SUMMARY PLAN DESCRIPTION FOR THE

DENTAL BENEFITS UNDER THE HELMERICH & PAYNE, INC. MEDICAL AND DENTAL PLAN

Effective January 1, 2023

ERISA SUMMARY PLAN DESCRIPTION DISCLOSURES

This Section, along with the accompanying booklet "Summary of Dental Plan Benefits," is intended to constitute the Summary Plan Description for the group dental benefits under the Plan. Defined terms which are used in this Section and which are not defined herein will have the meaning set forth in the accompanying booklet.

ERISA INFORMATION

PLAN NAME, NUMBER AND TYPE:

Plan Name – Helmerich & Payne, Inc. Medical and Dental Plan (previously known as the Helmerich & Payne, Inc. Employees' Benefit Program) (the "Plan")

Plan Number – 501

Plan Type – Group Health Plan (Employee Welfare Benefit Plan) providing dental benefits.

NAME, ADDRESS, TELEPHONE NUMBER AND TAX IDENTIFICATION NUMBER OF PLAN SPONSOR AND PLAN ADMINISTRATOR:

Helmerich & Payne, Inc.
1437 S. Boulder Ave.
Tulsa, OK 74119
Telephone: (918) 742-5531
EIN: 73-0678979

PARTICIPATING EMPLOYERS:

The Employer is Helmerich & Payne, Inc., 1437 S. Boulder Ave., Tulsa, Oklahoma 74119. Any subsidiaries or affiliates of Helmerich & Payne, Inc., which adopt the Plan, are also eligible. A complete updated list of employers participating in the Plan may be obtained upon written request to the Plan Administrator and is also available in the office of the Plan Administrator for examination.

NAME AND ADDRESS OF THE AGENT FOR SERVICE OF LEGAL PROCESS:

The Corporation Company
1833 S. Morgan Rd.
Oklahoma City, OK 73128

SOURCE OF CONTRIBUTIONS AND PLAN FUNDING:

The Plan is self-insured by the Employer and the Participants. Contributions are determined by the Plan Sponsor and include Employer contributions and contributions by Participants.

PLAN YEAR:

The Plan year for purposes of maintaining the Plan's records is the annual period from January 1 through December 31.

TYPE OF ADMINISTRATION:

The Plan is self-administered by the Plan Administrator. However, the Plan Administrator has by contract obtained the performance of certain administrative functions such as the review, processing and payment of claims from the Claims Administrator. The name, address and telephone number of the Claims Administrator is:

Delta Dental of Oklahoma
16 NW 63rd, Suite 201
Oklahoma City, OK 73116
1-800-552-0188

The Claims Administrator provides claims administration for the Plan and does **not** insure or otherwise guarantee benefits.

PLAN ADMINISTRATOR'S POWERS AND DUTIES:

The Plan shall be administered by a Plan Administrator. The Plan Administrator may delegate such duties and responsibilities which in the opinion of the Plan Administrator can be properly supervised.

The Plan Administrator shall have such duties and powers as may be necessary to discharge the duties of the Plan Administrator hereunder, including, but not by way of limitation, the following:

1) Full discretionary authority to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder and to resolve any ambiguities with respect to any terms and provisions of the Plan as written or as applied in the operation of the Plan;

2) To prescribe procedures to be followed in an application for benefits;

3) To prepare and distribute information explaining the Plan in such a manner as the Plan Administrator determines to be appropriate;

4) To receive from the Employer and Participants such information as shall be necessary for the proper administration of the Plan;

5) To furnish the Employer and Participants, upon request, such annual reports as are reasonable and appropriate with respect to the administration of the Plan;

6) To receive, review and keep on file (when the Plan Administrator deems to be convenient or proper) reports of financial conditions and receipts and disbursements;

7) To appoint or employ such agents, subcontractors, and representatives to assist in the administration of the Plan and such other agents, including claims administrators, accountants, legal and actuarial counsel.

The Plan Administrator shall exercise such authority and responsibility that is appropriate in the opinion of the Plan Administrator in order to comply with ERISA and governmental regulations issued thereunder.

The Plan Administrator may adopt such rules as the Plan Administrator deems necessary, desirable, or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants and beneficiaries in similar circumstances. When making a determination of calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant.

The Plan Administrator may act in writing and keep a record of all its acts. All decisions of the Plan Administrator shall be made by the Plan Administrator or by the duly authorized agents of the Plan Administrator.

DESCRIPTION OF BENEFITS:

The Plan provides Participants with the payment of or reimbursement of certain eligible dental expenses, which are described in detail in the booklet entitled "Summary of Dental Plan Benefits."

PROVISIONS LIMITING BENEFITS (Summary Only):

There are provisions which may result in ineligibility or in denial, loss, suspension, offset, reduction or recovery of benefits that a Participant might reasonably expect the Plan to provide. These provisions include, but are not limited to:

1) deductibles, maximum lifetime limits, and maximum annual limits;
2) exclusions and limitations;
3) subrogation, reimbursement and third party recovery rights of the Plan;
4) coordination of benefits when a Participant is enrolled in more than one plan and this Plan is not the primary plan;
5) effects of Medicare;
6) reductions due to charges that exceed usual and customary allowances;
7) reductions or denials due to services that are not generally accepted as appropriate, and/or which are not medically necessary, and/or which are considered as overutilization;
8) treatment, services and supplies that are excluded from coverage by the Plan, whether or not medically necessary;
9) non-compliance with the Plan's certification requirements;
10) non-compliance with the Plan's claims filing deadline.

These provisions are described in greater detail throughout the accompanying booklet entitled "Summary of Dental Plan Benefits."

PLAN AMENDMENT AND TERMINATION:

The Plan may be changed and/or benefits may be reduced or eliminated by execution of an amendment to the Plan by the Plan Sponsor. The Plan Sponsor shall have the right to amend the Plan, at any time and from time to time, to any extent deemed advisable in its discretion, without prior notice to or consent of any Participant or of any person entitled to receive payment of benefits under the Plan. Any such amendment shall be set forth in a written instrument which is designated as an amendment to the Plan and executed by the Plan Sponsor.

All changes to the Plan shall become effective as of a date established by the Plan Sponsor, and thereupon all Participants, whether or not they became Participants prior to such amendment, shall be bound thereby.

The Plan shall continue in full force and effect unless and until the Plan Sponsor terminates the Plan. Although the Plan Sponsor has the intention and expectation that the Plan will be maintained indefinitely, the Plan Sponsor is not and shall not be under any obligation or liability whatsoever to continue or maintain the Plan for any given length of time. The Plan Sponsor, in its sole and absolute discretion, may discontinue or terminate the Plan at any time by providing written notice to the covered employees. Such termination will become effective on the date set forth in such written notice.

The Plan Sponsor reserves the right to terminate, amend or modify the Plan or any benefit under the Plan, in whole or in part, at any time. The Employee Benefits Committee of the Plan Sponsor is authorized to amend, modify or terminate this Plan.

COST SHARING:

Employee and/or dependent coverage may be conditioned upon whether required premium contributions have been made. Premium contributions, if required, are established by the Plan Administrator in its sole discretion and are subject to change from time to time. A current summary of these premium amounts may be obtained from the Employer at any time upon request. Additional cost-sharing provisions for which the Participant may be responsible include, but are not limited to, deductibles, copays/coinsurance, out-of-pocket expenses, penalties for non-compliance with the Plan's certification requirements, and non-covered expenses.

ELIGIBILITY REQUIREMENTS

A. EMPLOYEE ELIGIBILITY REQUIREMENTS

All full-time regular employees and part-time employees working a minimum of 20 hours per week are eligible to participate in the Plan on the first day of the month coinciding with or next following 2 months of regular employment.

Persons classified by the Employer as independent contractors, temporary employees, seasonal employees or leased employees are not eligible for coverage under the Plan even if such persons are subsequently reclassified as an employee by a governmental agency or court of law.

Enrollment is not mandatory; however, eligible employees and dependents that enroll agree to remain enrolled until the next plan anniversary date, except in the event of a qualifying change in status.

