DENTAL PLAN

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INTRODUCTION

The FirstEnergy Dental Plan ("the Plan" or "Dental Plan") offers two coverage level options. You may choose either the Basic Dental coverage or the Plus Dental coverage depending on your needs and the needs of your family. Coverage is provided through the Delta Dental Plan of Ohio, Inc. (Dental Plan Administrator). The employee is responsible for paying the whole premium through payroll deduction. Depending on your union affiliation and whether you are active or retired, the option(s), plan design, and cost of the plans available to you may be different. The form you receive each year, as part of the annual enrollment process, will indicate the dental plan option(s) available to you.

The following description of the Dental Plan has been prepared to help you gain a better understanding of the terms and conditions of the Dental Plan effective on January 1, 2020. Each employee's benefits and rights under the Dental Plan are governed at all times by the official contract with the Dental Plan Administrator, and are in no way altered or modified by the contents of this summary.

If you have any questions after reviewing this material, you can access the Delta Dental Web site at www.deltadentaloh.com. A link to this site is also available on www.myfirstrewards.com or you can contact the Human Resources Service Center for assistance.

GENERAL INFORMATION

For the purposes of this summary, the term "Company" means any operating companies or affiliates of FirstEnergy Corp. or to any other organization to which the Dental Plan has been offered (see section entitled "Participating Employers").

ELIGIBLE EMPLOYEES AND DEPENDENTS

Eligible Employees All non-bargaining full-time regular, and part-time regular employees, and certain retired employees of the Company are eligible to participate in the Dental Plan. In addition, the surviving spouse of an employee or eligible retiree may be eligible to participate. Employees represented by a labor union as indicated in the section entitled "Participating Unions" may participate to the extent provided by their respective collective bargaining agreement with the Company.

Eligible Dependents You may also enroll your eligible dependents, which include your legal spouse, and your child(ren) up to age 26, including adopted children and stepchildren, and your dependents incapable of self-support due to a physical or mental disability. Proof of incapacitation must be provided to the carrier before the child becomes ineligible at age 26. Proof of disability must be provided to the administrator within 31 days of the date the child would otherwise become ineligible for Dental Plan participation. Medical updates may be required periodically. If your child is incapable of self-support, contact your carrier to complete necessary forms.

If both you and your spouse work for the Company, you may both choose single dental coverage or you may elect coverage for yourself and your spouse. If you choose to cover your spouse, then your spouse must elect no coverage. If both you and your spouse elect separate coverage, then only one parent may elect to cover eligible dependent children.

It is fraudulent to enroll any dependent or other person not eligible for coverage or to fail to notify the Company of a change in eligibility for a covered dependent. Dismissals from employment as well as criminal or civil penalties can result from such fraudulent acts.

Domestic Partners Employees are eligible to cover their domestic partner on their health care coverage. Domestic partner criteria requires that you and your partner must be at least age 18 and have lived together 12 months in an exclusive relationship mutually responsible for each other's welfare demonstrated by three or more of the following:

- Common ownership of real property and/or a motor vehicle;
- Driver's license with common address;
- Joint bank and/or credit accounts;
- Designation as primary beneficiary for life insurance or retirement benefits, or under a partner's will;
- Assignment of durable power of attorney or health care power of attorney.

In addition, you must not be related to each other to a degree of closeness that would prohibit legal marriage in your residence state, married to anyone else or in the relationship for the sole purpose of obtaining benefits coverage. You will be responsible for payment of applicable taxes that result from FirstEnergy providing health care benefits to your domestic partner. To add a domestic partner to your health care, you will be required to complete a Domestic Partner Declaration form and provide appropriate documentation.

Qualified Medical Child Support Orders The Omnibus Budget Reconciliation Act of 1993 requires that group health plans, such as the Dental Plan, recognize "qualified medical child support orders" by providing benefits for participants' children in accordance with these orders. Upon receipt of an order, the Human Resources Department will follow these procedures:

1. Promptly notify the participant and each Alternate Recipient (participant's child) that the order has been received and inform them of the procedures for determining if the order is a Qualified Medical Child Support Order (QMCSO).

   A QMCSO is one that:

   - Does not require the Plan to provide any type or form of benefit that is not already offered;
   - Either creates or recognizes the right of an Alternate Recipient to receive benefits for which a participant is entitled under the group health plan;
   - Includes the name and address of the participant and the Alternate Recipient;
   - Includes a description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined; and
   - Specifies the period for which coverage must be provided and each plan to which it applies.

2. Review the Order to determine if it qualifies as a QMCSO. If necessary, the Order will be forwarded to the Company's Legal Department for review. The participant and any Alternate Recipient will be notified of the determination.

3. If the Order is determined to be a QMCSO, inform the Alternate Recipient that a representative (custodial parent or guardian) may be designated to receive any required notices. Also the Order would specify to whom the Plan would make any payments or reimbursements.

4. Provide the Alternate Recipient or representative a copy of this Summary Plan Description. Also, a supply of claim forms will be provided.

If you are required to provide health coverage as the result of a Qualified Medical Child Support Order issued on or after the date your coverage becomes effective, any Plan provisions which require evidence of good health, limits due to a pre-existing condition, or coverage delays due to a confinement will not apply to the initial health coverage for this child. If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claims will be paid to the custodial parent.

Retiree Dental Eligibility

Effective December 31, 2014, access to the Dental Plan was terminated for most retirees. The termination of access to the Dental Plan may not apply to all retirees, in particular those with individualized contracts or those who are covered under the terms of a collective bargaining agreement which specifically provides for access.

If as an active employee you elected Plus Dental coverage for the plan year in which you retire, you will be given the opportunity to continue this coverage under the COBRA program for the first 18 months immediately following your retirement as noted below on page 21.

Dental Plan benefits are not vested. Eligibility for coverage, the level of benefits and the contributions required from retirees for coverage are subject to change at the discretion of the Company.

ENROLLING FOR DENTAL PLAN COVERAGE

Enrollment and Date of Coverage You are eligible to participate in the Dental Plan on the first day of the month following your date of hire. During the first month of your employment, you will receive a Flexible Benefits enrollment form that you must complete to designate your Dental Plan election and the eligible dependents you wish to cover. Coverage begins for you and your eligible dependents on your eligibility date if you have enrolled. If you do not return an enrollment form during this initial enrollment period, you will not be covered and must wait until the next annual enrollment to elect dental coverage.

