

Mission Healthcare

Contract Period: February 1, 2014 through August 30, 2014

| BENEFIT SUMMARY- Plan #1 | | | |
|--|--|----------------------|----------------|
| | Delta Dental PPO | Delta Dental Premier | Out-of-Network |
| Diagnostic & Preventive | 100% | 100% | 100% |
| Basic Restorative Services | 80% | 80% | 80% |
| Endodontics | 50% | 50% | 50% |
| Periodontics | 80% | 80% | 80% |
| Oral Surgery | 80% | 80% | 80% |
| Major Restorative | 50% | 50% | 50% |
| Prosthetic Repairs/Adjustments | 50% | 50% | 50% |
| Prosthetics | 50% | 50% | 50% |
| Orthodontics (Per covered dependent child) | 50% | 50% | 50% |
| Annual/Individual Deductible | \$25 | \$25 | \$25 |
| Annual Maximum | \$1,000 | \$1,000 | \$1,000 |
| Lifetime Orthodontic Maximum | \$1,000 | \$1,000 | \$1,000 |
| Deductible Waived for: | Diagnostic & Preventive and Orthodontic Services | | |
| Sealants | Covered under Basic Restorative | | |
| Waiting Periods | As per your current plan | | |
| Product | Comprehensive Enhanced | | |
| Networks | Delta Dental PPO / Delta Dental Premier | | |
| Out-of-Network Reimbursement Level | As per your current plan | | |

| PROJECTED CLAIMS AND ASO FEE INFORMATION | | | |
|--|-------------------|--------------------|--------------------|
| Administrative Fee (Percentage of Claims): | 12.3% | | |
| Projected Claims: | \$140,393 | | |
| Annual Plan Cost: | \$157,660 | | |
| | Equivalency Rates | Current Enrollment | Monthly Cost |
| Employee | \$24.49 | 142 | \$3,477.58 |
| Employee & Spouse | \$46.81 | 37 | \$1,731.97 |
| Employee & Child(ren) | \$60.20 | 33 | \$1,986.60 |
| Family | \$82.53 | 72 | \$5,942.16 |
| Total | | 284 | \$13,138.31 |
| Rate Guarantee Period | 7 Months | | |

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RATING ASSUMPTIONS

General Provisions:

The quoted plan design is a summary of benefits only. Please refer to the plan description for further details.

This quote is net of commission.

The ASO contract assumes the group will submit to Delta Dental each week an amount equal to paid claims from the previous week plus the amount for administrative fees.

This quote assumes a Weekly ACH arrangement.

The quoted rates include the cost for printing and mailing standard ID cards and the Summary of Plan Description (SPD) to the employee home address.

This quote is valid for 90 days following the quote date.

Participation Requirements:

This quote is based on current enrollment in the plan. Please refer to the enrollment assumptions outlined in the rate information section. If the actual number of enrolled employees deviates from the assumed enrollment by 10% or more, Delta Dental reserves the right to re-evaluate the rates. Minimum participation for Self Insured Funding is 100 enrolled employees, if enrollment goes below 100 lives, Delta Dental reserves the right to offer alternate funding, rating and plan options or terminate the contract upon renewal.

This proposal reflects subgroups 0002 & 0003 leaving group #790. There are no benefit changes.