B. DEPENDENT ELIGIBILITY REQUIREMENTS

An eligible dependent includes the eligible employee's spouse to whom the eligible employee is legally married unless divorced or legally separated (documentation proving a legal marital relationship may be required), and all children of the eligible employee under 26 years of age. For this purpose, "children" mean the employee's natural children, legally adopted children (including children placed for adoption for whom legal adoption proceedings have been started), step-children, alternate recipients under Qualified Medical Child Support Orders, and any other child for whom the eligible Employee along with the employee's spouse, if applicable, has obtained sole legal guardianship and who is living with the eligible Employee in a regular parent-child relationship. Foster children are not considered as eligible dependent children under the Plan. A grandchild who resides in the Employee's household is not considered as an eligible dependent child under the Plan unless the Employee along with the employee's spouse, if applicable, has been appointed by a court as sole legal guardian for the grandchild or has adopted the grandchild, and the grandchild is living with the eligible Employee in a regular parent-child relationship.

It is the responsibility of the Employee to notify the Plan Administrator within 45 days of a dependent's loss of eligibility.

A dependent child, as defined above, is eligible for coverage until midnight of the last day of the month on which such dependent child attains age 26.

An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap upon attaining the age limit requirement may be considered as an eligible dependent while remaining incapacitated and continuously covered under the Plan provided he or she is chiefly dependent on the eligible employee for support. To continue a child under this provision, proof of incapacity must be submitted within 30 days of the child's attainment of the age limit requirement. Proof of continuing incapacity may be required by the Plan Administrator from time to time, but not more frequently than annually after the two-year period following the attainment of age 26 When a covered dependent is eligible for Medicare, Medicare will pay primary, secondary or last to the extent stated in federal law.

Any person who is covered as an eligible employee shall not be considered as an eligible dependent under the Plan. If two employees work for the same company and one spouse is covered under the Plan as the other's dependent, he shall not also be covered as an employee. Also, if both parents are employed at the same company, children will be covered as dependents of one parent only.

An employee must be covered under the Plan in order to cover any eligible dependents under the Plan.

C. PROOF OF DEPENDENT ELIGIBILITY

The Plan Sponsor retains the right to request whatever documentation is necessary to confirm that a dependent meets the Plan's dependent eligibility requirements.

In all cases, we may require proof of dependency (and, in the case of an adopted Child or a Child placed with you for adoption, proof of the adoption or placement for adoption) as a condition to enrolling an eligible Dependent or retaining an enrolled Dependent on the Plan. If we ask you for documentation to prove the eligibility status of one or more persons you have enrolled or are seeking to enroll as a Dependent under the Plan, and you fail to supply the requested documentation within the time prescribed by the Plan, the Plan may in its discretion decline to enroll the person(s) or, if the person(s) is/are already enrolled, disenroll them, and in the event of a disenrollment, may in the Plan's discretion disenroll the person(s) retroactively. You may treat any such adverse action as adverse action with respect to a claim, and appeal the Plan's action under the Plan's claims and appeals provisions.

D. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Dental coverage shall be provided to the child of an eligible employee who is the subject of a QMCSO in accordance with the Omnibus Budget Reconciliation Act of 1993, as amended, or who is the subject of a National Medical Support Notice (NMSN) that is deemed to operate as a QMCSO.

The term “Alternate Recipient” means any child of an eligible employee who is recognized under a QMCSO as having a right to enrollment under a group dental plan.

A QMCSO is a court order that usually results from a divorce that provides for child support or dental care coverage for the child of an eligible employee. The court order creates or recognizes the existence of the alternate recipient’s right to, or assigns to the alternate recipient the right to, receive benefits for which the employee is eligible under the Plan. The QMCSO must specify:

1) the name and last known mailing address of the employee required to pay for the coverage and the name and mailing address of each alternate recipient;
2) a reasonable description of the type of coverage to be provided by the Plan or the manner in which such coverage is to be determined;
3) each Plan to which the order applies; and
4) the period for which coverage must be provided.

The court order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

When a Plan Administrator receives a medical child support order, the following steps must be taken. The Plan Administrator must:

1) notify both the eligible employee and each alternate recipient of receipt of the order;
2) furnish an explanation of the Plan’s procedures for determining whether the court order is a QMCSO;
3) determine if it is qualified; and

4) notify the eligible employee and each alternate recipient of the determination and, if the order is determined to be qualified, provide the alternate recipient with a full explanation of the benefits hereunder.

The Plan Administrator is responsible for deciding whether the court order satisfies the conditions of a QMCSO.

E. ENROLLMENT REQUIREMENTS FOR EMPLOYEES AND DEPENDENTS

Coverage does not become effective until the eligible employee completes an enrollment for himself and/or his eligible dependent(s). Eligible dependents enrolled after the effective date of the Plan will become covered on the same date as the eligible employee or the date the dependent is acquired, whichever is later. If the employee does not request enrollment for himself and/or his eligible dependent(s) by the deadline designated by the Plan Administrator after becoming eligible to enroll in the Plan, then the employee may only request enrollment for himself and/or his eligible dependent(s) as follows:

1) upon the occurrence of a "change in status" which means any of the following events:

   (a) change in employee's legal marital status including marriage, death of spouse, divorce, legal separation, or annulment;

   (b) change in employee's number of dependents, including birth of a child, adoption or placement for adoption of a child, or death of a child;

   (c) termination or commencement of employment by employee, his spouse or child;

   (d) change in work schedule of employee, his spouse or child, including a switch between part-time and full-time status, a strike or lockout, or commencement of or return from an unpaid leave of absence, an FMLA leave (as required by FMLA), or absence on account of being in "uniformed service" (as defined under USERRA);

   (e) a dependent satisfying or ceasing to satisfy the dependent eligibility requirements on account of attainment of a specified age; or

   (f) change in place of residence or work of employee, his spouse or dependent.

The employee must request enrollment for himself and/or such dependent(s) within a 45 day period that begins on the date of the change in status event, provided that the change in status results in a gain or loss of coverage and the request for enrollment corresponds with such gain or loss coverage. If enrollment is requested and the required documentation is received by the Plan Administrator within 45 days of the change in status event, the requested coverage will be effective as of the first day of the month following receipt of request.

The Plan Sponsor may administratively define other changes in circumstances as "changes in status" as long as any such definition is consistent with applicable laws, regulations, rulings and announcements of the Internal Revenue Service and is applicable to participants on a uniform, non-discriminatory basis.

2) as a result of a Qualified Medical Child Support Order (QMCSO) which requires the employee to provide health coverage for his child.

3) as a result of a significant change (increase or decrease) in cost or significant curtailment of coverage (with or without a loss of coverage) by an independent third-party provider, previously elected by the employee and/or his eligible dependent. The employee must request enrollment for himself and/or such dependent(s) within a 45-day period which begins on the date that the significant change in cost or significant curtailment of coverage occurs. If enrollment is requested and the required documentation is received by the Plan Administrator within 45 days of the change in cost or curtailment of coverage, the requested change in coverage will be effective as of the first day of the month following receipt of request.

4) as a result of termination of entitlement to Medicare and Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act that provides for the distribution of pediatric vaccines) provided that the employee requests enrollment for himself and/or such dependent(s) within a 45-day period which begins on the date that the termination of entitlement to Medicare or Medicaid occurs. If enrollment is requested and the required documentation is received by the Plan Administrator within 45 days of termination of entitlement to Medicare or Medicaid, the requested enrollment will be effective as of the first day of the month following receipt of request.

5) as a late entrant as defined by the Plan but **only** during an open enrollment period held once each year at a time established by the Plan Sponsor.

F. COVERAGE IN THE EVENT OF:

AUTHORIZED LEAVE OF ABSENCE: If a covered employee ceases to be actively at work on a full-time or part-time basis due to an authorized leave of absence, coverage may be continued at the option of the Plan Sponsor but not beyond the expiration of the authorized leave of absence, subject to the payment of any required contributions.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA): The Plan shall at all times comply with FMLA as outlined in the regulations issued by the Department of Labor. During any leave taken under the FMLA, the Employer will maintain coverage under the Plan on the same basis as coverage would have been provided if the employee had been continuously employed during the entire leave period subject to payment by the Employee of any required premiums.