Qualified Status Changes You must notify the Human Resources Service Center and complete the necessary form within 31 days of any change in family status – such as marriage, birth of a child, divorce, or a child who is no longer an eligible dependent. Participants who have a status change that does not require a change of election have a 90-day window to cover additional dependents. Contingent upon the requisite notification, changes in coverage are effective on the first day of the month following the date the Company receives the required notification, except that newborn children are covered from the date of birth and coverage for an adopted child under age 18 will begin on the date the child is placed with you for adoption. For any changes in family status, failure to notify the Human Resources Service Center and complete the necessary form within 31 calendar days of the status change may eliminate the availability of

benefits that result from such changes. Participants that miss the 31-day window but require a status change must pay the difference between the cost of the original election and the new level of coverage on an after-tax basis for the remainder of the plan year.

Annual Enrollment Open enrollment for dental coverage is announced and conducted in the fall each year as part of the Flexible Benefits enrollment period. It is your annual opportunity to change your election for coverage. Changes in coverage made during the annual enrollment period are effective the following January 1.

Information about your Dental Plan options is provided on www.myfirstrewards.com. If you have questions or require additional information, contact the Human Resources Service Center or your local Human Resources Office.

Your Member Identification Card Once you have enrolled in one of the Dental Plan options, you will receive reference cards for yourself and enrolled family members. It is not necessary for you to present an ID card to the dentist to receive care. Instead, dentists verify eligibility information 24 hours a day, seven days a week, by accessing Delta Dental's Web-based Dental Office Toolkit or by calling the toll-free number.

The reference card provides both you and your dentist with payment information and the toll-free number for Delta Dental's Customer Service Department. The Dental Plan group number is **9673**. You may wish to note the group number on the back of your card in the space provided.

If your card is lost or stolen, you can contact Delta Dental's Customer Service at (800) 524-0149 to request a replacement card or go online and visit www.deltadentaloh.com to print a new card.

Pre-Existing Conditions Exclusions and limitations may apply to conditions that existed prior to the effective date of your coverage. For example, services or appliances started prior to the date you were covered under the Dental Plan are not covered. You should refer to the section "What the Dental Plan Does Not Cover" beginning on page 11.

COST OF COVERAGE AND PARTICIPANT CONTRIBUTIONS

Cost of Coverage The Dental Plan is insured by Delta Dental Plan of Ohio, Inc. Delta Dental determines the monthly premiums required for coverage. The level of benefits and contributions required from participants for dental coverage are determined by Company policy and, for employees represented by a participating labor union, the provisions of their respective collective bargaining agreements.

Employee Dental Plan Contributions The amount of the contribution required for each plan option and each level of coverage is communicated during the annual Flexible Benefits enrollment period. Currently, participating employees are required to pay the full cost of the dental coverage elected. Contributions are made on a before-tax basis as part of the FirstEnergy Flexible Benefits Plan and are generally deducted from 26 biweekly or 52 weekly pays each year.

Retiree Dental Plan Contributions If eligible for access and if elected, retirees are required to pay the full cost of the Basic Dental coverage. Contributions for retiree dental coverage are deducted from the retiree's monthly pension check. If the retiree is not currently receiving a monthly pension check, or if the amount of the check is not sufficient to pay

the required premium, the retiree will be billed for coverage through the Plan's third-party administrator.

Retiree dental benefits are not vested. The level of benefits, eligibility for coverage and required retiree contributions for coverage is subject to change at the discretion of the Company.

DENTAL PLAN BENEFITS

The Dental Plan offers a choice of two quality dental care options. You may choose either the Basic Dental coverage or the Plus Dental coverage for yourself and your family. Dental benefits are provided through Delta Dental Plan of Ohio, Inc. Dentists in both the Delta Dental PPO℠ and the Delta Dental Premier® dental networks are included in the Dental Plan. Coverage is still available if you choose to receive dental services outside the Delta Dental networks. However, if you receive services from a non-participating dentist, benefits will be reduced and you will be responsible for any charges in excess of the Delta Dental maximum allowable fee.

The maximum benefit payable in a calendar year is $1,000.00 per covered person in the Basic Plan, and $2,000.00 per covered person for the Plus Dental coverage, excluding orthodontics. Orthodontics is subject to a separate $1,500 lifetime maximum per eligible individual covered under the Plus Dental coverage option.

Dental Plan Deductibles Both the Basic Dental and the Plus Dental coverage have a deductible that must be met for services that are charged before a coinsurance amount is charged to the participant. The in-network deductible for the Basic Dental coverage is $100 deductible per person per calendar year limited to a maximum deductible of $300 per family per calendar year. The Plus Dental coverage deductible is $50 per person per calendar year limited to a maximum deductible of $150 per family per calendar year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, x-rays, and sealants.

Dentists that do not participate in either of the Delta Dental networks are considered non-participating and the out-of-network deductibles and coinsurance amounts apply to their services. The Basic Dental coverage out-of-network deductible is $200 per person per calendar year limited to a maximum deductible of $600 per family per calendar year. The Plus Dental coverage out-of-network deductible is $100 per person per calendar year limited to a maximum of $300 per year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, x-rays, sealants, and orthodontics.

Basic Dental Coverage You receive benefits for dental services covered under the Basic Dental coverage for dental care that is not work-related according to the following schedule:

The Basic Dental coverage covers diagnostic and preventive care including oral exams, routine cleaning and X-rays at 100% with no deductible. Diagnostic and preventive care received outside the Delta Dental networks is reimbursed at 80%. You are responsible for the remaining 20% of the cost of diagnostic and preventive care received outside the Delta Dental networks plus any charges incurred in excess of the Delta Dental network allowed fee. Prophylaxes (cleanings), including basic and/or periodontal prophylaxes, and routine oral examinations/evaluations are limited to twice per year. People with certain high-risk medical conditions may be eligible for two additional cleanings per year and one additional fluoride treatment per year. Bitewing X-rays are limited to once per year.

Basic restorative care such as fillings, endodontics, periodontics, and simple extractions is subject to the in-network deductible and covered at 50% under the Basic Dental coverage when received from a dentist participating in either the Delta Dental PPO or the Delta Dental Premier networks. You are responsible for the remaining 50% of the cost of basic restorative care received in-network. Basic restorative care received outside the Delta Dental networks is subject to the out-of-network deductible and reimbursed at 30%. You would be responsible for the remaining 70% of basic restorative care received outside the Delta Dental networks plus any charges incurred in excess of the Delta Dental network allowed fee.

