DELTA DENTAL®

Summary Plan Description (SPD)

Delta Dental PPO
Dentacare M - ASC

MIDWEST PUBLIC RISK
7226

(For Customer Service and Benefit Information)
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(800) 335-8266
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Delta Dental of Missouri
ASPD-PPO-DM-7 PO Box 8690, St. Louis, MO 63126-0690

About Your Coverage

About Delta Dental

Your dental coverage is provided by Delta Dental of Missouri (DDMO), a not-for-profit corporation. DDMO is a member of a nationwide system of dental benefit providers, known as Delta Dental Plans Association (DDPA), the largest provider of dental benefits in America.

Your Membership Card

Dentists do not typically require an ID card, and your dentist can always call DDMO to verify your coverage. If you, your employer or dentist prefers that you have an ID card, DDMO will provide you one. ID cards are available through your employer or DDMO, by mail or on our website.

Selecting Your Dentist

You may visit the dentist of your choice and select any dentist on a treatment by treatment basis. It is important to remember your out-of-pocket costs may vary depending on your choice. You have three options.

1. PPO Participating Dentist (Delta Dental PPO Network). Delta Dental's PPO network consists of dentists who have agreed to accept payment based on the applicable PPO Maximum Plan Allowance and to abide by Delta Dental policies. This network offers you cost control and claim filing benefits.

2. Non-PPO Participating Dentist (Delta Dental Premier Network). Delta Dental's Premier network consists of dentists who have agreed to accept payment based on the applicable Premier Maximum Plan Allowance. This network also offers you cost control and claim filing benefits. However, your out-of-pocket expenses (deductibles and coinsurance amounts) may be higher with a Premier dentist, based upon your plan design.

3. Non-Participating Dentist. If you go to a non-participating dentist (not contracted with a Delta Dental plan), DDMO will make payment directly to you based on the applicable Maximum Plan Allowance for the non-participating dentist. It will be your obligation to make full payment to the dentist and file your own claim. Obtain a claim form from your Plan Administrator's office or from DDMO.

Advantages of Selecting Participating Dentists

All participating dentists (PPO and Premier) have the necessary forms needed to submit your claim. Delta Dental participating dentists will usually file your claims for you and DDMO will pay them directly for covered services. Visit our website at *deltadentalmo.com* to find out if your dentist participates or contact DDMO to automatically receive, at no cost, a list of PPO and Premier participating dentists in your area. You are not responsible for paying the participating dentist any amount that exceeds the PPO or Premier Maximum Plan Allowance, whichever is applicable. You are only responsible for any noncovered charges, deductible and coinsurance amounts.

Claim Filing Deadline

Your claims must be filed by the end of the calendar year following the year in which services were rendered. DDMO is not obligated to pay claims submitted after this period. If a claim is denied due to a PPO or non-PPO participating dentist's failure to make timely submission, you will not be liable to such dentist for the amount which would have been payable by DDMO, provided you advised the dentist of your eligibility for benefits at the time of treatment.

Eligibility

To be eligible for this coverage, you must be a full-time employee and you must be actively at work, unless your group was enrolled in another DDMO program prior to changing to this program. You become eligible for the coverage on the day specified by your employer. For further information, contact your personnel administrator.

Enrolling

If your membership application is not received within 31 days after you first become eligible, your coverage will not become effective until your group's next anniversary date. If your spouse and/or children are not added to your membership within 31 days after they first become eligible dependents (an additional 10 days will be allowed to enroll a newborn child), their coverage will not become effective until your group's next anniversary date. Participants choosing to drop coverage cannot re-enroll for 12 months, and then only on the group's next annual anniversary date.

Dependent Children

A dependent child (natural, stepchildren or legally adopted) is eligible for coverage until the end of the month in which he or she reaches the dependent age limit (shown on your Schedule of Benefits).

Unmarried dependent children who are incapable of self-support because of physical or mental impairments can continue to be protected under your membership regardless of age, if they become impaired before reaching age 19. A special application must be completed by you and your dependent child's physician at least 31 days before your child's 19th birthday. DDMO may require proof of continued disability and dependence once a year thereafter.

Explanation of Benefits

Anytime a claim is filed by you or a dentist, you will receive a form called an Explanation of Benefits (EOB) from us. It tells you what services were covered and what, if any, were not. An explanation of how to appeal a claim is on the front of the EOB as well as in this Summary Plan Description (SPD).