LAPSE IN COVERAGE: For the purpose of coverage under the Plan, if a previously covered individual requests enrollment when there has been a lapse in coverage, the individual may **only** be enrolled as provided in **"Enrollment Requirements for Employees and Dependents"** (except in the case that COBRA has been elected and continued with no lapse in coverage).

REHIRED EMPLOYEES: For the purpose of coverage under the Plan, if an employee is rehired within 30 days following the day in which he terminated employment, the employee's previous election will be reinstated as if the termination never occurred. If the employee is rehired after 30 days, he will be entitled to make a new election when he becomes eligible again.

TRANSFERRED EMPLOYEES: If an employee transfers with no break in service from one wholly owned subsidiary that is covered under the Plan to another, the employee will be treated as if the transfer never occurred as far as coverage under the Plan is concerned (including, but not limited to, the waiting period, pre-existing condition exclusion period, applicable deductibles, out-of-pocket maximum, etc.).

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA): The Plan shall fully comply with USERRA. If any part of the Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent that there is no conflict with this Act.

G. TERMINATION WITH RESPECT TO EMPLOYEES

An employee's coverage under the Plan shall terminate on the earliest of the following dates:

1) the date of termination of the Plan;
2) in the event employment terminates (except as provided in **"Coverage in the Event of"**), the last day of the month for which the required contribution has been paid;
3) the last day of the month during which an employee ceases to meet the Plan's eligibility requirements for employees, except as provided in **"Coverage in the Event of"**;
4) the date all coverage or certain benefits are terminated for a particular class by modification of the Plan;
5) the last day of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due;
6) the date the Employer terminates coverage under the Plan;

See **CONTINUATION BENEFITS (COBRA)** for coverage continuation options.

H. TERMINATION WITH RESPECT TO DEPENDENTS

A dependent's coverage shall terminate under the Plan on the earliest of the following dates:

1) the date of termination of the Plan;
2) the date of termination of all coverage under the Plan with respect to dependents;
3) in the event a participant's employment terminates (except as provided in **"Coverage in the Event of"**), the last day of the period for which the required premium has been paid if the required premium for the next period is not paid when due;
4) the date the dependent becomes covered under the Plan as an employee;

5) the last day of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due;

6) the date the person ceases to meet the Plan's eligibility requirements for dependents, except as provided in **"Coverage in the Event of".**

It is the responsibility of the Employee or Qualified Beneficiary to notify the Plan Administrator within **60** days of the dependent's loss of eligibility as outlined above, in order to be offered Continuation of Coverage (COBRA). Additionally, it is the responsibility of the Employee to notify the Plan Administrator within **45** days of a loss of eligibility in order to terminate that dependent's benefit coverage and corresponding premium deductions.

See **CONTINUATION OF BENEFITS (COBRA)** for coverage continuation options.

SUBROGATION, THIRD PARTY RECOVERY AND REIMBURSEMENT

This provision shall apply to all benefits provided under any section of this Plan. This provision applies to all such benefits provided to (a) eligible employees and eligible dependents, COBRA beneficiaries, family members, and any other person who may recover on behalf of an eligible employee or eligible beneficiary including, but not limited to, the estate of a deceased eligible employee or deceased eligible beneficiary (collectively referred to as "Covered Person"); and, (b) as well as to all other agents, attorneys, representatives, and persons acting for, on behalf of, in concert with, or at the direction of a Covered Person (sometimes referred to as "Covered Person's Representatives") with respect to such benefits.

When this Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Illnesses caused by the act or omission of Another Party including a physician or other Provider for acts or omissions including but not limited to malpractice; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against Another Party for payment of the medical or other charges.

Defined Terms

"Another Party" shall mean any individual or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illnesses.

Another Party shall include the party or parties who caused the Injuries or Illness (first or third parties); the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; a medical malpractice or similar vaccination or a class action fund issue; and any other person, corporation or entity that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery" shall mean any and all money, fund, property, compensation, as well as all rights thereto, or damages paid or available to the Covered Person by Another Party through

insurance payments, settlement proceeds, first or third party payments or settlement proceeds, judgments, reimbursements or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness.

"Reimbursement" or "Reimburse" shall mean repayment to the Plan for dental or other benefits paid or payable toward care and treatment of the Illness or Injury and for any other expenses Incurred by the Plan in connection with benefits paid or payable.

"Subrogation" or "Subrogate" shall mean the Plan's right to pursue the Covered Person's claims against Another Party for medical or other charges paid by the Plan.

Conditions and Agreements

Benefits are payable only upon the Covered Person's acceptance of, and compliance with, the terms and conditions of this Plan. The Covered Person agrees that acceptance of benefits is constructive notice of this Section. As a condition to receiving benefits under this Plan, a Covered Person and each Other Obligated Party agree(s):

1) That the event a Covered Person under this Plan, and/or the Covered Person's Representatives receives any Recovery or other benefits arising out of any injury, accident, event, or incident for which the Covered Person has, may have, or asserts any claim or right to recovery under any theory of law or equity, tort, contract, statute, regulation, ordinance or otherwise against any other person, entity or source including, without limitation, any third party, insurer, insurance, and/or insurance coverage (e.g., uninsured and underinsured motorist coverage, personal injury coverage, medical payments coverage, workers' compensation, etc.), then any payment or payments made by the Plan to Covered Person for such benefits shall be made on the condition and with the agreement and understanding that the Plan will be reimbursed by Covered Person and Covered Person's Representatives to the extent of, but not to exceed the Recovery amount or amounts received by Covered Person from such Another Party or source by way of any agreement, settlement judgment or otherwise;

2) That the Plan shall be subrogated to all rights of Recovery the Covered Person has against Another Party potentially responsible for making any payment to Covered Person as a result of any injury, damage, loss or illness Covered Person sustains to the full extent of benefits provided or to be provided by the Plan to Covered Person or on Covered Person's behalf with respect to that illness, injury, damage or loss immediately upon the Plan's payment or provision of any benefits to Covered Person or on Covered Person's behalf. The Plan's recovery, subrogation and reimbursement rights provided herein exist even where a party allegedly at-fault or responsible for any loss, injury, damage or illness Covered Person sustains does not admit responsibility and regardless of the designation or characterization given to the funds Covered Person receives or agrees to be disbursed from that party or that party's representative;

3) To notify the Plan Administrator if a Covered Person has a potential right to receive payment from someone else; to promptly execute and deliver to the Plan Administrator, if requested by the Plan Administrator or its representatives, a Subrogation and Reimbursement agreement; and, to supply other reasonable information and assistance as requested by the Plan Administrator regarding the

claim or potential claim. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests either to pay, or to not pay, medical or other benefits for the Injuries or Illness before the Subrogation and Reimbursement agreement has been signed; however, in either event, the Plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section;

4) To serve as a constructive trustee, and to hold in constructive trust for the benefit of the Plan any Recovery from Another Party, and agrees not to dissipate any such Recovery without prior written consent of the Plan, or to otherwise prejudice or impair the Plan's first rights to any such Recovery, regardless of how such Recovery may be characterized, designated or allocated. The Covered Person agrees to hold, as trustee (or co-trustee) in trust for the benefit of the Plan all Recovery and funds the Covered Person receives in payment of or as compensation for any injury, illness, damage and loss the Covered Person sustained resulting from any such event, incident, accident, injury, illness and occurrence. Any such Recovery or funds received by, on behalf of, with the consent of, or at the direction of the Covered Person, or to which the Covered Person is entitled to receive or direct payment, or over which the Covered Person (or a Covered Person's Representatives) has, or exercises, any control, are deemed and shall be considered and treated as assets of the Plan. Failure to hold Recovery and such funds in trust or to abide by these Plan terms will be deemed a breach of the Covered Person's (or the Covered Person's Representative's) fiduciary duty to the Plan. The Plan has a right of subrogation or reimbursement before any Recovery and funds are paid to the Covered Person from the responsible source and no attorneys' fees or costs may be subtracted from such amount. The Plan may, at its option and sole discretion, exercise either its subrogation and/or its repayment rights. The Plan is also entitled to any Recovery and funds the Covered Person receives or is entitled to receive regardless of whether or not the payment represents full compensation to the Covered Person. The Plan expressly disclaims all make whole and common fund rules and doctrines and/or any other rule or doctrine that would impair or interfere with the Plan's rights herein. The Plan shall be entitled to an accounting from the Covered Person of all Recovery, funds and activities described herein;