Major restorative care such as crowns, caps, implants, bridgework or dentures is subject to the in-network deductible and covered at 25% under the Basic Dental coverage when received from a dentist participating in either the Delta Dental PPO or Delta Dental Premier dental networks. You are responsible for the remaining 75% of the cost of major restorative care received in-network. Major restorative care received outside the Delta Dental networks is not covered under the Basic Dental coverage option.

The following oral surgical procedures are covered at 100% for in-network dentists and 80% of the allowed fee for out-of-network dentists: removal of impacted teeth (complex extractions), root amputation, and alveoloplasty. These procedures are exempt from the annual maximum.

Orthodontics is not covered under the Basic Dental coverage option.

For more information see the “Summary of Dental Plan Benefits” on Page 9. Other limits and exclusions may apply. Please refer to the section “What the Dental Plan Does Not Cover” beginning on page 14.

Plus Dental Plan You receive benefits for dental services covered under the Plus Dental Plan for dental care that is not work related according to the following schedule:

The Plus Dental Plan covers diagnostic and preventive care including oral exams, routine cleaning and X-rays at 100% with no deductible. Diagnostic and preventive care received outside the Delta Dental networks is reimbursed at 80%. You are responsible for the remaining 20% of the cost for diagnostic and preventive care received outside the Delta Dental networks plus any charges incurred in excess of the Delta Dental network allowed fee. Prophylaxes (cleanings), including basic and/or periodontal prophylaxes, and routine oral examinations/evaluations are limited to twice per year. People with certain high-risk medical conditions may be eligible for two additional cleanings per year and one additional fluoride treatment per year. Bitewing X-rays are limited to once per year.

Basic restorative care such as fillings, endodontics, periodontics, and simple extractions is subject to the in-network deductible and covered at 80% under the Plus Dental Plan when received from a dentist participating in either the Delta Dental PPO or the Delta Dental Premier dental networks. You are responsible for the remaining 20% of the cost of basic restorative care received in-network. Basic restorative care received outside the Delta Dental networks is subject to the out-of-network deductible and reimbursed at 60%. You would be responsible for the remaining 40% of the cost for basic restorative care received outside the Delta Dental networks plus any charges incurred in excess of the Delta Dental network allowed fee.

Major restorative care such as crowns, caps, implants, bridgework or dentures is subject to the in-network deductible and covered at 50% under the Plus Dental Plan when received from a dentist participating in either the Delta Dental PPO or the Delta Dental Premier networks. You are responsible for the remaining 50% of the cost of major restorative care received in-network. Major restorative care received outside the Delta Dental networks is subject to the out-of-network deductible and reimbursed at 30%. You would be responsible for the remaining 70% of the cost for major restorative care received outside the Delta Dental networks plus any charges incurred in excess of the Delta Dental network allowed fee.

The following oral surgical procedures are covered at 100% for in-network dentists and 80% of the allowed fee for out-of-network dentists: removal of impacted teeth (complex extractions), root amputation, and alveoloplasty. These procedures are exempt from the annual maximum.

The Plus Dental Plan covers orthodontics at 50%, with no deductible, up to a lifetime maximum of $1,500 for each covered individual. Services may be received from any licensed orthodontist. You would be responsible for the remaining 50% of the cost of orthodontic care plus any charges in excess of the Delta Dental allowed fee. Orthodontic benefits are available to covered individuals up to age 19.

For more information see the "Summary of Dental Plan Benefits" below. Other limits and exclusions may apply. Please refer to the section "What the Dental Plan Does Not Cover" beginning on page 11.

Summary of Dental Plan Benefits The following chart provides a summary of the benefits available through the Dental Plan. All non-network care is subject to Delta Dental network allowed fee limitations.

Benefit Category	Basic Benefits		Plus Benefits	
	Network	Non-Network*	Network	Non-Network*
Diagnostic & Preventive Services				
Dental Examination (Twice per calendar year)	100%	80%	100%	80%
Oral Prophylaxis *** (Twice per calendar year)	100%	80%	100%	80%
Bitewing X-rays (Once per calendar year)	100%	80%	100%	80%
Full-Mouth X-rays (Once every 60 months)	100%	80%	100%	80%
Fluoride Application (up to age 16 – twice per calendar year)	100%	80%	100%	80%
Sealants on permanent bicuspids and molars Children (up to age 19) (Once per tooth per lifetime)	100%	80%	100%	80%
Space maintainer for children (to age 14) (Once per tooth per lifetime)	100%	80%	100%	80%
Emergency Palliative Treatment	100%	80%	100%	80%
Basic Restorative Services				
Amalgam Fillings (under local anesthesia)	50%	30%	80%	60%
Resin Fillings – Anterior and Posterior (under local anesthesia)	50%	30%	80%	60%
Pin Retention (under local anesthesia)	50%	30%	80%	60%
Denture Reline and Repair	50%	30%	80%	60%
Endodontic Services (under local anesthesia)				
Root Canal Treatment	50%	30%	80%	60%

Therapeutic Pulpotomy	50%	30%	80%	60%
Apexification/Recalcification	50%	30%	80%	60%
Retrograde Filling	50%	30%	80%	60%
Hemisection	50%	30%	80%	60%
Pulpal Therapy	50%	30%	80%	60%
Oral Surgery (under local anesthesia)				
Simple Extractions	50%	30%	80%	60%
Root Removal	50%	30%	80%	60%
Certain Other Oral Surgery Procedures**	50%	30%	80%	60%
Periodontics-Gum Treatment (under local anesthesia)				
Nonsurgical***	50%	30%	80%	60%
Scaling & Root Planing	50%	30%	80%	60%
Major Restorative ****				
Crowns, Caps, Implants	25%	Not Covered	50%	30%
Fixed Bridgework	25%	Not Covered	50%	30%
Full or Partial Dentures	25%	Not Covered	50%	30%
Calendar Year Maximum Per Person	$1,000	$1,000	$2,000	$2,000
Orthodontics ($1,500 Lifetime Maximum)	Not Covered		50%	50%

* Member is responsible for non-network co-pay plus amounts charged by a non-network dentist that exceed Delta Dental's allowed network fee for the service. However, if a non-network dentist charges less than Delta Dental's allowed fee, the benefit payable will be based on the billed charge for the service rendered.