Coordination of Benefits

If you have other dental coverage, benefits under this program are coordinated with benefits under any such other program to avoid duplication of payment. The two programs together will not pay more than 100% of covered expenses.

Conversion of Coverage

Coverage may not be converted to an individual plan upon termination of employment. For continuation of your Group Dental Plan, see your Benefits Office regarding the provisions of COBRA.

Claim Predetermination

If the care you need costs less than $200 or is emergency care, your dentist will proceed with treatment at your option. If the cost estimate is more than $200 and is not emergency care, your dentist will determine what treatment you need and could submit a treatment plan to DDMO for predetermination of benefits. This estimate will enable you to know in advance how much of the cost will be paid by your dental coverage and how much you will be responsible for paying.

Benefit Outline

Your Schedule of Benefits included in this SPD will show which of the levels of coverage listed below are included in your dental program. It will also show the amount of your deductible and which levels of coverage the deductible applies to. After you satisfy your dental deductible (if it applies), your dental benefits will pay a specific percentage of the allowed amount of covered services, up to your benefit maximum each benefit period. You will be responsible for the remaining coinsurance amount.

For your benefit maximum(s) and your covered percentage(s), refer to your Schedule of Benefits. (If you have orthodontic benefits, you will have a separate lifetime maximum for these benefits.) **Your dental benefits are provided according to a benefit period as described in your Schedule of Benefits.**

Refer to your **Schedule of Benefits** to determine the extent of your coverage.

Dental Services - Levels of Coverage

A: Preventive Services

- Oral examinations (evaluations), twice in any benefit period (includes all types)
- Bitewing and periapical x-rays as required
- Full-mouth x-rays, once in any 36 consecutive months
- Dental prophylaxis (cleaning, scaling, and polishing including periodontal maintenance visits), twice in any benefit period.
- Topical fluoride application for patients under age 19, once in any benefit period
- Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain)
- Space maintainers that replace prematurely lost teeth of eligible dependent children under age 16, once in 5 years; except for accidental injuries

B: Basic Services

- Restorative services using amalgam, synthetic porcelain, and plastic filling material
- Periodontics: treatment for diseases of the gums and bone supporting the teeth
- Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth)
- Simple and surgical extractions
- Sealants for dependent children under age 19, limited to caries –free occlusal surfaces of the first and second permanent molars, once in 5 years
- General anesthesia in conjunction with covered surgical procedures

C: Major Services

- Prosthetics: bridges and dentures, once in 5 years
- Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes, once in 5 years
- Oral surgery (except for extractions under coverage B)

Coverage Limitations

Under Coverage A

- Sealants are limited to caries-free occlusal surfaces of the first and second permanent molars once in 5 years for all eligible participants.
- A panoramic film with or without other films is considered equivalent to a full mouth series for coverage purposes. Coverage for multiple radiographs on the same date of service will not exceed the coverage level for complete mouth series.

Under Coverage B

- Endodontic (root canal treatment) on the same tooth is covered only once in a 2 year period. Re-treatment of the same tooth is allowed when performed by a different dental office.
- Charges for replacement of filling restorations are only covered once in a 24 month period, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

Under Coverage C

- If an existing bridge or denture cannot be made satisfactory, a replacement will be covered only once in 5 years, but not during the first year of Coverage C benefits.
- Dental benefits for an initial or replacement crown, jacket, labial veneer, inlay or onlay on or for a particular tooth will only be provided once in 5 years, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

If you receive care from more than one dentist for the same procedure, benefits will not exceed what would have been paid for one dentist for that procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy). If alternative treatments are available, DDMO will be liable for the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of an amalgam (silver) filling: or fixed bridges, in which case the benefits may be based on the cost of a removable partial denture. Implants are not a covered benefit, however the plan will provide benefits up to the maximum plan allowance that would have been allowed for a covered alternative treatment such as a permanent bridge, partial denture, or full denture.