5) To restore to the Plan any such benefit paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by Another Party;

6) To transfer title to the Plan for all benefits paid or payable as a result of said Illness or Injury. The Covered Person acknowledges that the Plan has a property interest in the Covered Person's Recovery, and that the Plan's Subrogation rights shall be considered a first priority claim to any Recovery, and shall be paid from any such Recovery before any other claims for the Covered Person as the result of the Illness or Injury, regardless of whether the Covered Person is made whole;

7) That the Plan is granted a first right and priority to, as well as a first lien against, 100% of any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the Plan in enforcing this provision; and such lien is an asset of the Plan. The Plan's first lien fully supersedes any right of first payment, or Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person is made whole or has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs;

8) That the Covered Person also agrees to notify the Plan of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation with respect to any matter for which the Covered Person has obtained or will obtain any benefits from the Plan. The Covered Person will be required to provide all information requested by the Plan or its representative regarding any such claim. The Covered Person also agrees to keep the Plan informed as to all facts and communications that might affect the Plan's rights;

9) To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for the injury or condition without obtaining the Plan's written approval;

10) To notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing a settlement agreement;

11) Without limiting the preceding, the Plan shall be subrogated to any and all claims, causes, action or rights that the Covered Person has or that may arise against Another Party for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized;

12) If the Covered Person (or guardian or estate) decides to pursue Another Party, the Covered Person agrees to include the Plan's Subrogation claim in that action and if there is failure to do so, the Plan will be legally presumed to be included in such action or Recovery;

13) In the event the Covered Person decides not to pursue Another Party, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claim in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. Such cooperation shall include a duty to provide information and execute and deliver any acknowledgement or other legal instrument documenting the Plan's Subrogation rights. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the Subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its Subrogation claim. This includes attempts by the Covered Person, (or by his or her attorney or other agent) to have payments characterized as non-medical in nature, or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives, or friends;

14) The Plan will not pay, offset any Reimbursement, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing. The Plan's right of first Reimbursement will not be reduced for any reason including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

15) The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan Document. The Plan Administrator may amend the Plan in its sole discretion at any time without notice. This right of Subrogation shall bind the Covered Person's guardian(s), estate, executor, personal representatives, and heirs; and

16) That the Plan Administrator may, in its sole discretion, require the Covered Person or his or her attorney to sign a subrogation/recovery agreement acknowledging and agreeing to the Plan's rights herein as a condition to any

payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, the Plan Administrator may, in its sole discretion, require that the attorney sign a subrogation/recovery agreement acknowledging and agreeing to the Plan's rights herein as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will not pay the Covered Person's attorney's fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Person's attorney's fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

An attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person's attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully Reimbursed.

In addition, the Plan may further require that (i) Covered Person utilizes the services of attorneys, representatives or agents who will execute a Reimbursement Agreement and who will not assert the make whole and common fund rule or doctrines, and (ii) Covered Person agrees to terminate any relationship with anyone who refuses to do so, or benefits will not be payable under the Plan in connection with that matter. The Plan is also entitled to receive and has priority to receive the first funds from payments received by Covered Person until the Plan has been repaid for all sums expended. Covered Person shall execute and deliver any instruments and documents reasonably requested by the Plan and shall do whatever is necessary to fully protect all the Plan's rights. Covered Person shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation, including, without limitation, any attempt by Covered Person or others to have payments characterized as non-medical in nature (e.g., for emotional distress, pain and suffering, embarrassment, mental anguish, loss of consortium, etc.) or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives or friends).

When the Covered Person is a Minor or is Deceased

The provisions of this section apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.

When a Covered Person Does Not Comply

1) If (a) the subrogation agreement is not properly executed and returned as provided for in this provision; (b) information and assistance is not provided to the Plan Administrator upon request; or, (c) any other provision or obligation of this

Article is not timely complied with, no benefits will be payable under the Plan with respect to costs Incurred in connection with such Illness or Injury.

2) If a Covered Person fails to Reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any Recovery received as provided in this Plan, or otherwise fails to comply with any other provision or obligation of this Article, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money or property from the Covered Person; and, the Plan shall be entitled to offset and apply any future benefits that might otherwise be due, for the benefit of the Covered Person, the Covered Person's family members, or any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the Plan's rights or interests against such reimbursements that should have been made to the Plan, as well as to suspend or terminate further coverage until such reimbursements are recovered by the Plan. This right of Reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

3) Additionally, the Covered Person shall be fully responsible for the actions of the Covered Person's Representatives, attorneys, agents, family members, and all persons acting for, on behalf of, in concert with, or at the direction of the Covered Person regarding the Plan or the Covered Person's obligations described herein. The Covered Person shall be responsible to ensure that such persons cooperate and comply with the Covered Person's obligations herein. If the Covered Person or the Covered Person's agents, attorneys or any other representative fails to fully cooperate with any subrogation, reimbursement, or repayment efforts, or directly or indirectly defeats, hinders, impedes, or interferes with any such efforts, the Covered Person shall be responsible to account for and pay to the Plan all attorney's fees and costs incurred by or on behalf of the Plan in connection with such efforts.

4) Additionally, the Plan may, in the discretion of its final decision maker, terminate the Covered Person's participation in the Plan or the participation of any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the Plan's rights or interest. In the event that any claim is made that any wording, term or provision set forth in this Subrogation and Right of Reimbursement portion of the Summary Plan Description is ambiguous or unclear, or if any questions arise concerning the meaning or intent of any of its terms, the Plan through its final decision maker, shall have the sole authority and discretion to construe, interpret and resolve all disputes regarding the interpretation of any such wording, term or provision.

5) If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, then the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action if the Plan prevails in that action. The Plan may offset any such fees and costs against covered Person's future medical expenses.

6) The Plan's subrogation and reimbursement rights described herein are essential to ensure the equitable character of the Plan and its financial soundness, and to ensure that funds are recouped and made available for the benefit of all Covered Persons under the Plan collectively.

CONTINUATION OF BENEFITS (COBRA)

Continuation of dental coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) shall not duplicate dental coverage continued under any state or federal law. This Section shall not extend coverage to eligible employees and dependents beyond the minimum required by Section 4980B of the Code and Sections 601 through 607 of ERISA, nor provide lesser coverage than required by such statutes.

A. DEFINITIONS

As used in this provision, the following terms shall mean:

"Entitlement to Medicare" or **"Entitled to Medicare"** means the covered employee has enrolled in either Medicare Part A or Part B.

"Qualified Beneficiary" means:

1) a covered employee, for termination or reduced hours;
2) a spouse or a dependent child who were covered dependents under the Plan on the day before the covered employee's Qualifying Event occurred;
3) a child who is born to a covered employee, or placed with a covered employee for adoption, during a period of COBRA continuation coverage.

"Qualifying Event" for a covered employee means a loss of coverage due to:

1) termination of employment for any reason other than gross misconduct;
2) reduction in hours of employment.

"Qualifying Event" for a covered dependent means a loss of coverage due to:

1) a covered employee's termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;
2) a covered employee's death;
3) a spouse divorce or legal separation from a covered employee;
4) a covered employee's entitlement to Medicare; or
5) a dependent child's loss of dependent status under the Plan.

