A Guide to Your Dental Care Benefits for Employees of

Gordmans

Claim Administration by:

BlueCross BlueShield of Nebraska

A not for profit mutual insurance company and
independent licensee of the Blue Cross and Blue Shield Association

NOTICE

Non-participating provider charges may be higher than the benefit amount allowed by this group plan. You may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center concerning maximum benefit amounts allowed for specified procedures when using non-participating providers.

About Your Summary Plan Description

This document is the Summary Plan Description of available dental coverage for associates of Gordmans. It has been written to help you understand Gordmans' Dental Plan administered in accordance with the provisions set forth in the Master Group Contract between Gordmans and your Contract Administrator, Blue Cross and Blue Shield of Nebraska*, an independent licensee of the Blue Cross and Blue Shield Association. Your rights under the Employee Retirement Income Security Act of 1974 (ERISA) are also described in this document.

This booklet provides only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Contract to which it refers. It describes the more important parts of that document in a general way. It is not, and should not be considered a contract or any part of one. The Master Group Contract controls the coverage for your group.

If you misplace your copy of this document or your Schedule of Benefits, you may request a copy from Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Whenever you have a question about your coverage or claim, Blue Cross and Blue Shield of Nebraska's Customer Service representatives will be glad to assist you or you may contact Gordmans' Corporate Benefits Department.

The Master Group Contract (hereafter known as Group Plan Document) and this summary plan description may be amended or modified or terminated by Gordmans and Blue Cross and Blue Shield of Nebraska to reflect changes in benefits, eligibility requirements, or any other provisions. Such changes shall be binding on each covered employee and his or her eligible dependents.

**Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Cross and Blue Shield of Nebraska liability may occur only under a stop loss provision set forth in the Administrative Services Agreement.*

Important Telephone Numbers

customer service:

Omaha 402-390-1820
Toll-free 1-800-642-8980
TTY/TTD (for the hearing impaired) 402-390-1888

coordination of benefits:

Omaha 402-390-1840
Toll-free 1-800-462-2924

subrogation:

Omaha 402-390-1847
Toll-free 1-800-662-3554

workers' compensation:

Omaha 402-398-3615
Toll-free 1-800-821-4786

GORDMANS

Summary of Dental Benefits

Coinsurance Percentage:

Coverage A	0%
Coverage B	20%
Coverage C	50%

Calendar Year Deductibles:

Coverage A	$0
Coverage B and C combined (Per Person)	$25

Maximum Dental Benefits:

Calendar year maximum benefits (Per Person) for Types A, B and C Dental Coverage combined	$2,500

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Some Important Facts About Your Dental Coverage

Your I.D. Card — A Passport to Dental Care

Blue Cross and Blue Shield of Nebraska will issue you an identification card. Your I.D. number is a unique alpha numeric combination including an alpha prefix and a numeric suffix. If other members of your family are covered by your membership, their names and dates of birth will also appear on your I.D. card. Each family member will be assigned a different numeric suffix. Only five names can appear on one I.D. card; therefore, you will receive more than one card if there are more than five eligible family members.

Always put your I.D. card in your wallet or purse, along with your driver's license, credit cards and other essential items. With your Blue Cross and Blue Shield of Nebraska I.D. card, U.S. hospitals and physicians can identify your coverage and will usually submit their claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center. Remember, only persons who are eligible for coverage under your membership may use your Blue Cross and Blue Shield of Nebraska I.D. card.

Schedule of Benefits

Your Schedule of Benefits is a personalized document that provides information concerning: deductibles, coinsurance, special benefits, and maximums and limitations of your coverage. It also identifies the type of membership option you have.

Eligibility & Enrollment

Eligibility for Coverage

All regular, full-time associates of Gordmans, working a minimum of 35 hours per week, are eligible to enroll for coverage following a probationary period (60 days for exempt and 90 days for non-exempt). Your application for coverage should be submitted within 30 days of your eligibility. If you acquire dependents through marriage, birth or adoption, a 30-day special enrollment period is allowed to request coverage for them under this group dental plan.

Please see the section titled “Late Enrollment” for additional information. You may also contact Blue Cross and Blue Shield of Nebraska’s Customer Service Center for information.

Types of Membership

There are four types of enrollment options offered by Gordmans. The enrollment option you have elected is shown on your Schedule of Benefits.

Please note that Gordmans refers to employees as "Associates." Therefore, you may wish to think of the following membership units in your employer's terms. For example, a "Single Membership" would be an "Associate Membership" and a "Subscriber-Spouse Membership" would be an "Associate-Spouse Membership."

Single Membership: Provides coverage for you only.

Subscriber-Spouse Membership: Provides coverage for you and your spouse.

Single Parent Membership: Provides coverage for you and your eligible dependent children, but not for your spouse.

Family Membership: Provides coverage for you, your spouse and your eligible dependent children.

Eligible Dependent is defined in the Definitions section of this book.

Note: *If two eligible persons in the same employer group are married to each other, each person and/or their eligible dependents may not enroll under more than one membership option.*

Late Enrollment

A “late enrollee” is defined as a subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll.

Late enrollment is only allowed during the open enrollment month of February each year. Coverage requested during February will be effective on the first of March.

Please note that in order to avoid late enrollment restrictions, you must request enrollment within 30 days of your (or your dependent’s) initial eligibility, or during a special enrollment period, if applicable.

Termination of Dental Coverage

If you cancel your dental coverage for yourself or your dependents, reenrollment is not allowed until your group's next open enrollment month. If you should end your employment, your dental coverage will also end and no conversion rights are available.

Major Events Affecting Coverage

Marriage

When you marry, your spouse and any other new eligible dependents may enroll for coverage under an appropriate membership unit offered by your group plan. A 30-day period is allowed to make a change to your membership if necessary, and to request coverage for the new dependents. If the request is received within 30 days of the marriage, the effective date of coverage will be the date of the marriage.