Dental Services Not Covered

- Services for which the participant, absent this coverage, would normally incur no charge, such as care rendered by a dentist to a member of his immediate family or the immediate family of his spouse.
- Services for which coverage is available under Workers' Compensation or Employers' Liability Laws.
- Services performed for cosmetic purposes or to correct congenital malformations
- Charges for services that require multiple visits, which commenced prior to the membership effective date (including, but not limited to, prosthetics and orthodontic care).
- Services or supplies related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws).
- Any services not specifically stated as Covered Services (including hospital or prescription drug charges).
- Replacement of dentures and other dental appliances which are lost or stolen.
- Services rendered by a dentist beyond the scope of his license.
- Hypnosis.
- Duplicate services provided by another group dental plan.
- Diseases contracted or injuries or conditions sustained as a result of any act of war.
- Denture adjustments for the first six months after the dentures are initially received. Separate fees may not be charged by participating dentists.
- Charges for complete occlusal adjustments, crowns for occlusal correction, Nightguards, Bruxism Appliances, and Bite Therapy appliances.
- Tooth preparation, temporary crowns, bases, impressions, and anesthesia or other services which are part of the complete dental procedure. These services are considered components of, and included in the fee for the complete procedure. Separate fees may not be charged by participating dentists.
- Analgesia, including Nitrous Oxide.
- Charges covered under a terminal liability, extension of benefits, or similar provision, of a program being replaced by this program.
- Services rendered by 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.
- Services provided or paid for by any governmental agency or under any governmental program or law, except charges which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act and its Amendments).
- Charges for duplication of radiographs.
- Charges for temporary appliances.
- Implants and related procedures.
- Charges for experimental or investigational services or supplies.
- A dentist need not provide dental services which for any reason, in his professional judgment, should not be provided. Charges for such services are not covered expenses.
- Instructions in dental hygiene, dietary planning, or plaque control.
- Missed appointments or completion of claim forms.
- Infection control, including sterilization of supplies and equipment.
- Repair or replacement of space maintainers that are lost or damaged due to neglect.

How To Appeal A Claim

If a claim for benefits is denied, either in whole or in part, you will receive written notification from DDMO explaining the reason for denial. Within 180 days after receiving the denial, you may submit a written request for reconsideration of the claim to the Appeals Committee for DDMO. Any such request should be accompanied by documents or records in support of the appeal. You may review pertinent documents relating to the claim and submit issues and comments in writing for consideration by the Appeals Committee. The Committee will review your appeal and will notify you in writing of the decision within 60 days after your appeal is received.

In the case of an appeal involving medical judgment, DDMO will consult with a health care professional who has training and experience in the field involved in the medical judgment. The consultant will be an individual who is neither an individual who was consulted in connection with the initial denial, nor the subordinate of any such individual. DDMO will identify the consultant whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination.

Any request for reconsideration should be sent to:

Delta Dental of Missouri
Appeals Committee
12399 Gravois Rd
St. Louis, Missouri 63127-1702

This is a "summary plan description" (SPD) of your dental care plan. Eligibility for benefits and the actual amount of benefit payments are determined by the legal plan document and laws that govern that plan. This SPD describes the plan in an easier to read, summarized format. If there is any conflict between the description in this publication and the legal plan document, the legal plan document will be followed. The plan administrator maintains the right to interpret the terms of this plan. Your employer intends to maintain this plan for employees, but reserves the right to change or end the plan at any time. This SPD is not a guarantee of employment or an employment contract.

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Delta Dental of Missouri

Schedule of Benefits

For employees of:	Participating Midwest Public Risk Members
Group Number:	7226 (all sublocations)

Refer to the section, Benefit Outline, in this Summary Plan Description **(SPD)** for a more detailed explanation of levels of coverage.

PROGRAM FEATURES	**BENEFITS**
Coverage Levels:	A, B, & C
Deductible:	$50
Applies to:	B & C Coverage
Family limit:	$150
Benefit Maximum:	
Coverage A, B, and C:	$750
Orthodontic Lifetime Maximum:	N/A

Covered Percentages:	**PPO Dentist**	**Non-PPO Dentist**
Coverage A:	100%	100%
Coverage B:	85%	80%
Coverage C	55%	50%
Coverage D:	N/A	N/A

Dependent Age Limit:	26
Effective Date of Program:	7/1/2013

For all participants of Midwest Public Risk, benefits are provided according to a benefit year which renews each July 1.

- MAX*Advantage*℠ Benefit Option is included in this program. Charges for exams, cleanings, x-rays, and fluoride treatments do not apply towards your annual maximum.