during the first 18 months of COBRA coverage (or within the first 29 months in the case of a disability).

A second qualifying event includes:

- your death;
- your divorce or legal separation;
- your entitlement to Medicare; or
- your Dependent Child's eligibility for coverage ends.

The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Note, however, if your first qualifying event was your entitlement to Medicare, the maximum amount of continuation coverage available for your spouse and Dependents when a second qualifying event occurs is 36 months from the date on which you became entitled to Medicare.

You must provide written notification to your benefit administrator within 60 days after the second qualifying event occurs (see **Contacts**).

Electing COBRA Coverage

Upon notification to your benefit administrator of a COBRA qualifying event, COBRA election notices are prepared and mailed to your home address. You and/or your covered Dependent(s) will have 60 days from the date coverage would be lost due to a qualifying event (or the date you are notified of your right to continue coverage, if later) to elect COBRA continuation coverage.

You and each of your covered Dependents may independently elect COBRA coverage. You or your spouse, however, may elect COBRA coverage on behalf of all the covered Children who are under age 18.

If you choose to waive coverage during the 60-day election period, you may revoke the waiver in writing at any time before the 60-day period ends, and you will be entitled to COBRA continuation coverage as long as you and/or your covered Dependent(s) meet all of the other conditions for continuation of coverage and the required contributions are paid on a timely basis.

If you do not elect continuation coverage, your benefits will terminate in accordance with the terms of the Plan.

Paying for COBRA Coverage

In order to continue your coverage under COBRA, you will be required to pay the **full** cost of coverage (your premium and the Company's contribution), plus a 2% COBRA administration fee. If you or your qualified beneficiaries is receiving the additional 11 months of COBRA coverage because of disability (**see Extension of COBRA Coverage Due to Disability)**, the cost for each of those additional 11 months is 150% of the full monthly cost.

- The first payment of premiums will be due within 45 days of the date you elect to continue coverage.
- Premiums for coverage will be retroactive to the date you and/or your qualified beneficiaries lost eligibility due to the qualifying event.
- Claims for reimbursement will not be processed and paid until you have elected COBRA continuation coverage and the first contribution payment has been timely paid and received.

  To continue COBRA coverage, you will need to make ongoing contribution payments. Each contribution payment is due on the first day of the month for which COBRA coverage is to be provided. If payment is not received by the 30th day following such due date, your COBRA coverage may be terminated.

If you do not make the full payment for any coverage period, COBRA coverage will be terminated retroactively to the end of the month for which the last full payment was made, and you will lose all rights to further COBRA continuation coverage under the applicable COBRA plan, except as otherwise prohibited by applicable law. Once coverage is terminated, it cannot be reinstated.

Adding Dependents During a COBRA Continuation Period

If through birth, adoption, marriage or completion of six months in a new domestic partnership, you acquire a new Dependent during the continuation period, your Dependent can be added to your coverage for the remainder of the continuation period if:

- he or she meets the definition of an eligible Dependent (see **Dependent Eligibility**);
- you notify your benefit administrator of your new Dependent within 31 days of eligibility (see **Contacts**); and
- you pay any additional contributions for continuation coverage on a timely basis.

You must notify your benefit administrator if, at any time during your continuation period, any of your qualified beneficiaries cease to meet the eligibility requirements for coverage.

Termination of COBRA Coverage

COBRA continuation coverage will end when the first of the following occurs:

- the Company no longer provides group health plan coverage to its employees;
- you or your qualified beneficiaries do not pay the premium on or before its due date;
- you and/or your qualified beneficiaries' applicable COBRA continuation period ends;
- you become entitled to Medicare following an election of COBRA coverage;
- you or your qualified beneficiaries becomes covered under another group health plan following an election of COBRA coverage. However, if the other plan contains an exclusion or limitation with respect to any preexisting conditions, you or your qualified beneficiaries to whom such an exclusion or limitation applies may continue COBRA coverage under the Plan; or
- in the case of extended coverage due to disability (see **Extension of COBRA Coverage Due to Disability**), the disabled individual is no longer determined to be disabled under the Social Security Act.