** Certain oral surgery procedures are included under both the Basic and Plus Dental Plans as part of basic restorative care at 100% R&C. These benefits include and are limited to the surgical removal of impacted teeth, dental root resection, and alveoloplasty. Other benefits for treatment of the mouth may be available under the medical plan.

*** Periodontal cleanings are paid at the periodontics level and are included in the twice per calendar year cleaning frequency limitation.

**** Major restorative services often have additional limitations such as limited frequency of services, and may only apply to age 16 and over. Please seek pre-treatment estimate.

Alternative Treatment Some dental conditions may be treated by one or more methods. In this case, benefits are payable for the procedure that provides the proper treatment, according to accepted standards of dental practice with the lowest usual, customary and reasonable charge. In some cases, additional information, X-rays, and/or dental records may be requested from your dentist for further evaluation.

Pre-treatment estimate Pre-treatment estimates or advance claim review is an important part of the Dental Plan. If charges for a proposed course of treatment are expected to be $200 or more, a description of the treatment plan and cost may be submitted in advance to Delta Dental using a Delta Dental claim form. Your Delta Dental network dentist can submit the treatment plan for you. Delta Dental will determine the estimated benefit in advance and will inform both you and your dentist how much the Dental Plan will pay and what part, if any, will be your responsibility.

The initial stages of a course of treatment such as emergency treatment, oral examinations, and dental X-rays may take place before the pre-treatment estimate is made. Delta Dental has the right to recommend alternative forms of treatment. If you elect to receive a more expensive form of treatment, Delta Dental may limit the Dental Plan's payment to the level of care that provides

proper treatment, according to accepted standards of dental practice up to the lower usual, customary and reasonable charge.

Specialty Care Before you start specialty care for procedures that exceed $200, ask the specialist to submit a Delta Dental claim form for a pre-treatment estimate. Delta Dental will then notify you in advance of the amount covered under the Dental Plan. This will enable you to know what the Dental Plan will pay and what portion of the cost of treatment, if any, will be your responsibility.

If you receive services from a specialist not in the Delta Dental PPO or the Delta Dental Premier networks, the out-of-network benefit will be applied. You will be responsible for the benefit co-payment and any amount in excess of the Delta Dental network allowed fee.

Out-of-Area Emergency Benefit If you have a dental emergency while you are away from home, you should call Delta Dental's Customer Service number on your identification card for referral to a dentist participating in Delta Dental PPO or Delta Dental Premier networks. If you receive emergency care from a non-participating dentist, the Dental Plan will provide benefits at the out-of-network level.

An emergency is defined as a traumatic condition or injury that occurs unexpectedly, requires immediate diagnosis and treatment and causes severe pain, bleeding, or infection. You should return to your primary care dentist as soon as possible to have the overall dental problem treated.

Accidents If you have a dental emergency that results from an accident, seek coverage under your medical plan, not the dental network. The medical plan provides coverage for the treatment of injuries to natural teeth within the calendar year of the injury or the next one, including the replacement of teeth within that period.

Customer Services When you have questions about your coverage or claims, contact a Delta Dental Customer Service representative at (800) 524-0149. You should also contact Delta Dental's Customer Service to request a replacement for a lost or stolen reference card or go online at www.deltadentaloh.com to print your own card.

What the Dental Plan Does Not Cover No payment will be made by Delta Dental for the following services. All charges for the following services will be the responsibility of the participant.

- Diagnostic and preventive care received by any covered individual more than twice in any calendar year.
- More than one set of bitewing X-rays in any calendar year. More than one set of full mouth X-rays (which include bitewing X-rays) or a panorex in a five-year period. A panorex taken with bitewing X-rays is considered a full-mouth X-ray.
- Services that are not within the classes of benefits in the Summary of Dental Plan Benefits or that are not in the Contract with Delta Dental Plan of Ohio, Inc.
- Charges in excess of the approved network fee for the service or supply received from a dentist not participating in the Delta Dental PPO or the Delta Dental Premier dental networks.

- Services or appliances started before an individual became eligible under this plan.
- Services for injuries or conditions payable under Worker's Compensation or Employer's Liability laws.
- Benefits for services that are available from any government agency, political subdivision, community agency, foundation or similar entity. This does not apply to any programs provided under Title XIX of the Social Security Act(that is, Medicaid).
- Cosmetic dentistry including veneers on any tooth, or repairs to the facings of teeth posterior to the second bicuspid position.
- Services or supplies which are not recommended by a dentist.
- Services, as determined by Delta Dental, for correction of congenital or developmental malformations, cosmetic surgery or dentistry for aesthetic reasons. This includes, but is not limited to plastic, reconstructive or cosmetic surgery or other dental services or supplies that improve, alter, or enhance appearance.
- Prescription drugs (except intramuscular injectable antibiotics), pre-medications, medicaments/solutions and relative analgesia.
- Retreatment of a root canal by the same dentist within 24 months of the original root canal treatment.
- Replacement or modification made within five years after the last placement of any prosthetic or orthodontic appliance, cast restoration, inlay, onlay, crown, or fixed bridge.
- Reline, rebase or any adjustment or repair within six months of the delivery of a partial denture.
- General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless medically necessary.
- Charges for hospitalization, laboratory tests and histopathological examinations.
- Charges for failure to keep a scheduled visit with the dentist. Charges for the completion of claim forms.
- Services, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental or investigational in nature as determined by the standards of generally accepted dental practice.
- Treatment by other than a dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
- Services and supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage.
- Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
- Services and supplies needed as a result of intentionally self-inflicted injury or sickness, while sane or insane.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
- Services and supplies needed as a result of committing or attempting to commit a felony, or being engaged in an illegal occupation or act.

- Services rendered by a person who is an immediate relative of or who ordinarily resides with the covered person requiring treatment. "Immediate relative" means spouse, child, brother, sister, or parent of the covered person, of the employee or of his or her spouse.
- Services that are covered under a hospital, medical/surgical or prescription drug plan.
- Fluoride rinses, self-applied fluorides, whitening or desensitizing medicaments.
- Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
- Lost, missing or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
- A space maintainer for maintaining space due to the premature loss of the anterior primary teeth.
- The replacement of teeth beyond the normal complement of teeth.
- Porcelain crowns on posterior teeth.

Other services may be limited or excluded under the contract with Delta Dental Plan of Ohio, Inc. and by the policies and procedures of Delta Dental, including Delta Dental's Processing Policies. Your Delta Dental network dentist can advise you on coverage for specific dental services. If you have any questions or need to confirm plan benefits ask your dentist to submit a request for pre-treatment estimate or contact Delta Dental customer service by calling the telephone number on your reference card.