If the request for coverage is not made within 30 days of the marriage, late enrollment provisions may apply. Please see the section titled "Late Enrollment" for additional information.

Marriage, Birth, Adoption, Foster Child

Please notify Gordmans to make a change in your coverage within 30 days so that they may update their records. All changes must be handled by Gordmans in order to eliminate any delays in claim processing.

Adopted Children

If you are adopting a child, the effective date of the child's coverage will be the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you. Please notify Gordmans within 30 days of the placement, so that they may update your records and to avoid any future delay in the payment of claims. (This plan does not pay for the expenses incurred at the time of the child's birth.)

If you have a Single or Subscriber-Spouse Membership in effect, you must request a change to Single Parent or Family Membership and enroll the child within 30 days of the placement for adoption and pay the additional premium.

If your spouse was not enrolled under your membership at the time of the adoption, he or she may enroll for coverage during this 30-day period, and the effective date of coverage for your spouse will be the date the child is placed with you for adoption. The applicable premium must be paid. Please contact Gordmans for premium information.

If you request enrollment of the child (and spouse, if applicable) after the 30-day period, late enrollment provisions may apply.

Newborn Children

If you have a Single or Subscriber-Spouse Membership in effect at the time of birth, coverage shall begin at birth provided that you request a change to Single Parent or Family Membership from Gordmans within 30 days of the birth, and pay the additional premium.

If your spouse was not enrolled under your membership at the time of the child's birth, he or she may also enroll for coverage during this 30-day period, and the effective date of coverage for your spouse will be the date of the child's birth. The applicable premium for Family Membership must be paid.

If you request enrollment of the child (and spouse, if applicable) after the 30-day period, late enrollment provisions may apply.

Disabled Dependent Children

A physically or mentally disabled child may remain an eligible dependent child upon reaching age 19 if incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and dependent upon you for support and maintenance. The application for such coverage must be received within 30 days of the dependent's 19th birthday and the dependent must meet all other group coverage eligibility requirements.

A child who becomes physically or mentally disabled while a covered student over 18 years of age may continue under your dental coverage while remaining incapable of returning to school as a full-time student, unmarried and dependent upon you for support and maintenance. You must furnish proof of disability within 30 days of its onset. (This extended coverage is subject to all other group coverage requirements.)

An application for extension of dependent coverage is available through Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Foster Children

If you are acquiring a foster child who meets the definition of an eligible dependent, and you already have a Family or Single Parent Membership, coverage will be made available for that foster child on the day he or she is placed in your home, subject to the waiting period for pre-existing conditions. Please enroll the child within 30 days of the foster child's placement to avoid any future delay in the payment of claims or late enrollment restrictions. Legal documentation must be provided to Gordmans.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity disputes. The order may direct the group plan to enroll the child(ren), and also creates a right for the alternate recipient to submit claims and receive benefits for services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered “qualified.” A National Medical Support Notice received by the employer or plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Plan’s procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Active Employees Ages 65 and Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over may elect to continue full benefits under this group benefit plan. (Those associates who are enrolled with a Medicare Supplemental health care plan are not eligible for dental coverage.)

Family Medical Leave Act (FMLA)

Public Law 103-3 (FMLA) requires that, subject to certain limitations, an employer of 50 or more persons offer continued coverage to employees and their eligible dependents, while the employee is on FMLA leave for birth, adoption or foster care placement of a child, or due to a serious health condition of the employee or his/her son, daughter, spouse or parent. In addition, an employee who has terminated his/her group dental coverage while on approved FMLA leave may reenroll for group dental coverage upon return to employment. **Please check with your employer for details regarding your eligibility under FMLA.**

Short-Term Disability Leave

Associates on approved short-term disability leaves of absence (excluding FMLA) may remain on this group dental plan for a period of up to 180 days, with the associate paying the regular premium contribution amount. At the end of that period, an associate's employment with the company terminates, unless the associate returns to work. Associates who choose to drop dental insurance coverage while on a leave of absence will be subject to late enrollment requirements, if re-enrollment is requested. Remember, late enrollment may only be done during the open enrollment month.

If the associate does not return to work following the 180-day period and termination of employment occurs, a COBRA notice will be sent by the employer to the associate, advising the associate of his or her election rights.

Continuation Of Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act, known as COBRA, is a federal law which provides that covered employees and their dependents may elect to continue coverage under the group plan if coverage is lost due to the occurrence of certain "qualifying events." Persons who are eligible to continue coverage are called "qualified beneficiaries." A qualified beneficiary also includes a child born to, or placed for adoption with you during a period of COBRA coverage. The COBRA qualifying events are described below, as well as the procedures for electing COBRA continuation coverage. **Payment for continuation coverage is at the employee's or dependent's own expense.**

NOTE: To protect your rights under COBRA, please keep your employer informed of your current address.

Please share the COBRA information found in this section with your eligible dependents.

Termination of Employment or Reduction in Hours

COBRA provides that if you should lose eligibility for coverage due to:

- a reduction in work hours
- termination of employment
- a layoff, or
- discharge for misconduct (other than gross misconduct),

you and your covered dependents may be able to continue the group coverage at your own expense for **up to 18 months.** Your employer is required to notify the plan administrator within 30 days. The plan administrator will send you a COBRA notification within 14 days after receiving notice from the employer.

Special provisions regarding COBRA eligibility for certain retirees may apply if an employer files a Chapter 11 bankruptcy. Please check with your employer for details.

Disability--If a qualified beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA coverage, you may be entitled to extend the COBRA coverage from **18 to 29 months.** You must provide written notice of the disability determination to the plan within 60 days of the later of the Social Security Administration's determination or the qualifying event, and before the end of the initial 18-month COBRA period.