You and/or your qualified beneficiaries must notify your benefit administrator if, after electing COBRA, you become entitled to Medicare, become covered under other group health plan coverage or are determined by the Social Security Administration to no longer be disabled.

GENERAL CLAIMS PROCEDURE

Filing Claims for Benefits

Claims for Benefits must be filed on a standard Claim Form that is available in most Provider offices. Contract Providers will fill out and submit your claims paperwork for you. If you receive Emergency Dental Services or covered Specialized Services from a non-Contract Provider, you must submit a claim directly to us. Some non-Contract Providers may fill out and submit your claim upon your request. 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 Insurance Company
P.O Box 1803
Alpharetta, GA 30023
(800) 422-4234

To constitute a claim for purposes of this Plan, the claim must identify: (1) the claimant, (2) a specific medical condition or treatment to which the claim relates, and (3) a specific treatment, service, or product for which approval is requested and must be received by a person or organizational unit that customarily is responsible for handling benefit matters.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted to the Claim Administrator within three hundred sixty-five (365) days (or, with respect to Emergency Dental Services or covered Specialized Services, within ninety (90) days) of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after such date will not be considered for payment of benefits under the Plan, unless required by state or federal law.

Authorized Representative

A claim may be filed by you or your authorized representative (the “claimant”). Such authorization must be provided in the form and manner prescribed under the Plan; provided, however, a health care professional with knowledge of the Participant's medical condition shall be permitted to act as the Participant's authorized representative hereunder without submitting evidence of his or her authority to act as such.

Payment and Assignment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided. In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan’s responsibility to the Employee or Dependents for benefits available under the Plan.

Overpayment of Benefits

The Claim Administrator for the Plan may deduct from its benefit payment any amounts it is owed by the participant of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to the Plan, will be considered in satisfaction of its obligations to you under the Plan.

Notice of Decision

Depending on the type of claim, different rules may apply. As a general matter, however, only post-service claims will be submitted under this Plan.

In the case of a Post-Service Claim, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time after receipt of the claim by the Plan, but not later than thirty (30) days after receipt of the claim.

The Claims Administrator may extend this period, one time, for a period of up to fifteen (15) days; provided that the Claims Administrator: (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the additional information required. You will be given at least forty-five (45) days from receipt of such notice to provide the specified information. If such extension is necessary, the period for making the claim determination

shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Written notice of the adverse benefit determination shall be delivered or mailed to the claimant by certified or registered mail to the claimant's last known address and shall contain the following:

- The specific reason or reasons for the denial of benefits;
- A specific reference to the pertinent provisions of the Plan upon which the denial is based;
- A description of any additional material or information which is necessary;
- An explanation of the review procedures and the time limits that apply; and
- Such other information as may be required by applicable law.

Internal Appeals

A participant who feels he or she is being denied any benefit or right provided under the Plan shall have the right to file an appeal with the Claims Administrator within 180 days after receipt of notice of an adverse benefit determination as provided above. Such claim may be filed directly by you or your authorized representative. All such appeals shall be submitted in the form and manner prescribed by the Claims Administrator, and shall be considered filed on the date the claim is received by the Claims Administrator.

Appeal Standards

The Claims Administrator shall provide the claimant the opportunity to submit written comments, documents, records, and other information related to the claim. The Claims Administrator will give the claimant and/or authorized representative reasonable access to all pertinent documents necessary for the preparation of the appeal. In conducting its review, the Claims Administrator shall consider any written statement or other evidence presented by the claimant in support of the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Claims Administrator will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination or a subordinate of such individual. Where applicable, the Claims Administrator shall consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the claim, and shall provide for the claimant the identification of any such professional, without regard to whether the advice was relied upon in making the benefit determination.