Termination of employment following a Qualifying Event that is a reduction in hours of employment is not a second Qualifying Event entitling the Qualified Beneficiary to an extension of the period of COBRA coverage continuation.

"Timely contribution payment" means that the required contribution payment is made within the applicable time period. The applicable time period is 30 days of the due date. A timely contribution payment is deemed to have been made if it is not significantly less than the

amount due unless the Qualified Beneficiary is notified of the deficiency and given 30 days to pay the balance.

B. CONTINUATION OF DENTAL COVERAGE

Continuation of dental coverage shall be available to an employee and/or his covered dependents upon the occurrence of a Qualifying Event. To continue dental coverage, the Plan Administrator must be notified of a Qualifying Event by the employee or a Qualified Beneficiary, within 60 days of such event, if the Qualifying Event is:

1) for a spouse divorce or legal separation from a covered employee;

2) for a dependent child, loss of dependent status under the Plan; or

3) the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

Notice by an Employee or Qualified Beneficiary must be given to the Plan Administrator using the procedures specified in the Section entitled “Notice Procedures” below. An employee or Qualified Beneficiary who does not provide timely notice to the Employer of one of the above such Qualifying Events using such procedures will lose his rights to be offered COBRA continuation coverage or an extension of the COBRA continuation coverage due to a second qualifying event under COBRA.

The Plan Administrator must, within 14 days of receiving such notice, notify any Qualified Beneficiary of their right to continue coverage under the Plan. Notice to a Qualified Beneficiary who is the employee’s spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Upon termination of employment or reduction in hours, a Qualified Beneficiary who is determined by the Social Security Administration to be disabled under Title II or Title XVI of the Social Security Act on such date, or at any time during the first 60 days of COBRA continuation coverage, will be entitled to continue coverage for up to 29 months if the Plan Administrator is notified of such disability within 60 days from the date of determination and before the end of the 18-month period. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

Such notice must be provided in accordance with the procedures specified in the Subsection below entitled “Notice Procedures”. In addition, the notice must include the name of the disabled Qualified Beneficiary, the date that the Qualified Beneficiary became disabled, and the date the Social Security Administration made its determination. The notice must also include a copy of the Social Security Administration’s determination. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.

Qualified Beneficiaries who are disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the later of: (i) date of final determination that they are no longer disabled, or (ii) the date on which the individual is

informed through the Plan's Summary Plan Description or general notice of both the responsibility to provide such notice and the Plan's procedures for providing such notice.

NOTICE PROCEDURES:

Any notice that an employee or a Qualified Beneficiary provides to the Plan Administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. The employee or Qualified Beneficiary must mail or hand deliver his or her notice to the Human Resources-Benefits Manager at the following address, as applicable:

Mailing Address:
Human Resources-Benefits Manager
Helmerich & Payne, Inc.
1437 S. Boulder Ave.
Tulsa, OK 74119

Hand Delivery Address:
Human Resources-Benefits Manager
Helmerich & Payne, Inc.
1437 S. Boulder Ave.
Tulsa, OK 74119

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name of the Plan, the name and address of the employee covered under the Plan, and the name(s) and address(es) of the qualified beneficiary(ies). The notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

ELECTION PROCEDURES:

A Qualified Beneficiary must elect Continuation of Dental Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the **"ELIGIBILITY REQUIREMENTS"** section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator.

Any election by an employee or his spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue dental coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contributions to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period. If the initial contribution payment is not made within 45 days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted 30-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

Except as provided below, if the initial coverage election and required contribution payments are made timely, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as timely contribution payments, are met.

C. PREMIUMS FOR COBRA COVERAGE

The Qualified Beneficiary may be required to pay premiums for any period of COBRA coverage equal to 102% of the applicable premium, in accordance with applicable law. However, any Qualified Beneficiary (including all family members of such individual who are Qualified Beneficiaries) who is entitled to the disability extension (as specified above), may be required to pay premiums equal to 150% of the applicable premium for the coverage period following the initial 18-month period.

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available.

The cost of COBRA coverage may be subject to future increases during the period it remains in effect.

D. TERMINATION OF COVERAGE

COBRA continuation coverage will end upon the earliest of the following to occur:

1) if an employee is terminated or has his hours reduced:
   (a) 18 months from the date of the Qualifying Event; or
   (b) 29 months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first **60** days of COBRA continuation coverage and provides notice as required by law (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).
2) the day, after the 18 month continuation period, which begins more than 30 days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to 29 months, is determined to be no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).
3) for a covered dependent, 36 months from the date of the Qualifying Event if the Qualifying Event is:
   (a) the covered employee's death;
   (b) the covered employee's entitlement to Medicare;
   (c) a spouse’s divorce or legal separation from a covered employee; or
   (d) a dependent child's loss of dependent status under the Plan.

4) if any of the Qualifying Events listed in 3) occurs during the 18 month period after the date of the initial Qualifying Event listed in 1), coverage terminates 36 months after the date of the initial Qualifying Event listed in 1).

5) the date on which the Employer ceases to provide any group dental plan coverage to any employee.

6) the last day of the month in which the last contribution payment was made if the Qualified Beneficiary fails to make any required contribution payments within the allotted **30**-day grace period as described in this section.

7) the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group dental plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary.

8) the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare.

PROHIBITION AGAINST FALSE INFORMATION

A covered Participant is prohibited from submitting false or fraudulent information, or fraudulently omitting information, related to eligibility or benefit determinations, subrogation, coordination of benefits, or any other purpose under the Plan.

If the Plan Administrator determines that any covered Participant submitted false or fraudulent information, or fraudulently omitted information, for the purpose of receiving benefits under the Plan, the Plan Administrator can take appropriate actions to remedy the covered Participant's actions terminating their future participation in the Plan. This possible termination applies to the covered employee and his or her eligible dependents, regardless of which covered Participant was responsible for the fraudulent act or omission.

ERISA RIGHTS STATEMENT

A. RECEIVING INFORMATION ABOUT THE PLAN AND ITS BENEFITS

As a participant in the Plan, an employee is 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:

(1) 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;

(2) 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 Plan Administrator may make a reasonable charge for the copies;

(3) 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; and

(4) receive a summary of material reduction in covered services or benefits provided under the Plan within 60 days after the adoption of the changes (unless summaries of changes to the Plan are provided at regular intervals of 90 days).

B. CONTINUING GROUP DENTAL PLAN COVERAGE

A participant shall be entitled to continue dental care coverage for himself, his spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The participant or his dependents may have to pay for such coverage. Participants should review this Summary Plan Description and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

A participant shall also be entitled to reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the group dental plan if he has creditable coverage from another plan. The participant should be provided a certificate of creditable coverage, free of charge, from his group dental plan or dental insurance issuer when his coverage is lost, if he becomes entitled to elect COBRA continuation coverage, or when his COBRA continuation coverage ceases, provided that he requests the certificate before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, a participant and/or his beneficiaries may be subject to a pre-existing condition exclusion for 12 months after the participant’s or beneficiary’s enrollment date for coverage.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and their beneficiaries. No one, including the Employer, union, or any other person, may fire an employee or otherwise discriminate against a participant in any way to prevent him from obtaining a welfare benefit or exercising his rights under ERISA.

D. ENFORCING RIGHTS AS A PARTICIPANT

If a claim for a welfare benefit is denied or ignored, in whole or in part, the participant has 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 a participant can take to enforce the above rights. For instance, if the participant requests a copy of Plan Documents or the latest annual report from the Plan and does not receive the materials within 30 days, he may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to $110.00 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a participant has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if a participant disagrees with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, he may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if a participant is

discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person he has sued to pay these costs and fees. If the participant loses, the court may order him to pay these costs and fees, for example, if the court finds his claim is frivolous.