THE DELTA DENTAL NETWORK

How the Delta Dental Network Works After enrolling in the Delta Dental Plan, simply let your dentist know that you have dental benefits coverage with Delta Dental.

To maximize your benefits under the Delta Dental networks, you must receive dental care services from a network dentist. It is not necessary to designate a dentist when you enroll, and you may seek care from any Delta Dental dentist at any time. FirstEnergy participates in both the Delta Dental PPO and the Delta Dental Premier dental networks. You may access an updated network directory on the Delta Dental Internet Web site at www.deltadentaloh.com or selecting the "Employee Benefits" tab at www.myfirstrewards.com. You may also request a list be sent to your home of participating dentists in your area by calling the customer service number on your reference card and following the prompts for "Find a Dentist".

When a network dentist provides your dental care, the Dental Plan pays the full cost of diagnostic and preventive care. You are required to pay a portion of the cost of restorative care depending on the level of coverage you choose. The applicable coinsurance may be required on the day of your visit. This is the only amount that you are responsible to pay. There are no deductibles for care received within the dental network. However, there are applicable calendar year maximums per person, excluding orthodontics. Orthodontic care, which is available under the Plus Dental coverage, has a $1,500 lifetime maximum benefit per participant, spouse and eligible dependents up to age 19. Your network dentist will file a claim for benefits on your behalf. Claim payments will be mailed directly to your network dentist.

Except for orthodontics, if you seek dental care from a dentist who is not participating in either the Delta Dental PPO or the Delta Dental Premier networks, the coverage levels are reduced in most cases by 20%. In addition to the coinsurance amount, you are responsible for any amounts charged by a non-network dentist in excess of Delta Dental's allowed network fee for the service, including orthodontics. The applicable coinsurance may be required on the day of your visit. The various benefit levels are shown in the "Summary of Dental Plan Benefits" on page 9. Any amounts charged by a non-network dentist in excess of Delta Dental's allowed network fee will be billed to you by your dentist. If you receive dental care from a dentist who is not in the Delta Dental network, you must complete and submit a Delta Dental claim form. Claim payments will be made directly to you and you are required to pay your dentist.

Whether you seek care from a network or non-network dentist, the allowable amount under the Network will be the dentist's actual charge or the Delta Dental allowed fee, whichever is less.

Out-of-Area College Students An eligible dependent child may select a dentist either near to home or at school from either the Delta Dental PPO or Delta Dental Premier networks. Services received out of the network by full-time college students will be covered at the non-network level.

HOW TO SUBMIT A CLAIM

Filing A Claim for Benefits When services are provided by a network dentist, the claim will be filed by the provider. You don't need to worry about submitting any paperwork. However, if a non-network dentist provides the services, you must submit a claim form for benefits. You may access and print a copy of the Delta Dental Claim Form by clicking on Employee Benefits tab and the dental link at www.myfirstrewards.com.

Notification of Payment After a claim is processed for which the remaining balance is greater than zero, you will receive an Explanation of Benefits (EOB) form from Delta Dental. The total amount of the benefit from the Dental Plan will be shown as well as the amount paid. The explanation will also show any ineligible charges and the reason they were not allowed.

If you have questions concerning the benefits paid, call Delta Dental's Customer Service at the number shown on your reference card.

If a Claim is Denied If a claim for benefits is denied in whole or in part, you will receive a written notice of the denial from Delta Dental. The notice will explain the reason for the denial, identify the part of the Dental Plan on which the denial is based, and outline Delta Dental's claims appeal procedure, which is also set forth below.

Assignment and Responsibility for Payment The Dental Plan reimburses expenses for covered dental services and supplies according to the terms of the Dental Plan you have selected and administrator contracts. In many cases, benefits are assigned directly to the dentist, doctor or other dental provider. Charges that are not reimbursed by the Dental Plan are the patient's responsibility. Generally, these would include coinsurance and charges for services that are not covered or greater than the maximum allowable fee for a non-network dentist.

Coordination of Benefits Some people have other dental coverage in addition to coverage under this Plan. When this is the case, the dental benefits from other plans will be taken into

consideration and coordinated with the benefits paid by the Dental Plan. When Delta Dental is secondary, its payments will be based on the amount remaining after the primary plan has paid. Delta Dental will not pay more than that amount, and it will not pay more than it would have paid as primary.

For example, if a claim for a cleaning is submitted by a participating dentist and the approved fee is $100, Delta Dental will first determine what it would pay if Primary as follows:

Submitted Fee	$100.00
Delta Dental would pay 100% as primary	$100.00
Delta Dental then determines its liability as the secondary carrier as follows:	
Submitted Fee	$100.00
Primary carrier paid	$ 50.00
Balance	$ 50.00
Delta Dental will pay $50 because it is less than it would pay as primary.	$ 50.00
Your balance is:	$ 0

If a claim for a filling is submitted by a non-participating dentist for $100 but the maximum allowable fee for a non-participating dentist is $80, Delta Dental will first determine what it would pay under the Plus Option if Primary as follows:

Submitted fee	$100.00
Maximum allowable fee	$ 80.00
Delta Dental would pay 60% of $80	$ 48.00
Delta Dental then determines its liability as the secondary carrier as follows:	
Submitted Fee	$100.00
Primary carrier paid	$ 50.00
Balance	$ 50.00
Delta Dental will pay $48 which is the amount it would pay as primary .	$ 48.00
Your balance is	$ 2.00

If a claim for a root canal is submitted by a non-participating dentist for $300, but the maximum allowable fee for a non-participating dentist is $150, Delta Dental will first determine what it would pay under the Plus Option if Primary as follows:

Submitted fee	$300.00
Maximum allowable fee	$150.00
Delta Dental would pay 60% of $150	$ 90.00
Delta Dental then determines its liability as the secondary carrier as follows:	
Submitted fee	$300.00
Primary carrier paid:	$120.00

Balance	$180.00
Delta Dental will pay $90 which is the amount it would pay as primary	$ 90.00
Your balance is	$ 90.00

Delta Dental will pay only for health care expenses that are covered by Delta Dental.

Delta Dental will pay only if you have followed all applicable procedural requirements.