The notice to the plan must include sufficient information to enable the administrator to identify the disabled beneficiary, the date of the disability and the date of the determination. The failure to provide timely and effective notice of a disability determination may result in the loss of the right to extend COBRA coverage.

The cost for COBRA coverage for the 19th through the 29th month may be increased to 150% of the applicable premium for coverage.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage (19th through 29th month) will be terminated the month that begins more than 30 days after the final determination. You must notify the plan within 30 days of a final determination that the individual is no longer disabled.

Change in Dependent Status, Divorce or Separation or Medicare Entitlement

COBRA requires that continued coverage under your group plan be offered to your covered spouse and eligible dependent children if they would otherwise lose coverage as the result of:

- a child losing dependent status
- divorce or legal separation, or
- you becoming entitled to Medicare.

When one of these circumstances occurs, you are obligated to notify your employer or plan administrator within 60 days. The failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.

After receiving a timely notice of such an event, your employer or plan administrator will send your spouse or dependents an election form and information needed to apply for coverage, if eligible. The coverage may be continued at his/her expense **for up to 36 months.**

If your spouse or dependent is not eligible to continue coverage under your group plan, conversion privileges may be available. Application for conversion coverage must be made no later than 31 days from the end of eligibility.

Your Death

If you should die while you are covered under this group plan, continued coverage under this group plan is available to your spouse and eligible dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the group coverage at their own expense for up to 36 months. **Federal law requires your employer to send the surviving family members instructions as to how to apply for continued coverage, if they are eligible.**

Electing COBRA Coverage

Please share the COBRA information found in this section with your eligible dependents, in the event that a qualifying event occurs.

Within 14 days after notice of a qualifying event is received by the plan administrator, you and/or your dependents (qualified beneficiaries) will be sent a written notice of the right to continue health coverage, and an election form(s).

Reminder: *In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or plan administrator of this qualifying event within 60 days after the later of the event or the date the coverage would be lost.*

Qualified beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions to help you complete the form, and to whom it should be sent.

The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end, or
- 60 days after the notice is sent to you by the employer or plan administrator.

COBRA continuation coverage may only begin on the day after coverage under the plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to whom such premium should be paid.

Second Qualifying Event--In the event your family experiences another qualifying event while receiving an 18-month period of COBRA coverage (or the extended 29 month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months, if notice of the second event is properly given to the employer or plan administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die, b) you become entitled to Medicare, c) you get divorced or legally separated, or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred. **In all of these cases, you or the dependent must notify the employer or plan administrator within 60 days of the second qualifying event.**

Termination of COBRA Coverage

A qualified beneficiary COBRA continuation coverage will end at midnight on the earliest of:

- the day your employer ceases to provide any group health plan to any employee,
- the day the premium is due and unpaid,
- the day the individual first becomes covered under any other group health plan (after the COBRA election), which does not exclude or limit any pre-existing conditions or to whom such an exclusion is not applicable due to creditable coverage,
- the day the individual again becomes covered as an employee or dependent under the policy,
- the day the individual becomes entitled to benefits under Medicare (after the COBRA election), or
- the day health insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

Note: *In the event more than one continuation provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.*[1]

Uniformed Services Employment And Reemployment Rights (Military Leave)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that continued coverage under an employer group health plan be offered to an employee and covered dependents if coverage would otherwise be lost due to a military leave.

Continuation of Group Health Coverage:

If coverage under your employer group health plan ends because of service in the uniformed services, you may elect to continue health coverage for yourself and your covered dependents, until the earlier of:

- 24 consecutive months from the date active duty began; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You are responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, your required premium is the standard employee share of the applicable premium; for a leave in excess of 30 days, the required premium shall be no more than 102% of the total premium applicable for your membership option. Your employer will inform you of the amount and procedure for payment of premiums.

A covered person's continued coverage under these USERRA provisions will end at midnight on the earliest of:

- the day the employer ceases to provide any group health plan for its employees;
- the day premium is due and unpaid;
- the day a covered person again becomes covered under the plan;
- the day coverage has been continued for the period of time stated in the previous paragraph, above.

Reemployment:

Following service in the uniformed services, an employee may be eligible to apply for reemployment with the employer in accordance with USERRA. Such reemployment includes the right to reenroll for group health coverage provided by the employer, with no new waiting periods imposed.

Please contact your Benefit Office for further information regarding your rights under USERRA.

Dental Services And Supplies

The following section provides a brief outline of the group dental plan available to associates of Gordmans. It has been written to help you understand your dental coverage. Please refer to your employer's Group Plan Document for more complete information.

Your dental coverage has an overall annual benefit limit for each covered person in your family. This annual benefit limit is specified on your Schedule of Benefits. Your dental coverage consists of the following three categories:

- **Dental Coverage A - Preventive and Diagnostic Dentistry**
- **Dental Coverage B - Maintenance and Simple Restorative Dentistry, Oral Surgery, Periodontic and Endodontic Dentistry**
- **Dental Coverage C - Complex Restorative Dentistry**

These benefits work together to provide you with a dental care program. Benefit payment of your claim depends on whether the service or treatment falls under Type A, B or C dental coverage.

Important Dental Terms

There are a number of dental terms that will be used quite often in this document. Knowing what these terms mean will help you understand your dental benefits under this group plan.

ALLOWABLE CHARGE - All benefits for covered dental services are based on the allowable charge for the service. In general, the allowable charge is the lesser of the billed amount, a specific reimbursement amount established by Blue Cross and Blue Shield of Nebraska's agreement with the provider or the maximum benefit amount.

COINSURANCE - This is the percentage of allowable charges which you must pay, less any applicable deductible. Coinsurance percentage amounts are indicated on your Schedule of Benefits.