E. ASSISTANCE WITH QUESTIONS

If the participant has any questions about the Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA or HIPAA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his 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. A participant may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Este resumen descriptivo del plan contiene un resumen en inglés de sus derechos y beneficios del plan bajo el Programa de Beneficio para Empleados de Helmerich & Payne, Inc. Si tiene dificultad entendiendo cualquier parte de este informe, comuníquese con el administrador del plan, Helmerich & Payne, Inc. Departamento de Beneficios, en sus oficinas ubicadas en 1437 S. Ave. Boulder, Tulsa, OK 74119. Las horas de oficina son de 8:00 A.M. a 5:00 P.M. de lunes a viernes. También puede llamar a la oficina del administrador del plan al (918) 742-5531 o sin cargo al 1-(800) 331-7250 para obtener ayuda.

Helmerich & Payne, Inc.

Summary of Dental Plan Benefits

SUMMARY OF DENTAL PLAN BENEFITS

CLAIMS ADMINISTERED BY	Delta Dental Plan of Oklahoma P.O. Box 54709 Oklahoma City, Oklahoma 73154 (405) 607-2100 or (800) 522-0188
GROUP NO.	5730

HOW TO USE YOUR PLAN

Delta Dental Networks of Participating Dentists

You may visit the properly licensed dentist of your choice, because your plan provides for in-network as well as out-of-network benefit coverage. However, Delta Dental Plan of Oklahoma, the Claims Administrator for this plan, utilizes two nationwide networks of dentists—the Delta Dental Premier network and the Delta Dental PPO network—through Delta Dental Plan of Oklahoma's membership in a nationwide system known as Delta Dental Plans Association. These networks are among the largest in the dental benefits industry, both locally and nationwide, providing you easy access to participating dentists in most geographical areas.

Delta Dental Plans have unique "participating agreements" with those dentists in the networks described above. In most cases, these agreements mean you simply present your identification card to the dentist at the time of treatment and he or she will file your claim for you. Delta Dental Plan of Oklahoma, as Claims Administrator, will pay the participating dentist direct for any covered services.

To find a participating dentist, you may access the Delta Dental National Provider Listing on the Internet at www.DeltaDentalOK.org or contact Delta Dental Plan of Oklahoma's Customer Service Department at the toll-free number listed on the back of your dental identification card.

Benefit Payment Procedure, Participating Dentists

Under the Delta Dental participating agreements with participating dentists, benefit claims are reimbursed based on the lesser of the dentist's submitted fee for his or her service or the maximum allowable amount for participating dentists, as described below. Participating dentists accept the amount that Delta Dental determines to be the maximum allowable amount for participating dentists as payment in full.

If a Delta Dental PPO participating dentist provides treatment, the benefit claim will be reimbursed based on the dentist's submitted fee for his or her service or the maximum allowable amount for Delta Dental PPO participating dentists, whichever is less. You are responsible for paying any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

If a Delta Dental Premier participating dentist provides treatment, the benefit claim will be reimbursed based on the dentist's submitted fee for his or her service or the maximum allowable amount for Delta Dental Premier participating dentists, whichever is less. You are responsible for paying any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

Nonparticipating Dentists, Out-of-Network Services

If treatment is provided by a dentist who has not signed a participating agreement with Delta Dental (nonparticipating dentist), any benefit payment will be paid directly to you, or to other participant or beneficiary if required by law, and will be based on the lesser of the dentist's submitted fee for his or her service or the prevailing fee in the specific geographic area where the services were rendered, as established by Delta Dental. You are responsible for paying the dentist and for filing your own claim.

Emergency Care and Claim Predetermination

If you require emergency care, there is no preauthorization requirement. If the cost of the dental care you need is less than $250, your participating dentist will probably proceed with treatment. If the cost estimate is more than $250 and the treatment is not emergency care, your dentist can determine the treatment needed and submit a treatment plan to DDPOK for predetermination of benefits. This procedure will enable you and the dentist to know in advance of treatment what services are covered, how much of the cost will be paid by your dental plan, and how much of the cost you will be responsible for paying.

This plan does not require any preauthorization for any dental services; however, said services are subject to the plan's specific limitations, non-covered charges, deductibles, and co-payment amounts, as well as any charges over your plan maximum.

Claim Filing

You or someone in the dental office must complete the information portion of the claim form with the Subscriber's full name, Subscriber's social security number, the name and date of birth of the person receiving dental care, and the group name and number.

If you have any questions about the plan, please check with your employer's benefits office or write to Delta Dental Plan of Oklahoma, Customer Service Department, P.O. Box 54709, Oklahoma City, Oklahoma 73154. *All correspondence with DDPOK should include the group name and group number; the Subscriber's social security number, telephone number, and address; name of patient; and date of service.*

Once treatment is completed, the participating dentist will submit the claim form to Delta Dental Plan of Oklahoma for payment. If treatment is provided by a nonparticipating dentist, you are responsible for filing your claim.

Participants and beneficiaries can obtain, without charge, the necessary claim filing forms from DDPOK. The complete claim appeal procedure is furnished upon request by the Plan Administrator, without charge, as a separate document.

Claim Filing Deadline

The Plan is not obligated to pay any claim submitted later than 12 months following the date of service.

WARNING: *Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.*

Explanation of Benefits

Anytime you or a dentist file a claim, you will receive a form called an Explanation of Benefits (EOB) from Delta Dental Plan of Oklahoma within a reasonable time, but no later than 30 days after receipt of a claim. DDPOK may extend this time period one time up to 15 days, prior to the expiration of the 30-day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be given 45 days from receipt of the notice within which to provide the necessary information.

The EOB indicates what services were covered and what services, if any, were not. You are responsible to pay only the amount designated as "Patient Payment"; if you are billed for amounts over those identified, please contact DDPOK's Customer Service Department. An explanation of how to appeal a claim is included on the EOB, as well as in this Summary Plan Description.

Coordination of Benefits

The Coordination of Benefits provision is designed to provide maximum coverage if a patient is eligible for benefits under two or more dental plans and more than one of those plans provides coverage for a particular service. In no event will either plan pay a greater amount than it would have paid had dual coverage not existed, and the dental programs together will not pay more than 100% of covered expenses.

HOW TO APPEAL A CLAIM

Claim Benefits Denial

A copy of the Explanation of Benefits will be sent to the Subscriber by DDPOK, indicating if any services are denied, in whole or in part, and stating the reason or reasons for the denial, according to the time frame described in the Explanation of Benefits section in this Summary Plan Description.

Appeal of Claim Benefits Denial

Within 180 days after receipt of a notice of denial, a Subscriber or dentist may make a written request for review of such denial by addressing the request to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154, stating the reason(s) re-evaluation of the denial is being requested. The Subscriber or dentist may submit written comments, documents, records, and other information relating to the claim for benefits. As a Subscriber, you may request reasonable access to and, at no charge, copies of all documents, records, and other information relevant to your claim for benefits. All requests for review of denials shall be made taking into account all comments, documents, records, and other information submitted by the Subscriber relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Full and Fair Review of Request

DDPOK shall make a full and fair review of each request for re-evaluation and may require additional documents, as it deems necessary or desirable in making such a review. The Subscriber shall receive a decision on his/her initial request for a review, in writing, within 30 days after DDPOK receives the request.

If the Subscriber wishes to have the initial review determination appealed further, the Subscriber must make a written request for a second review of the denial by addressing the request to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154, stating the reason(s) re-evaluation of the denial is being requested. The Subscriber shall receive a decision on his/her second request for a review, in writing, within 30 days after DDPOK receives the second request.

Any complaints other than those involving the denial of services should also be addressed, in writing, to the office identified above. Such complaints will be reviewed according to the same procedure. The complete claim appeal procedure is furnished upon request, without charge, as a separate document.

Upon final determination of the second request for appeal, you have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act.

COVERED SERVICES

SELECTED BENEFITS

The dental services included in the Plan Sponsor's group dental plan are listed in this Summary, under "Description of Covered Services", and described by classes of service. After an eligible person satisfies the plan benefit year deductible, if any, the Plan will pay a percentage of the lesser of the dentist's submitted fee or the maximum allowable amount. The Plan's percentage payment will be based on the class of dental service provided, as indicated next to each class of service. ***Note: Some benefits are subject to limitations, e.g. age of patient, frequency of procedure, etc., or excluded in some instances. Please review "LIMITATIONS" and "EXCLUSIONS" in this Summary.***

MAXIMUM CONTRACT BENEFIT

The maximum benefit payable for combined Class I, Class II, and Class III covered dental services rendered to an eligible person during the benefit year shall be $1,000. The separate maximum lifetime benefit payable for covered Class IV services rendered to an eligible dependent child shall be $1,500.