Delta Dental will pay no more than the "allowable expenses" for the health care involved. If the allowable expenses are lower than the primary plan's, Delta Dental will use the primary plan's allowable expenses. This may be less than the actual bill. In order to administer this provision, the Dental Plan may obtain information from all plans involved and release to other plans any information necessary for coordination of benefits.

The Coordination of Benefits rules are as follows:

- The plan covering an individual as an active employee is primary over a plan covering an individual as a dependent.
- The plan covering an individual as an active employee is primary over a plan covering the individual as a retiree or a dependent of a retired employee. If both plans do not have this provision, it will not apply.
- If a covered person is a spouse, the Dental Plan will be secondary if the spouse has dental coverage from his or her employer.
- In the case of covered dependent children, the plan of the parent whose birthday occurs first in the calendar year is primary over the plan of the parent whose birthday occurs later in the calendar year. If the other plan does not have this provision regarding birthdays, then the rule set forth in the other plan will determine the order of benefits.
- In the case of a divorce, if there is a court decree which makes one parent financially responsible for dental care of the children, the plan of the court ordered parent is primary over the plan of the other parent.
- If the decree does not expressly make one parent financially responsible for the dental care of the dependent children, and the custodial parent is not remarried, the plan of the parent with custody is primary over the plan of the parent without custody. If the custodial parent is remarried, the plan of the custodial parent is primary, the plan of the stepparent is secondary, and the plan of the parent without custody is tertiary.
- Benefits payable under any medical expense plan sponsored by the Company will be primary to benefits payable under the Dental Plan, and in no circumstances will the benefits paid by all sources exceed 100% of covered charges.

Third Party Liability and Subrogation In some cases, you or a covered dependent may incur medical expenses as the result of an injury or illness for which a third party may be liable. For example, you may incur dental care expenses as the result of an injury received in an automobile accident. In these cases, the Dental Plan has the right to recover any benefits it has

paid for these dental care expenses from any settlement you may receive from the third party. The Plan also has the right to act on your behalf (subrogate) in filing suit against the third party to recover the benefits it has paid for dental care expenses related to the illness or injury for which the third party may be liable.

CLAIMS AND APPEALS PROCEDURES FOR GROUP HEALTH BENEFITS

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate. If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a co-payment to satisfy the balance, you may also treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim for benefits, you can take the following steps:

First, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, (800) 524-0149, and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at P.O. Box 30416, Lansing, Michigan, 48909-7916. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered with respect to your claim for benefits. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was denied improperly and to allow Delta Dental to correct this error quickly.

Claims Appeal Procedure Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Claims Appeal Procedure described here. To request a formal review of your claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916

Please include your name and address, the Social Security number for the employee through whom coverage is provided, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and also indicate in your letter that you are requesting a formal appeal of your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are appealing an adverse determination of

a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his or her decision within 30 days of receiving your request for review of Pre-Service Claims or within 60 days for Post-Service Claims. If your claim is denied on review (in whole or in part), you will be notified of the denial in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his or her adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

If your claim is denied in whole or in part after you have completed this required Claims Appeal Procedure or if Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling (614) 633-2673 or (800) 686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 2100 Stella Court, Columbus, Ohio, 43216-1067.

Legal Claims Any civil suit brought against the Plan, its Administrator, Sponsor or any other Plan fiduciary may only be submitted and filed in the United States District Court for the Northern District of Ohio.

CLAIMS AND APPEALS PROCEDURES REGARDING CLAIMS FOR OTHER THAN GROUP HEALTH BENEFITS

The claims procedures described in this section shall apply to claims regarding eligibility or participation by any eligible employee or eligible retired employee, eligibility for a dependent to be entitled to coverage or benefits, and to claims other than claims for group dental benefits. Plan documents (including amendments to the Plan) shall govern all situations concerning the provisions of the Plan.

Initial Claim Decision for Claims Relating to Eligibility and Participation Any participant who wishes to file a claim for any benefit relating to the terms of eligibility or participation under the Plan, including but not limited to eligibility to participate in any benefit program or coverage option, the dependent status of an individual, eligibility to make a mid-year change in a coverage election, eligibility to pay premiums on a pre-tax or after-tax basis, the amount of any premium, or for benefits other than group health benefits, shall file such claim with the Administrator.

The address for filing a claim with the Administrator is:

FirstEnergy. Welfare Plan
Attention: Plan Administrator
76 South Main Street
Akron, Ohio 44308

The Administrator shall process each properly filed claim within a reasonable time but not later than 90 days after its receipt of an application for benefits. This period may be extended by an additional 90 days if the Administrator provides the claimant with written notice of the extension within the initial 90-day period. The extension notice shall explain the reason for the extension and the date by which the Administrator expects a decision will be made. If the extension is necessary because additional information is needed to decide the claim, the extension notice shall describe the required information. The claimant should provide the required information as soon as possible.

The Administrator shall notify the claimant in writing, delivered in person or mailed by first-class mail to his or her last known address, if any part of a claim has been denied. The notice of a denial of any claim shall include: (i) the specific reasons for the denial; (ii) a reference to specific provisions of the plan document upon which the denial is based; (iii) a description of any internal rule, guidelines, protocol or similar criterion relied on in making the denial (or a statement that such internal criterion will be provided free of charge upon request); (iv) a description of any additional material or information deemed necessary by the Administrator for the claimant to perfect his or her claim and an explanation of why such material or information is necessary; and (v) an explanation of the claims review procedure under the plan.

If the notice described above is not furnished and if the claim has not been granted within the time period specified above, the claim shall be deemed denied and shall be subject to review as set forth below.

Appeals of Denied Claims If a claim is denied, in whole or in part, the claimant may request that the FirstEnergy Corp. Employee Benefit Claims and Appeals Committee ("Appeals Committee") review his or her claim. A claimant shall have 60 days in which to request a review. Such request shall be in writing and delivered to the Appeals Committee. If no such review is requested, the decision of the Administrator shall be considered final and binding. The address for the Appeals Committee is:

FirstEnergy Corp. Employee Benefit Claims and Appeals Committee,
76 South Main Street, 7th floor
Akron, Ohio 44308.

A request for review must specify the claimant's reason(s) for requesting that the denial be reversed. The claimant may submit additional written comments, documents, records, and other information relating to and in support of his or her claim; all information submitted shall be reviewed regardless of whether it was available for the initial review. A claimant may request reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits. If a review is requested, a full and fair review of the decision will be made by a person different than, and who is not a subordinate of, the original decision maker.