DEDUCTIBLE - The deductible is the amount you must pay before dental benefits begin. Deductible amounts are indicated on your Schedule of Benefits. (Your dental deductible is a separate deductible from your health plan deductible.)

MAXIMUM BENEFIT - Benefits payable are limited to a calendar year maximum for Dental Coverage Types A, B and C. This amount will be specified in your plan's Master Group Contract and indicated on your Schedule of Benefits.

If You're Treated By More Than One Dentist

If you transfer from the care of one dentist to another during the course of treatment, or if more than one dentist provides services, this plan will make the benefit payment as if only one dentist provided the service.

Use Of The Lesser Charge

Where there are optional techniques of dental treatment with different charges, this plan will pay the lesser charge.

Covered Dental Services

DENTAL COVERAGE A - PREVENTIVE AND DIAGNOSTIC DENTISTRY

- Two oral examinations each calendar year.
- Two treatments including cleaning, scaling and polishing each calendar year.
- Two sets of x-rays (bitewing) each calendar year.
- Topical fluoride application.
- Space maintainers for prematurely lost teeth for children under age 16.
- Initial application of sealants to the permanent first and second molar teeth of children between the ages of 6 and 16 and reapplication thereof; but not more often than every 4 years.

DENTAL COVERAGE B - MAINTENANCE AND SIMPLE RESTORATIVE DENTISTRY, ORAL SURGERY, PERIODONTIC AND ENDODONTIC SERVICES

- Simple and impacted extractions.
- Fillings consisting of silver amalgam. If other filling material is used, payment is limited to the amount payable for silver amalgam.
- Palliative treatment limited to opening and draining of a tooth to relieve pain when no treatment follows; or smoothing down chipped teeth.
- Treatment of diseases and injuries that affect the tooth pulp, root and surrounding tissue, including surgical removal of the crown or connective tissue; and pulp capping and root canal treatment.
- Oral surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cysts and abscesses.
- Periodontic service consisting of:

  Surgical examination of the connective tissue between the teeth and their bony sockets.

  Removal of growths or other material from gums.

  Surgical removal of infected and diseased gums and modeling to obtain a normal contour.

  Osseous (bone) surgery, including flap entry and closure.

  Surgery to repair the gums.

  Treatment of acute infection and oral lesions.
- Inlays.
- Recementing inlays and crowns on diseased or damaged teeth.
- One denture relining each 36 consecutive month period.
- Up to $25.00 for the repair of dentures each calendar year.
- Medically necessary anesthesia services related to Type B dental services.

DENTAL COVERAGE C - COMPLEX RESTORATIVE DENTISTRY

- Temporary crowning of teeth as a result of an accident if done within 72 hours of the accident.
- Crowns.
- Bridges (including pontics).
- Dentures -- full and partial.

- Adjustments of dentures after six months from the date of installation.

- Medically necessary anesthesia services related to Type C dental services.

Note: Blue Cross and Blue Shield of Nebraska may request all x-rays, records and data concerning dental services provided.

Treatment Plans Save Time and Trouble

A treatment plan is a written report showing the recommended treatment of a dental disease, defect or injury, prepared by a dentist as a result of an examination made by the dentist. A treatment plan for an estimation of benefits may be submitted by a dentist for Coverage B and C services. If the dentist bills a single charge for the entire treatment, payment will be made as follows:

- If the expected period of treatment is less than two years, this plan will divide the charge by the number of full three month periods in the period of treatment, and pay the appropriate amount at the end of each three month period.

- If the expected period of treatment is two years or more, this plan will divide the charge by eight and pay the quarterly benefits accordingly.

Adjustment will be made, if necessary, by reason of change in the estimated single charge, change in the estimated period of dental treatment, or termination of dental coverage.

Selecting a Participating Dentist

Blue Cross and Blue Shield of Nebraska has contracted with many physicians and dentists. These people are called "Participating Providers." The payment of dental benefits for covered dental services to a Participating physician or dentist may be affected by Blue Cross and Blue Shield of Nebraska's contractual agreement with them. However, such basis for payment will not affect or change your dental coverage.

The cooperation of Participating Providers helps to hold down dental care costs. There are several advantages to you in using a Participating Provider:

- A Participating Provider has agreed with Blue Cross and Blue Shield of Nebraska to accept your deductible and/or coinsurance amount (if applicable) plus this plan's benefit payment up to the Usual, Customary and Reasonable or Maximum Benefit Amount as payment in full for a covered service. There will be no charge to you over the Usual, Customary and Reasonable or Maximum Benefit Amount.

- When Blue Cross and Blue Shield of Nebraska pays the benefit for the service provided to you, they pay directly to the Participating Provider. This way you do not have to pay the provider more than a deductible or coinsurance amount at the time the service is provided.

- Participating Providers have also agreed to file your claims to Blue Cross and Blue Shield of Nebraska.

Noncovered Dental Services And Supplies

This plan covers a wide variety of dental expenses. However, there are some services and supplies not covered. They are:

- Services that are not covered services as described in this plan; or services to the extent that they exceed the limitations stated in your Group Plan Document.
- Any amount over the actual charge for a covered service, or in excess of the reasonable charge.
- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
- Appliances, services or restoration necessary to modify vertical dimensions of, or restore, the occlusion.
- Gold restorations, except as provided under Coverage C.
- Full or partial denture replacement for:

  Any denture replacement made less than 5 years after a denture placement or replacement,
  which was covered under this Contract.