Effective January 1, 2018: The maximum benefit payable for combined Class I, Class II, and Class III covered dental services rendered to an eligible person during the benefit year shall be $1,500. The separate maximum lifetime benefit payable for covered Class IV services rendered to an eligible dependent child shall be $1,500.

Note: Benefits payable by the Plan for covered oral evaluations (examinations), procedure codes D0120-D0180, and routine prophylaxis (cleaning), procedure codes D1110 and D1120, will not reduce the maximum benefit per person during the benefit year for combined Class I, Class II, and Class III covered dental services.

DEDUCTIBLE

Each plan benefit year, a $50 deductible applies to Class II and Class III services, per person. The $50 deductible may be met in Class II services or Class III services, or any combination of Class II and Class III services.

Note: The maximum family deductible applicable each plan benefit year is $150. The deductible provisions do not apply to Class I or Class IV services.

DESCRIPTION OF COVERED SERVICES

CLASS I SERVICES – 100%

Diagnostic Services: Procedures performed by properly licensed dentists in evaluating existing conditions to determine the required dental treatment. By way of description, such covered services include: Oral evaluations (examinations), emergency palliative treatment for minor relief of pain, and radiographic images (x-rays).

Preventive Services: Procedures performed by properly licensed dentists to prevent the occurrence of disease. By way of description, such covered services include: Routine prophylaxis (cleaning), and scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation; and topical application of fluoride and space maintainers for eligible dependent children.

CLASS II SERVICES – 80%

Basic Restorative Services: Procedures performed by properly licensed dentists in the treatment of carious lesions (decay/cavity). By way of description, such covered services include: Amalgam and composite restorations (fillings); and limited sealants and stainless steel restorations (crowns) for eligible dependent children.

Oral Surgery Services: Procedures performed by properly licensed dentists for extractions and other oral surgical procedures.

Endodontic Services: Procedures performed by properly licensed dentists for the treatment of non-vital teeth. By way of description, such covered services include: Pulpal therapy and root canal treatment.

Periodontic Services: Procedures performed by properly licensed dentists for the treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance (D4910) following active treatment.

CLASS III SERVICES – 50%

Major Restorative Services: Provides porcelain or cast restorations (other than stainless steel) for the treatment of carious lesions (decay/cavity) when teeth cannot be restored with another filling material. ***Note: A crown or cast restoration is optional treatment unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or composite restoration.***

Prosthodontic Services: Procedures for construction of fixed partial dentures (bridges), removable partial dentures, and complete dentures, including adjustment or repair of an existing prosthodontic device provided under this Plan.

Implant Services: Procedures for implant placement, implant-supported prosthetics, and maintenance and repair of implants, and implant-supported prosthetics provided under this Plan.

CLASS IV SERVICES – 50% (Available to eligible Dependent Children under age 19)

Orthodontic Services: Procedures provided by properly licensed dentists for the necessary treatment required for the correction of malposed teeth.

LIMITATIONS

The benefits to be provided to Subscribers and eligible Dependents under this Plan shall be limited as follows:

- For purposes of this Plan, any procedure frequency limitation is measured in a period of continuous calendar-year months (a consecutive-month period), which begins on the date of service for which the procedure was last paid, or where specifically stated, measured on the basis of the calendar year(s).
- Prophylaxis is a benefit twice in a calendar year. *Note: Cleanings/prophylaxis of any type, including periodontal maintenance and scaling in the presence of generalized moderate or severe gingival inflammation, are limited to any combination of two in a calendar year.*
- Oral evaluation is a benefit twice in a calendar year.
- Limited (emergency) oral evaluation is a benefit twice in a calendar year. *Note: Benefits for limited (emergency) oral evaluation may be disallowed if other services are provided on the same day*
- Consultation is a benefit once in a 12 consecutive month period.
- Bitewing radiographic images are a benefit once in a 12 consecutive month period. *Note: Benefits may be limited if multiple same-day radiographic images are provided on the same day by the same dentist/dental office.*
- Full-mouth radiographic images, a panoramic image, or multiple same-day radiographic images are a benefit once in a 60 consecutive month period unless necessary for the diagnosis and treatment of a specific disease or injury. *Note: Panoramic radiographic image is a benefit for persons age six (6) and older.*
- Topical application of fluoride solutions is a benefit for patients through age 18, and once in a 12 consecutive month period.
- A space maintainer is a benefit for missing primary posterior teeth for persons through age 15, and not for orthodontic purposes.
- Sealants are a benefit for persons through age 15, limited to permanent first and second molar teeth free of caries and restorations on the occlusal surfaces. Sealants are a benefit once per tooth in a 60 consecutive month period.

- Stainless steel crowns are a benefit only for persons through age 11, and once per tooth in an 84 consecutive month period.
- General anesthesia/IV sedation is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. The fee for general anesthesia/IV sedation is denied when billed by anyone other than a licensed dentist.
- Payment is made for a single tooth surface repair once in a 24 consecutive month period, regardless of the number of combinations of restorations placed therein.
- Root canal therapy is a benefit once per tooth in a 36 consecutive month period.
- Prosthodontics: (1) An upper or lower denture is a payable benefit once per arch in a 60 consecutive month period; (2) a removable partial denture or fixed partial denture (bridge) may not be provided more often than once per arch in a 60 consecutive month period, except where the loss of additional teeth requires the construction of a new appliance; (3) reline and rebase is a benefit once in a 36 consecutive month period for any one appliance.
- Crowns/onlays/veneers on the same tooth are a benefit once in an 84 consecutive month period.
- Orthodontic Benefits: (1) Benefits are available to eligible dependent children under age 19; (2) benefits are limited to periodic payments; and (3) benefits cease the last day of the month in which: (a) such child attains the maximum age specified in this Summary or becomes ineligible for coverage under this Plan, (b) treatment is terminated for any reason before completion of the treatment plan, or (c) the maximum orthodontic benefit has been paid, whichever occurs first.
- Implant Benefits: The implant and the associated crown over the implant are a benefit for persons 16 years of age and over, limited to once per tooth in an 84 consecutive month period. *Note: Some implant procedures or procedures associated with implants are not covered services under the plan and no benefits will accrue or be payable for those excluded procedures (please contact DDPOK Customer Service with any questions).*
- Single crowns/onlays/veneers are benefits for persons age 12 and over.
- Fixed partial dentures (bridges) and removable partial dentures are benefits for persons age 16 and over.
- Alternate Benefits/Optional Treatment: DDPOK may consider alternate dental services that are suitable for care of a specific condition if those alternate services will produce a professionally acceptable result, as determined by DDPOK. If patient and dentist elect other treatment, patient will be responsible for any charges in excess of DDPOK's payment. For example: if a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment based on such procedure will be made toward a more elaborate or precision appliance the dentist and patient may choose to use, and patient is responsible for the balance of the cost; a fixed partial denture (bridge) will be allowed only when a removable partial denture will not suffice; if a crown or cast restoration is not allowed, an alternate benefit allowance for an amalgam or composite restoration may be made and any fee charged in excess of the allowance is chargeable to the patient; etc.
- The Plan's obligation to provide benefits for covered dental services terminates on the last day of the month in which the patient becomes ineligible for benefits under the Plan.
- Care terminated due to death will be paid in full, to the limit of the Plan's liability, for services completed or in progress.
- When services in progress are interrupted and completed later by another dentist, DDPOK will review the claim to determine the payment to each dentist.
- Processing policies, if applied, may limit benefits and can be found on each Explanation of Benefits.
- Charges for any covered dental service or supplies which are included as covered medical expenses under the plan of Major Medical or Comprehensive Medical Expense Benefits Plan must first be submitted for payment to the medical carrier. This Plan may benefit as the secondary carrier.