The Appeals Committee shall render its final decision within a reasonable period of time but not later than 60 days from its receipt of a request for review. This period may be extended up to an additional 60 days, if the Appeals Committee determines that special circumstances exist (such as the need for a hearing) which require an extension of time for processing the review. The Appeals Committee shall provide the claimant with written notice of the extension within the initial 60-day period. The extension notice will explain the reason for the extension and the date by which the Appeals Committee expects a decision will be made. If the extension is necessary because additional information is needed, the extension notice will describe the required information. The claimant should provide the required information as soon as possible.

If, after review, the claim continues to be denied, the Appeals Committee shall provide the claimant with a notice of the denial of his or her appeal which shall contain the following information: (i) the specific reasons for the denial of the appeal; (ii) a reference to the specific provisions of the plan document on which the denial was based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits; (iv) a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the denial (or a statement that such information would be provided free of charge upon request); and (v) a statement describing his or her right to bring a civil suit under Federal law no later than 180 days after receipt of the denial and a statement concerning any other voluntary alternative dispute resolution options that may be available.

Legal Claims Any civil suit brought against the Plan, its Administrator, Sponsor or any other Plan fiduciary may only be submitted and filed in the United States District Court for the Northern District of Ohio.

BENEFITS UPON TERMINATION OF COVERAGE

Termination of Coverage Coverage for you and your eligible dependents will terminate at the end of the month in which you leave the Company for reasons other than retirement; if you cease to be an eligible employee; or if the Dental Plan is discontinued.

Coverage will also terminate immediately if the required employee contribution, if applicable, has not been made. A dependent's coverage will terminate at the end of the month in which he or she is no longer an eligible dependent.

There is no option for conversion of Dental Plan coverage to personal insurance upon termination of group dental plan coverage under the Dental Plan.

Extension of Benefits A covered person may be undergoing a course of treatment at the time coverage under the Dental Plan terminates. If an eligible person loses eligibility while receiving dental treatment, only covered services received while that person was covered under the Plan will be payable. Certain services begun before the loss of eligibility may be covered if they are completed within a 60-day period measured from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. Any balance of the total fee not paid by Delta Dental is your responsibility. Charges incurred for any other dental services rendered are not covered under this extension of benefits.

Your Rights to Continued Dental Care Coverage The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 is an act of Congress that protects you and your dependents from loss of group health coverage (including Dental Plan coverage) if certain events occur that would otherwise result in your loss of coverage. When your coverage as an active employee ends you can elect continued coverage — at your own expense and without evidence of good health — which is identical to the coverage provided for all other employees.

Coverage may be continued for a period of 18, 29, or 36 months for the following COBRA qualified reasons:

- Loss of coverage due to termination of employment

  If your employment is terminated due to any reason other than gross misconduct, you and your covered dependents may continue dental coverage for up to 18 months.

- Eligibility for continued coverage because of disability

  If you or your dependent are Social Security disabled at the time you qualify for COBRA, or within 60 days of the date COBRA continuation begins, coverage may be extended from 18 months to 29 months. You must be eligible for Social Security disability benefits and notify the Company of your eligibility for Social Security disability benefits before your first 18 months of COBRA ends.

- Termination of coverage due to a divorce or death

  If you should die, or become divorced, your covered dependents may continue dental care coverage for up to 36 months. If you are already covered by COBRA under the 18-month provision, and any of the preceding events occur, your dependents can extend coverage to a maximum of 36 months from the first date of eligibility for COBRA coverage.

- Termination of coverage due to loss of eligibility

  Your covered dependents may continue dental coverage for up to 36 months after they no longer qualify as covered dependents. Note: If you are already covered by the 18-month provision, your dependents can extend coverage to a maximum of 36 months from the first date of eligibility for COBRA coverage.

How To Continue Coverage If your employment ends for any reason other than gross misconduct, you will receive notification from the Plan's COBRA administrator with a detailed explanation of your COBRA rights and all necessary application forms.

If your coverage ends because of a divorce, or you are no longer an eligible dependent, you must notify the Company in writing within 60 days after the date your eligibility for coverage ends. If written notice is not received within 60 days of the later of (i) date the qualifying event occurs, or (ii) the date the qualified beneficiary loses coverage as a result of the event, coverage cannot be continued. When your notice is received, you and your dependents will be notified by the Plan's COBRA administrator of your rights to continue coverage under COBRA. If you or a covered dependent decides to continue coverage, the election must be completed within 60 days of the date notification was received.

The Cost of Continued Coverage You are responsible for paying the premium cost for continued dental care coverage. The amount of the monthly premium for continued coverage will be included in the notice sent to you or your dependents.

Once you have elected to continue group dental coverage, the first premium payment must be received by the Plan's COBRA administrator within 45 days after continued coverage is elected. Premiums for continued coverage are due on the first day of each month. If the required premium is not paid within 30 days from the first of the applicable month, continued coverage under COBRA will be terminated.

When Continued Coverage Ends Your group dental coverage will continue until the earliest of the following:

- The required monthly premiums are not paid.
- The person becomes covered by another dental plan or network.
- The person becomes eligible for Medicare.
- The date the Company terminates all of its dental plans.

After a period of 18, 29, or 36 months of continued coverage depending upon the circumstances of the termination of coverage.

HIPAA PRIVACY NOTICE

As a plan under the FirstEnergy Corp. Welfare Plan, the Dental Plan will only disclose Protected Health Information (PHI) to the Employer in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan agrees not to use or further disclose PHI other than as permitted in FirstEnergy Corp. Welfare Plan's privacy notice, or as required by law.

The Plan will train any employees who have access to PHI regarding the requirements of HIPAA. The Plan ensures that any of its business agents that receive PHI from the Plan agree to the same restrictions and conditions. PHI will not be used or disclosed for employment-related actions or in connection with any other benefit or employee benefit plan.

Access to and use of PHI by Human Resources personnel shall be restricted to plan administration functions performed for the Plan. Such access or use shall be permitted only to the extent necessary to perform the duties of the Plan.

Seeking assistance from Human Resources The Dental Plan will attempt to limit PHI received from participants or beneficiaries by encouraging participants and beneficiaries to directly contact the provider who administers benefits payable by the applicable health and welfare plan. However, in the event that the Company receives PHI, the following procedures will be in effect to protect the privacy of that information.