Notice on Appeal

Within a reasonable period of time, but not more than 60 days, after receipt by the Claims Administrator of a request for appeal, the Claims Administrator shall notify the claimant of its decision by delivery or by certified or registered mail to the claimant's last known address

The Claims Administrator may extend this period, one time, for a period of up to sixty (60) days; provided that the Claims Administrator: (1) determines that such an extension is necessary due to special circumstances and (2) notifies you before the end of the initial 60-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Written notice of the adverse benefit determination shall be delivered or mailed to the claimant by certified or registered mail to the claimant's last known address. The notice of the decision on appeal shall include the specific reasons for the decision, references to all relevant Plan provisions on which the decision was based, your right to file a claim under ERISA, and any other information as may be required by law.

Exhaustion of Claims Procedures

The decision of the Claims Administrator shall be final and conclusive.

You must exhaust the internal claims procedures provided hereunder prior to pursuing any other legal or equitable remedy. No legal action may be brought after three (3) years from the date the claimant's participation in the Plan ends or, if earlier, the date the claim is denied following exhaustion of the appeal procedures outlined above.

ADDITIONAL INFORMATION

As a participant or beneficiary under this Plan, you have certain rights and protections as more fully described in **Your Rights Under ERISA**. Other important information about the Plan is provided below:

Plan Name	The Andeavor DeltaCare DHMO Dental Plan (a constituent benefit program of the Andeavor Omnibus Group Welfare Benefits Plan)
Type of Plan	Welfare benefit plan
Plan Sponsor	Andeavor, 19100 Ridgewood Parkway San Antonio, TX 78259 (210) 828-8484
Plan Sponsor's Employer Identification Number	95-0862768
Plan Administrator	Andeavor Employee Benefits Committee 19100 Ridgewood Parkway San Antonio, TX 78259 (866) 688-5465, press options 3, then option 5
Plan Number	501
Plan Year	January 1 – December 31
Plan Funding	The Plan is funded by employee and employer contributions
Type of Administration	Insurance contract with Delta Dental Insurance Company
Plan Insurer	Delta Dental Insurance Company
Claims Administrator	Delta Dental Insurance Company P.O Box 1803 Alpharetta, GA 30023 (800) 422-4234
Agent for Service of Legal Process	Andeavor, c/o General Counsel 19100 Ridgewood Parkway, San Antonio, TX 78259 In addition, service of legal process may be made upon the Plan Administrator.

CONTACTS

The following contacts are available to answer questions and provide information about the Plan.

Benefits Administrator

Legacy Tesoro Employees:

Andeavor Benefits Center
P.O. Box 3129
Bellaire, TX 77402
www.andeavor.com/benefits
(866) 787-6314

Legacy Western Employees:

Benefits Department
1250 W. Washington Street
Tempe, AZ 85281
www.andeavor.com/benefits2018
(844) 224-4996

Andeavor Benefits Department

Legacy Tesoro Employees:

Corporate Benefits Department
19100 Ridgewood Parkway, TX1-055
San Antonio, TX 78259
satbenefits@andeavor.com
(866) 688-5465

Legacy Western Employees:

Benefits Department
1250 W. Washington Street
Tempe, AZ 85281
Benefits.department@andeavor.com
(844) 224-4996

ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and 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 written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 each participant with a copy of this summary annual report.

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 plans. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, 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.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of 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 the Plan and do not receive them within 30 days, you may file suit in a 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court if you have exhausted the Plan’s claims procedures. In addition, if you disagree with a Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, as applicable, you may file suit in 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 any questions about your Plan, you should contact the Plan Administrator. If you have any 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 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.

FUTURE OF THE PLAN

Andeavor expects to continue the Plan indefinitely, but reserves the right to amend or discontinue any or all parts of the Plan at any time and for any reason. In no event will you become entitled to any vested rights under this Plan.

INTERPRETATION OF THE PLAN

Only the Plan Administrator, or its delegate, is authorized to make administrative interpretations of the Plan and will do so only in writing. You should not rely on any representation, whether oral or in writing, which another person may make concerning provisions of the Plan and your entitlements under them. The Plan Insurer has authority to administer claims and to manage and interpret the Group Policy, consistent with the provisions of the Plan.