EXCLUSIONS

The following shall be excluded from the benefits to be provided to Subscribers and eligible Dependents.

- Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability laws.
- Benefits or services available from any federal or state government agency, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.
- Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.
- Benefits for services or appliances started prior to the date the patient became eligible under this Plan may be excluded.
- Benefits for services when a claim is received for payment more than 12 months after services are rendered.
- Charges for treatment by other than a properly licensed dentist, except that cleaning and scaling of teeth and topical application of fluoride may be performed by a properly licensed hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.
- Charges for completion of forms or submission of documentation required by DDPOK for a benefit determination.
- Charges for missed or cancelled appointments, hospitalization or additional fees charged for hospital treatment, and bleaching of teeth.
- Prescription drugs, pre-medications, and relative analgesia.
- Experimental procedures.
- Benefits or services to correct congenital or developmental malformations.

- Services for the purpose of improving appearance when form and function are satisfactory and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).
- Restorations for altering occlusion (bite), involving vertical dimensions, replacing tooth structure lost by attrition (grinding of teeth), erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting.
- Charges for replacement of lost, missing, or stolen crowns or appliances, or for repair of an orthodontic appliance.
- Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).
- All other benefits and services not specified in the Plan, including but not limited to the services in the following table of excluded services.

Procedure Code	Description of Excluded Service	Procedure Code	Description of Excluded Service
D0171	Re-evaluation-post operative office visit	D0502	Oral pathology procedures
D0190/D0191	Screening of a patient/Assessment of a patient	**D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum
D0250/D0251	Extra-oral radiographic images	D0999	Unspecified diagnostic procedure
D0310	Sialography	D1310	Nutritional counseling
D0320-D0322	TMJ radiographic images and tomographic survey	D1320	Tobacco counseling regarding oral disease
*D0340/D0350	Cephalometric radiographic image/Oral-facial photographic images	D1330	Oral hygiene instructions
D0351	3D photographic image	D1354	Interim caries arresting medicament application
D0364-D0368	Cone beam CT - image capture and interpretation	D1999	Unspecified preventive procedure, by report
D0369	Maxillofacial MRI capture and interpretation	D2410-D2430	Gold foil restorations
D0370	Maxillofacial ultrasound capture and interpretation	**D2949	Restorative foundation for an indirect restoration
D0371	Sialoendoscopy capture and interpretation	**D2953	Each additional cast post-same tooth
D0380-D0384	Cone beam CT	**D2957	Each additional prefab post-same tooth
D0385	Maxillofacial MRI image capture	D2975	Coping
D0386	Maxillofacial ultrasound image capture	D2981	Inlay repair, necessitated by restorative material failure
D0391	Interpretation of diagnostic image by practitioner not associated with capture of the image, including report	D2990	Resin infiltration of incipient smooth surface lesions
D0393-D0395	Post processing of image or image sets	D2999	Unspecified restorative procedure
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	**D3110-D3120	Pulp caps
D0415/D0416	Bacteriologic studies/Viral culture	**D3331	Treatment of root canal obstruction
D0417/D0418	Collection and preparation of saliva sample for laboratory diagnostic testing/Analysis of saliva sample	D3333	Internal root repair of perforation defects
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	D3355-D3357	Pulpal regeneration; does not include final restoration
D0423/D0425	Genetic test for susceptibility to diseases–specimen analysis//Caries susceptibility test	D3428-D3429	Bone graft in conjunction with periradicular surgery
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	D3460	Endodontic endosseous implant
*D0470	Diagnostic cast	D3470	Intentional reimplantation
**D0472-D0474	Accession of tissue	**D3910	Isolation of tooth with rubber dam
**D0475-D0479	Oral pathology tests and examinations	**D3950	Canal preparation and fitting of post
**D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	D3999	Unspecified endodontic procedure
**D0481-D0483	Oral pathology laboratory procedures	D4230-D4231	Anatomical crown exposure
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	D4320-D4321	Provisional splinting
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	D4381	Localized delivery of antimicrobial agents via release vehicle into diseased crevicular tissue, per tooth

Procedure Code	Description of Excluded Service	Procedure Code	Description of Excluded Service
**D4920	Unscheduled dressing change	D7292-D7294	Surgical placement of temporary anchorage device
D4921	Gingival irrigation – per quadrant	D7295	Harvest of bone for use in autogenous grafting procedure
***D4999	Unspecified periodontal procedure	D7320-D7321	Alveoloplasty not in conjunction with extractions
D5810-D5811	Interim complete dentures	D7340-D7350	Vestibuloplasty
D5862	Precision attachment, by report	D7410-D7465	Surgical excision of soft tissue/intra-osseous lesions
D5867	Replacement of replaceable part of semi-precision or precision attachment	D7471-D7490	Excision of bone tissue
D5899	Unspecified removable prosthodontic procedure, by report	**D7511	Incision and drainage of abscess-intraoral soft tissue-complicated
D5911-D5999	Maxillofacial prosthetics	D7520-D7560	Surgical incision
**D6011	Second stage implant surgery	D7610-D7780	Treatment of fractures
D6040-D6050	Implant services	D7810-D7899	Reduction of dislocation & mgmt. of TMJ
**D6051	Interim abutment	**D7910	Suture of recent small wounds up to 5 cm
D6091	Replacement of semi-precision or precision attachment of implant/abutment supported prosthesis	D7911-D7912	Complicated suturing
D6103	Bone graft for repair of periimplant defect	D7920-D7960	Other repair procedures
D6104	Bone graft at time of implant placement	**D7963	Frenuloplasty
D6190	Radiographic/surgical implant index, by report	**D7970-D7971	Other repair procedures
D6199	Unspecified implant services	D7972-D7999	Other repair procedures
**D6253	Provisional pontic	*D8000-D8680	Orthodontic services
D6548	Retainer-porcelain/ceramic	D8681	Other orthodontic services
D6600-D6607	Inlays	*D8690	Other orthodontic services
D6624	Inlay-titanium	D8691-D8692	Other orthodontic services
**D6793	Provisional retainer crown	*D8693-D8694	Other orthodontic services
D6920/D6940	Connector bar/Stress breaker	D8999	Unspecified orthodontic service
D6950	Precision attachment	**D9210-D9215	Anesthesia
D6985	Pediatric partial denture, fixed	D9219	Evaluation for deep sedation or general anesthesia
D6999	Unspecified fixed prosthodontic procedure	D9230	Inhalation of nitrous oxide/analgesia, anxiolysis
D7260	Oroantral fistula closure	D9248	Non-intravenous moderate (conscious) sedation
D7261	Primary closure of a sinus perforation	**D9311	Consultation with a medical health care professional
D7270	Tooth re-implantation and/or stabilization	D9410-D9450	Professional visits
D7272	Tooth transplantation	D9610-D9630	Drugs
*D7280	Surgical exposure of unerupted tooth	D9910-D9930	Miscellaneous services
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	D9932-D9935	Cleaning and inspection of dentures/partials
*D7283	Placement of device to facilitate eruption of impacted tooth	D9940-D9987	Miscellaneous services
D7285-D7286	Incisional biopsy of oral tissue	**D9991-D9992	Dental case management –addressing appointment compliance barriers/care coordination
D7287	Cytology sample collection	D9993-D9994	Dental case management – motivational interviewing/patient education to improve oral health literacy
*D7290	Surgical repositioning of teeth	D9999	Miscellaneous services
*D7291	Transseptal fiberotomy, by report		

***Procedure will be disallowed when submitted by a Participating Dentist for periodontal probing and/or laser disinfection (laser charges) in conjunction with other services. Procedure may be denied when submitted for other miscellaneous periodontal procedures or as a stand-alone procedure. **Disallowed – The fee for a procedure or service is disallowed—it is not benefited by DDPOK, nor collectable from the patient by a Participating Dentist. *Orthodontic – Orthodontic services will be allowed if group contract stipulates orthodontic coverage.