  Any denture replacement made necessary by reason of the loss or theft of a denture.
- Charges for missed appointments, or for filling out claim forms or furnishing information or reports.
- Charges for veneers placed on crowns or pontics, other than the 10 upper and 10 lower anterior teeth.
- Services provided for any covered person before their effective date of coverage, or after their termination; or services provided to a noncovered person.
- Interest, sales or other taxes on covered services.
- The portion of benefits provided at government expense (except Medicaid), whether or not you elect to receive such benefits. This will not apply to Medicare-eligible associates or their spouses age 65 or over who have elected this plan as their primary carrier.
- Charges payable by another health or dental benefit plan by application of the Coordination of Benefits provision.
- Services for which you are not legally obligated to pay, or for which no charge would be made if this coverage did not exist.
- Services covered under Workers' Compensation or employer's liability law.
- Charges for services provided by a hospital, ambulatory surgical facility, or any other facility charges.
- Charges for services that are covered services under any other plan issued by Blue Cross and Blue Shield of Nebraska.
- Oral surgery, except as specifically provided for, or treatment of the temporomandibular (jaw) joint.
- Orthodontic services, including related extractions and x-rays.

Coordination Of Benefits

This contract includes a Coordination of Benefits provision. This provision limits duplication of benefits when a covered person has coverage under more than one health/dental plan. These provisions also help establish a uniform order in which the plans pay their claims, and for the transfer of information between the plans, to help avoid claim payment delays. This provision is intended to comply with the most recent NAIC Model Group COB regulations.

Definitions for Coordination of Benefits

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the plans covering the person, during a claim determination period. When benefits are reduced under a primary plan because the person did not comply with requirements for preadmission certification or second surgical opinions, the amount of such reduction will not be considered an allowable expense. A reduction due to the use of a noncontracting provider will not be considered an allowable expense unless the services are received from a closed panel provider. Items of expense under coverages such as dental or prescription drug programs may be excluded from the definition of Allowable Expense.

Claim Determination Period: The period of a calendar year during which the covered person is covered under this contract. It does not include any part of a year before the date this coordination of benefits provision or a similar provision took effect.

Plan: A form of coverage with which coordination is allowed, to include:

- group, blanket or franchise insurance coverage (except student accident-type coverage).
- uninsured arrangements of group or group-type coverage.
- any coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans.
- hospital indemnity type coverages written on a non-expense incurred basis to the extent the benefits available are more than $200 per day.
- group or group type coverage through HMOs and other prepayment, group practice and individual practice plans.
- individual or family coverage including HMO coverage or subscriber contracts.

The term "plan" as defined for the purpose of coordination of benefits does not include non-group hospital or surgical indemnity plans. Plan also does not include plans whose benefits, by law, are in excess to those of any private insurance program or other nongovernmental program.

Primary Plan: The plan which will determine allowable benefits without regard to other covered allowable expenses.

Secondary Plan: The plan which will determine allowable benefits for the balance of the remaining charges in the claim determination period.

Primary Plan/Secondary Plan: The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to the covered person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

Order of Benefits

If benefits are payable under any other plan or coverage which does not provide for coordination of benefits, the insurer or plan providing that coverage shall be the primary carrier.

If one of the plans has prescription drug card coverage, the coverage first used by the covered person becomes the primary coverage. If the other coverage is used first, this group health plan will be the secondary plan.

If benefits are payable under any other plan which does include a coordination of benefits provision, this plan determines its order of benefits using the first of the following rules which applies to the covered person:

- The plan which covers the person as an employee/subscriber is primary to the plan covering the person as a dependent.
- For a child of parents not separated or divorced, the primary plan is the plan of the parent whose birthday falls earlier in the year. Where both parents have the same birthday, the primary carrier shall be the one which has covered the parent for the longer period of time.
- For a child of parents who are divorced or separated, first shall be the plan of the custodial parent, then the plan of the spouse of the custodial parent, and then the plan of the non-custodial parent. However, if there is actual knowledge that the court decree or qualified court order requires one parent to be responsible for health care expenses, the primary carrier shall be the plan provided by that parent.
- The plan of an employee who is neither laid off nor retired (or as that employee's dependent) is primary to the plan which covers that person as a laid off or retired employee (or that employee's dependent). If the other health benefit plan coverage does not have this provision and, if as a result, the carriers do not agree on the order of benefits, this section is ignored.
- A plan providing coverage to a person under federal (COBRA) or state continuation law is secondary to a plan providing coverage to that person as an employee, subscriber, retiree (or that person's dependent).
- If none of the above rules determines the order of benefits, the benefits of the plan which covered a subscriber longer are determined before those of the plan which covered that person for the shorter time.

Administration of Coordination of Benefits

If this plan is the primary plan, there shall be no reduction of benefits paid under this plan--benefits will be paid as if the other plan did not provide benefits.

If this plan is the secondary plan, its benefits will be determined after those of the other plan, and may be reduced because of the other plan's benefits. Payment will not be made for any amount for which the covered person is contractually held harmless by either plan. Payment between the plans shall not exceed the amount paid under this contract, had it been primary.

Credit Savings: If this plan does not have to pay its full benefits because it is the secondary plan, the savings will be credited to the covered person during a claim determination period. These savings will not exceed the allowable expenses. The amount by which this plan's benefits has been reduced will be used to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period. Items of expense under coverages such as dental and prescription drug programs may have a separate credit savings.

To properly administer coordination of benefits, this plan may obtain from or release to any insurance company or other organization or person, any information necessary to determine whether coordination of benefits applies. Any person who claims benefits under this plan agrees to furnish this plan information that may be necessary to effect coordination of benefits.

If another plan pays benefits which should have been paid under this contract, then this plan will reimburse such other plan any amounts determined to be necessary. Amounts paid to other plans in this manner will be considered benefits paid under this plan. This plan is also released from liability of any such amount paid in this manner.

If the benefits paid by this plan exceed what should have been paid, this plan has the right to recover any excess from any insurer, any other organization, or

any person to or for whom such payments are made, including covered persons under this plan.