The Company will designate specific Human Resources representatives to have access to PHI at each Company location. To the extent possible, only the designated Human Resources representative and members of the Benefits Section of the Human Resources Department will have access to PHI. Under HIPAA regulations, designated Human Resources representatives or members of the Benefits Section of Human Resources will not be permitted to disclose PHI to a health care provider unless authorized in writing by the participant/beneficiary or their authorized personal representative.

OTHER FACTS AND INFORMATION

Benefit Rights This summary describes the current level of benefits and contributions required for active employees, retirees, and eligible dependents. The decision to offer dental care benefits and the levels of coverage are based on management decision or with respect to bargaining unit employees, upon the agreements reached between the Company and the unions. Retirement health care benefits, including dental benefits, are not vested. Health care benefits and the contributions required for coverage including retiree dental care benefits and contributions may be amended or terminated at any time by the Chief Executive Officer of FirstEnergy Corp. or his or her appointed designee.

Source of Benefits Dental benefits are provided under an insurance arrangement with Delta Dental Plan of Ohio, Inc. as described in this Summary Plan Description and offered by the Company to eligible employees and their dependents.

The complete terms of the Dental Plan are set forth in the contract between FirstEnergy Service Company and Delta Dental Plan of Ohio, Inc. As the Dental Plan Administrator, Delta Dental determines the benefits for which an individual qualifies for under the Dental Plan. All payments are based upon that determination.

Participant's Rights As a participant in the Dental Plan you are entitled to:

- Examine, without charge, at the Plan Administrator's office and plant or field Human Resources Offices, a copy of the Plan, the latest annual report and the Plan description;
- Obtain copies of Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report; and
- Expect that the people who operate your Plan, called "fiduciaries" of the Plan, will do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one — the Company, your union or any other person — may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Dental Plan benefit or exercising your rights under the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials and do not receive them for 30 days, you may file suit in a federal court. 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 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 form the U.S. Department of Labor, or you may file suit in a federal court.

If you are successful, the court may order the person you have sued to pay court costs and legal fees; if you lose, the court may order you to pay these costs and fees.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Administration 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 NW, Washington, D.C. 20210.

Plan is Not an Employment Contract The Dental Plan shall not be deemed to constitute a contract between the Company and any employee, nor shall anything herein contained be deemed to give any employee any right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any employee at any time and to treat the employee without regard to the effect which such treatment might have upon the employee as a participant in the Dental Plan.

Right to Amend Plan The Dental Plan may be amended or terminated by the Chief Executive Officer of FirstEnergy Corp or his or her appointed designee at any time or for employees represented by a labor union in accordance with the applicable collective bargaining agreements.

Administration FirstEnergy Service Company as the Plan Administrator has the authority to control and manage the operation and administration of the Dental Plan with benefits provided in accordance with the provisions of the contract with Delta Dental Plan of Ohio, Inc. Inquiries should be made to the Plan Administrator:

FirstEnergy Service Company
76 South Main Street
Akron, OH 44308
1-800-543-4654

FirstEnergy Corp. is the Plan Sponsor for the Dental Plan.

General inquiries about the Dental Plan should be directed to Delta Dental who has contracted with FirstEnergy to process claims. Any questions about benefit coverage for a dental service or supply, or the processing of a claim should be directed to Delta Dental Customer Service at the address or telephone number below:

Delta Dental
P.O. Box 9089
Farmington Hills, MI 48333-9089
(800) 524-0149
www.deltadentaloh.com

Type Of Plan
The Dental Plan is a welfare benefit plan.

Agent For Service Of Legal Process

CT Corporation System
400 Easton Commons Way
Suite 125
Columbus, OH 43219

Fiscal Year
The last day of the Plan's Fiscal Year is December 31.

Plan Number
503

Plan Sponsor
FirstEnergy Corp.

PARTICIPATING EMPLOYERS AND IDENTIFICATION NUMBERS

FirstEnergy Service Company
EIN 34-1968288

Ohio Edison Company
EIN 34-0437786

Pennsylvania Power Company
EIN 25-0718810

The Cleveland Electric Illuminating Company
EIN 34-0150020

The Toledo Edison Company
EIN 34-4375005

Jersey Central Power & Light Company
EIN 21-0485010

Metropolitan Edison Company
EIN 23-0870160

Pennsylvania Electric Company
EIN 25-0718085

American Transmission Systems, Incorporated
EIN 34-1882848

Monongahela Power Company
EIN 13-5229392

West Penn Power Company
EIN 13-5480882

Potomac Edison Company
EIN 13-5323955

Additions or deletions to the list of Participating Employers may be made at any time at the sole discretion of the Program Sponsor. An up-to-date listing of Participating Employers may be obtained from the Plan Administrator.

PARTICIPATING UNIONS

Participating Unions in accordance with the labor agreement between The Toledo Edison Company, and:

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 245

Participating Unions in accordance with the labor agreement between Metropolitan Edison Company and:

International Brotherhood of Electrical Workers A.F.L.-C.I.O
Local Union No. 777

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 777S – Reading Call Center

Participating Unions in accordance with the labor agreement between Ohio Edison Company and:

International Brotherhood of Electrical Workers A.F.L.-C.I.O
Local Union No. 1194

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union Nos. 118/126

Participating Unions in accordance with the labor agreement between Jersey Central Power and Light Company and:

International Brotherhood of Electrical Workers A.F.L.-C.I.O
Local 1289

Participating Unions in accordance with the labor agreement between The Toledo Edison Company, FirstEnergy Service Company and:

Office & Professional Employees International Union, A.F.L.-C.I.O.
Local Union No. 19

Participating Unions in accordance with the labor agreement between Pennsylvania Power Company and:

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union No. 140

Participating Unions in accordance with the labor agreement between Pennsylvania Electric Company and:

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union No. 180

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 459

Participating Unions in accordance with the labor agreement between The Cleveland Electric Illuminating Company, and:

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union No. 270

Participating Unions in accordance with the labor agreement between Monongahela Power Company and:

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union No. 102

Participating Unions in accordance with the labor agreement between Monongahela Power Company and:

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 2357

Participating Unions in accordance with the labor agreement between FirstEnergy Service Company on behalf of Allegheny Energy Supply, LLC and the Potomac Edison Company and West Penn Power Company doing business as Allegheny Energy:

International Brotherhood of Electrical Workers, A.F.L.-C.I.O
Local Union No. 50

Participating Unions in accordance with the labor agreement between FirstEnergy Corp. on behalf of Monongahela Power Company and:

Utility Worker's Union of America, Local Union 304