This plan's duty regarding coordination of benefits, is limited to making a reasonable effort to avoid liability as the primary plan in appropriate cases brought to its attention; to making reasonable efforts to compute the amount payable under any other plan; and to making reasonable efforts to recover any excess payments made by it.

Subrogation And Contractual Right To Reimbursement

Subrogation

Subrogation is the right to recover benefits paid for covered services provided as the result of an illness or injury that was caused by another person or organization. If benefits are paid for such covered services under the Master Group Contract, the group plan shall be subrogated to all of the covered person's rights of recovery against any person or organization to the extent of the benefits paid. The subscriber, the covered person or the person who has a right to recover for the covered person (usually a parent or spouse), agrees to make reimbursement to the plan if payment is received from the person who caused the illness or injury or from that person's liability carrier. This subrogation claim shall be a first priority lien on the full or partial proceeds of any settlement, judgment or other payment recovered by or on behalf of the covered person, whether or not there has been full compensation for all his or her losses. The rights of the group plan shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

Contractual Right to Reimbursement

If a covered person receives full or partial proceeds from any other source for covered services for an illness or injury, the group plan has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same illness or injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the covered person, whether or not the covered person has been fully compensated for all his or her losses.

Such proceeds may include any settlement, judgment, payments made under auto insurance, including no-fault, or medical payments insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to, and separate from, the subrogation right. The group plan's rights shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

No adult subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of such covered person or to any other person, without the express written consent of the group health plan. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a subscriber, incompetent or disabled subscribers, or their incompetent or disabled dependents.

The subscriber agrees to cooperate and assist in any way necessary to recover such payments, including notification to Blue Cross and Blue Shield of Nebraska of a claim or lawsuit filed on his or her behalf or on behalf of his or her dependents. He or she shall notify Blue Cross and Blue Shield of Nebraska prior to settling any claim or lawsuit to obtain an updated itemization of the amount due. Upon receiving any proceeds, the subscriber, eligible dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to the Plan. The party holding the funds that rightfully belong to the Plan shall not interrupt or prejudice the Plan's recovery of such payments.

Special Note: *If a covered person refuses or fails to comply with this subrogation or reimbursement, coverage can be canceled, including that of any covered dependents. The group health plan shall also be entitled to recover any costs incurred in enforcing these provisions, including, but not limited to, attorneys' fees, litigation and court costs and other expenses.*

Workers' Compensation

Benefits are not available for services provided for illness or injury arising out and in the course of employment, whether or not the covered person fails to assert or waive his or her rights to Workers' Compensation or Employer Liability coverage. Benefits are not payable for services determined to be not payable due to noncompliance with the terms, rules and conditions under a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for services that are related to work injury or illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

If a covered person enters into a lump-sum settlement which includes compensation for past or future expenses for an injury or illness, payment will not be made under the group plan for services related to that injury or illness.

In certain instances, benefits for such services are paid in error under this group plan. If payment is received by the covered person for such services, reimbursement must be made. This reimbursement may be funded from any recovery made from the employer, or the employer's Workers' Compensation carrier. Reimbursement must be made directly by the subscriber when benefits are paid in error, due to his or her failure to comply with the terms, rules and conditions of Workers' Compensation laws or a Certified or Licensed Workers' Compensation Managed Care Plan.

Claim Procedures

Filing a Claim

Many dentists and physicians will file a claim form for you. To expedite claims filed by dental care providers on your behalf, be sure they are given the following information:

- Correct Blue Cross and Blue Shield of Nebraska ID number, including the alpha prefix.
- The date and time of an accident or onset of an illness, and whether or not it occurred at work.
- The name and identification number of other dental care plan providing dental insurance.

Claims You File Yourself

You must file your own claim form if your health care provider does not file for you. Claim forms are available at Blue Cross and Blue Shield of Nebraska's Customer Service Center.

- Complete the appropriate dental claim form in full.
- Use a separate dental claim for each eligible family member.
- File your dental claims as soon as possible. Claims must be filed within 90 days of the date of service. Claims filed later than 90 days will be accepted in special circumstances, but Blue Cross and Blue Shield of Nebraska will not accept claims later than 18 months from the date of service.
- Complete each section of the claim form thoroughly. If a section doesn't apply, write "not applicable." Don't leave any sections blank or your dental claim may be returned for the missing information.
- Give the exact date and the time of an accident (if applicable).
- Always attach the original, itemized dental bill to your dental claim form. The dental bill must be on the letterhead stationary or billing form of the dental care professional that provided the dental services to you. Itemized dental bills must include:

  The complete name, address and professional status (M.D., D.D.S., etc.) of the individual who provided the dental service. (This is usually included on the letterhead or billing form.)

  Full name of the patient. (This is important, since the patient is not always the same as the person being billed.)

  Each dental service listed separately, along with the date of service, type of service for the dental service.
- Submit original dental bills to ensure quick payment of your dental claim for covered expenses. Bills you prepare yourself, cancelled checks, or cash register receipts cannot be accepted.
- Copy your Blue Cross and Blue Shield of Nebraska identification number directly from your I.D. card and double check to make sure you did not transpose any of the numbers.
- Keep copies of all bills and the dental claim form for your files.

- Claim forms are available at Blue Cross and Blue Shield of Nebraska's Customer Service Center upon request. Your dental claims should be sent to:

  Blue Cross and Blue Shield of Nebraska
  P.O. Box 3248
  Omaha, Nebraska 68180-0001

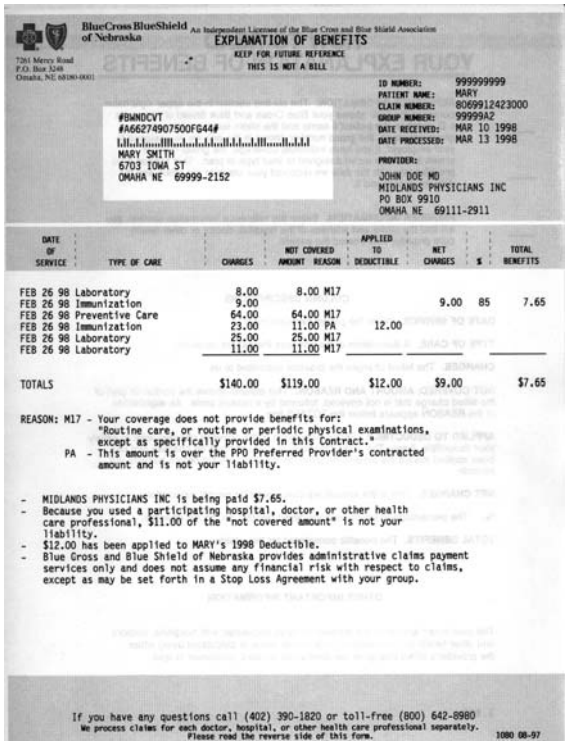
Explanation Of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent to you. This summary tells you:

- Type of service.
- Date of service.
- Name of provider of care.
- Charges.
- Charges applied toward your deductible or coinsurance.
- Noncovered charges with explanation.
- Benefits paid by other insurance.
- Other explanatory notes.

Also included on your Explanation of Benefits is information regarding your right to appeal a benefit determination.

Save your Explanation of Benefits forms in the event that you need them for other insurance or for tax purposes.



BlueCross BlueShield of Nebraska — An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS

KEEP FOR FUTURE REFERENCE

THIS IS NOT A BILL

7261 Mercy Road
P.O. Box 3248
Omaha, NE 68180-0001

#BWNDCVT
#A66274907500FG44#
MARY SMITH
6703 IOWA ST
OMAHA NE 69999-2152

ID NUMBER: 999999999
PATIENT NAME: MARY
CLAIM NUMBER: 8069912423000
GROUP NUMBER: 99999A2
DATE RECEIVED: MAR 10 1998
DATE PROCESSED: MAR 13 1998

PROVIDER:
JOHN DOE MD
MIDLANDS PHYSICIANS INC
PO BOX 9910
OMAHA NE 69111-2911

DATE OF SERVICE	TYPE OF CARE	CHARGES	NOT COVERED AMOUNT	REASON	APPLIED TO DEDUCTIBLE	NET CHARGES	%	TOTAL BENEFITS
FEB 26 98	Laboratory	8.00	8.00	M17				
FEB 26 98	Immunization	9.00				9.00	85	7.65
FEB 26 98	Preventive Care	64.00	64.00	M17				
FEB 26 98	Immunization	23.00	11.00	PA	12.00			
FEB 26 98	Laboratory	25.00	25.00	M17				
FEB 26 98	Laboratory	11.00	11.00	M17				
TOTALS		$140.00	$119.00		$12.00	$9.00		$7.65

REASON: M17 - Your coverage does not provide benefits for: "Routine care, or routine or periodic physical examinations, except as specifically provided in this Contract."
PA - This amount is over the PPO Preferred Provider's contracted amount and is not your liability.

- MIDLANDS PHYSICIANS INC is being paid $7.65.
- Because you used a participating hospital, doctor, or other health care professional, $11.00 of the "not covered amount" is not your liability.
- $12.00 has been applied to MARY's 1998 Deductible.
- Blue Gross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk with respect to claims, except as may be set forth in a Stop Loss Agreement with your group.

If you have any questions call (402) 390-1820 or toll-free (800) 642-8980
We process claims for each doctor, hospital, or other health care professional separately.
Please read the reverse side of this form.

1080 08-97

Appeal Procedures

Blue Cross and Blue Shield of Nebraska has the discretionary authority to determine eligibility for benefits under the group plan, and to construe and interpret the terms of the plan, consistent with the terms of the master group contract.

You have the right to seek and obtain a review of any adverse determination made regarding claims, benefit availability, or other complaint arising under this group plan.

First Level Appeal

If you disagree with the determination made on a claim, you may submit an appeal. A request for a first-level appeal must be submitted in writing within one year of the date the claim was processed. The letter must state that it is a request for an appeal, and if possible, include a copy of the Explanation of Benefits (EOB). The appeal should include:

- a general description of the appeal;
- the name of the covered person;
- Blue Cross and Blue Shield of Nebraska I.D. number;
- the date of service and claim number, if any; and
- any additional information that might help resolve the matter.

The written appeal should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

Written decisions for pre-service claim appeals will be provided within 15 calendar days, and for post-service claim appeals, within 30 calendar days.

An expedited review may be requested for an appeal of an urgent care claim denial, or if the time frame for a standard review would seriously jeopardize the life or health of the covered person. An expedited review decision will be made within 72 hours of receipt of the request, and written confirmation will be sent not later than three days after the oral notification. A request for an expedited review of a concurrent care denial must be made within 24 hours of the initial denial.

Notification of the Appeal Decision – A written notice of the appeal determination will be provided to you (the claimant). If the appeal determination is adverse, this written notice shall include the reasons for the decision, a reference to the contract provisions upon which the decision is based, a reference to the evidence or documentation used as a basis for the decision, and a statement regarding the claimant's right for further action or appeal. In addition, when applicable, the notice will state that an explanation of the scientific or clinical judgment used in making the decision will be provided to the claimant, free of charge, upon written request.

If the appeal involves medical judgment, Blue Cross and Blue Shield of Nebraska will consult with appropriate medical personnel in order to make the appeal determination. Identification of the medical personnel consulted during the appeal process, if any, will be provided upon written request. The appeal determination shall be made by individuals who were not involved in the original decision.

Second Level Appeal

If you are not satisfied with the first level appeal decision, a second level appeal may be submitted. It must be submitted within six months of receipt of the notice of the first level appeal decision. The letter must be mailed to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

The time frame for a second level **urgent care** appeal requires that the second review take place within the same 72 hours as the first review, if the request is made within 24 hours of receipt of the first level review decision. Second level appeal decisions of all other pre-service claims will be made within 15 days of the request. Second level appeal decisions of post-service claims will be made within 30 days of the request.

No deference will be given to either the initial determination or the first level appeal. The claimant will be provided with a written notification of the appeal decision, as described above.

Legal Actions

You must exhaust the first and second levels of appeal stated above prior to filing a lawsuit. Since the group health plan is subject to ERISA, you have the right to bring a civil action under section 502(a) of ERISA.

A lawsuit may not be filed less than 60 days after the claim is filed; nor more than three years from the time the claim is required to be filed.

Plan Information

The Name of this Plan is:	Gordmans Dental Plan
Employer and Plan Sponsor:	Gordmans 12100 West Center Road Omaha, Nebraska 68144 1-800-456-7463
Plan Administrator:	Gordmans
Designated Agent for Service of Legal Process:	Gordmans 12100 West Center Road Omaha, Nebraska 68144 1-800-456-7463
Employer Identification Number:	47-0771211
Plan Number	503
Type of Plan:	Welfare Benefit Plan: Dental
Plan Year:	March 1 through February 28
Plan's Fiscal Year End:	December 31st.
Type of Administration:	Insurer Contract Administration* (Administrative Services Agreement)
Contract administration* of this Plan is with:	Blue Cross and Blue Shield of Nebraska 7261 Mercy Road Omaha, Nebraska 68180-0001 (402) 390-1800
Sources of contributions:	Gordmans and associates share contributions toward the premium cost of this coverage. Your percentage (%) of premium contribution is determined by Gordmans. The actual premium amount is calculated by Blue Cross and Blue Shield of Nebraska, based on the plan's experience rating.
Procedure for amendment or termination of the Plan:	**All premiums (employer and associate contributions) are subject to change.** Benefits in this Summary Plan Document may be amended, modified or terminated at the sole discretion of the Director of Benefits and HR Services of Gordmans to reflect changes in premium, benefits, eligibility requirement or any other provisions.

*Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Cross and Blue Shield of Nebraska liability may occur only under a stop loss provision set forth in the Administrative Services Agreement.

Statement Of ERISA Rights

As a participant in this group insurance plan, you are entitled to certain rights and protections under ERISA (Employee Retirement Income Security Act of 1974).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event (COBRA). You or your dependents may have to pay for such coverage. Review your Summary Plan Description and the documents governing the Plan for the rules regarding your COBRA continuation rights.

- Reduction or elimination of pre-existing condition waiting periods under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay these costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

COINSURANCE: The amount (percentage) of each allowable charge which the covered person must pay.

CONTRACT: The agreement between Blue Cross and Blue Shield of Nebraska and Gordmans.

CONTRACTING OR PARTICIPATING DENTIST: Any dentist with whom Blue Cross and Blue Shield of Nebraska has contracted to furnish dental services according to the terms and provisions of your employer's Master Group Contract.

COVERED PERSON: You and/or your eligible dependents who have been enrolled under this dental care plan.

COVERED SERVICES: Care and treatment for which your employer's Master Group Contract provides payment.

DEDUCTIBLE AMOUNT: Part of an approved charge for covered services which the covered person must pay each calendar year before benefits are payable under this group plan.

DENTIST: Any duly licensed practitioner of Dentistry operating within the scope of his or her license.

ELIGIBLE DEPENDENT:

1. The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.

2. Unmarried children 18 years of age or less who are dependent on the Subscriber for support and maintenance.

   A child is dependent so long as he or she:

   - lives with the Subscriber, or
   - is provided financial support (voluntarily or by order of the court), or
   - is provided health coverage by order of the court

   "Children" means your biological and adopted children, a stepchild, or a grandchild or foster child under a legal guardianship who lives with you. A child is dependent so long as he or she lives with you, the child is provided financial support (either voluntarily or by court order), or the child is provided health coverage by order of the court.

3. Unmarried dependent children (students) 23 years of age or less for whom the Subscriber provides support and who are in full time attendance at an educational institution which has a curriculum, faculty and student body in attendance. Coverage will continue during normal school vacation periods.

4. Reaching age 19, or if a full-time student, age 24, will not end the covered child's coverage under this Contract as long as the child is, and remains, both:

   a. incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and

   b. dependent upon the Subscriber for support and maintenance.

   Proof of the requirements of paragraphs a. and b. from the Subscriber must be received within 31 days of the child's reaching age 19 (or if a full-time student, age 24) and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this provision will be made by Blue Cross and Blue Shield of Nebraska. Any extended coverage under this paragraph 4. will be subject to all other provisions of the Contract.

PHYSICIAN: Any person holding an unrestricted license and duly authorized to practice medicine and surgery where the medical or surgical services are performed.

TREATMENT PLAN: A written report showing the recommended treatment of any dental disease, defect or injury prepared by a dentist as a result of an examination by such dentist. Applies to Coverage B and C services only.

IMPORTANT NUMBERS

IDENTIFICATION NUMBER: _____

Physicians' Telephone Numbers:

Family Member: _____
Doctor: _____
Phone:_____

Family Member: _____
Doctor: _____
Phone:_____

Family Member: _____
Doctor: _____
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Family Member: _____
Doctor: _____
Phone:_____

IMPORTANT NUMBERS

Hospital's Telephone Number	_____
Poison Control Center	_____
Urgent Care Center	_____
Anti-Fraud Line	**390-1820**
BlueCard Program Website	**www.bcbs.com**