DELTA DENTAL®

Summary Plan Description (SPD)

Delta Dental PPO

Cooperating School District Insurance Trust

Wright City
9199-1400,-1401,-1402,-1410,-1411,-1412

Dentacare E - ASC

(For Customer Service and Benefit Information)

(314) 656-3001

(800) 335-8266

www.deltadentalmo.com

Delta Dental of Missouri
PO Box 8690, St. Louis, MO 63126-0690

About Your Coverage

About Delta Dental

Your dental benefits are administered 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 group or dentist prefers that you have an ID card, DDMO will provide you one. ID cards are available through your group 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.

Eligibility

To be eligible for coverage, you must meet the eligibility requirements set forth on the **Schedule of Benefits**. You become eligible for the coverage on the day specified on the **Schedule of Benefits**. If desired, you may obtain a copy of the qualified medical child support order and other special eligibility procedures, at no charge, upon request.

Enrolling

At the time of initial enrollment, a member must select one of the membership types offered in the application. If your membership application is not received within 31 days after you first become eligible, you are considered a Late Entrant and benefits will be limited as shown under Coverage Limitations. If your dependents (e.g., spouse and dependent 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), they will be considered Late Entrants and benefits will be limited as shown under Coverage Limitations. A member may change his or her selected membership type because of marriage, birth, adoption (or date of placement for purposes of adoption), divorce, death, a Dependent reaching the limiting age or another designated change in status (if any) under the Membership Certificate. Participants enrolled due to a change in status will not be considered Late Entrants provided they are enrolled within 31 days of the event (an additional 10 days will be allowed to enroll a newborn child). All other changes may be restricted to the Group's annual enrollment period.

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 ('handicapped dependent') can continue to be protected under your membership regardless of age, if they become impaired before reaching the applicable dependent age limit shown on the Schedule of Benefits. An unmarried dependent child who was covered as a handicapped dependent under your Group's previous dental plan may be enrolled at the time of initial enrollment, regardless of the age the child became impaired. A special application must be completed by you and your handicapped dependent's physician at the time of enrollment or at least 31 days before your child reaches the applicable dependent age limit. DDMO may require proof of continued disability and dependence once a year thereafter.

Explanation of Benefits

In certain situations, when a claim is filed by you or your dentist, you may receive a form called an Explanation of Benefits (EOB) from us (e.g., the claim is denied or a balance due to the dentist). 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 and Termination

If you have other dental coverage, benefits under the Plan 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. DDMO may recover benefit overpayments for the Plan. An enrollee's coverage will terminate for, among other things, the following: the enrollee no longer meets the eligibility requirements, the group's dental care is terminated, or the member dies. Termination of coverage does not prejudice claims originating prior to termination.

Conversion and Continuation of Coverage

Coverage may not be converted to an individual plan upon termination of employment. If coverage for you or an eligible dependent (qualified beneficiary) ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, child's ceasing to meet the definition of dependent) specified in a federal law called COBRA, then you or your eligible dependent may have the right to purchase continuing coverage for a limited period of time (which may be 18 or 36 months (or some other period of time) depending on the circumstances), if such coverage is timely elected during the 60 day election period, which 60 days after the date coverage would have stopped due to a qualifying event or 60 days after the date the person is sent notice of the right to continue coverage. The qualified beneficiary must timely pay the full applicable cost for this continuation coverage on a monthly basis. Enrollees that may be eligible for such continued coverage should contact their Plan Administrator's office to advise them of the qualifying event and to receive information specific to their circumstances. For more information about COBRA rights, please contact your Plan Administrator's office.

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 determine 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 Dental Services

- Oral examinations (evaluations), twice in any benefit period. Problem focused exams, as needed.
- Periapical x-rays as required
- Bitewing x-rays, two sets per benefit period
- Full-mouth x-rays once in any 36 month period
- Dental prophylaxis (cleaning, scaling, and polishing), twice in any benefit period
- Topical fluoride application for dependent children under age 16, once in any benefit period
- Space maintainers that replace prematurely lost teeth of eligible dependent children under age 16, once in 5 years, except for accidental injuries

B: Basic Dental Services

- Restorative services using amalgam, synthetic porcelain, and plastic filling material. Composite fillings are a benefit on all teeth
- Simple and surgical extractions
- Sealants: for dependent children under age 16, limited to caries-free occlusal surfaces of the first and second permanent molars, once in any 36 month period
- Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain)
- Gross debridement, limited to once per lifetime
- Occlusal guard, once in 5 years

C: Major Dental Services

- Prosthetics: bridges and dentures, once in 5 years.
- Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes and when teeth cannot be restored with a filling material, once in 5 years
- Oral surgery (except for extractions under Coverage B)
- Denture relines and rebases, limited to once in 36 months
- General anesthesia in conjunction with covered surgical procedures
- Periodontics: treatment for diseases of the gums and bone supporting the teeth (including periodontal maintenance visits, subject to your prophylaxis frequency limitation). Periodontal surgery is covered only once in a 3 year period for the same site. Coverage for scaling and root planing are limited to once per 24 months
- Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth)
- Implants and implant abutment (posts) are not a covered benefit; however individual crowns over implants are covered at the prosthodontic coverage level

D: Orthodontic Dental Services

- Orthodontic care: treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position. Applies to all eligible participants, excluding dependent children over age 19.

Coverage Limitations

- 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.
- 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.
- 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 your membership is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the end of the month of termination.
- Benefits will not be paid for repair or replacement of an orthodontic appliance.
- After completion of your orthodontic treatment plan or reaching your orthodontic lifetime maximum, no further orthodontic benefits will be provided.

Late Enrollment Penalty - A participant that does not enroll when first eligible cannot enroll until the next annual open enrollment or until a life event, whichever occurs first. If the late participant does enroll at the next or any subsequent annual open enrollment, then the benefits for the late participant are limited to the covered services listed under Coverage A during the first 12 months of the participant's coverage. Dependents enrolled prior to their third birthday are not subject to the late entrant penalty.

If you receive care from more than one dentist or service provider for the same procedure, benefits will not exceed what would have been paid to one dentist for that procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy). If alternative treatments are available, your coverage will only pay for the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as fixed bridges, in which case the benefits may be based on the allowed amount for a removable partial denture.

Services Not Covered

Charges for the following are not covered:

- Services or supplies for which the enrollee, 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 or supplies for which coverage is available under workers' compensation or employers' liability laws.
- Services or supplies performed for cosmetic purposes or to correct congenital malformations, except newborns with congenital dental defects.
- Services that require multiple visits, which commenced prior to the Membership Effective Date or prior to the expiration of a waiting period, if applicable (including prosthetics and orthodontic care).
- Services incurred prior to satisfying any applicable waiting period or Late Entrant Penalty.
- Services or supplies related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws).
- Services or supplies not specifically stated as covered dental services (including hospital or prescription drug charges).
- Replacement of dentures and other dental appliances which are lost or stolen.
- 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.
- Complete occlusal adjustments, crowns for occlusal correction, athletic mouthguards, 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, duplication of radiographs, temporary appliances, or implants and related procedures.
- Services or supplies covered under a terminal liability, extension of benefits, or similar provision, of a program being replaced by this program.
- Services or supplies rendered by a dental or medical department maintained by or on behalf of a group, a mutual benefit association, union, trustee or similar person or group.
- Services or supplies provided or paid for by or under any governmental agency or 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, as amended).
- Services rendered beyond the scope of a dentist's or service provider's license, or experimental or investigational services/supplies.
- Services or supplies that a dentist determines for any reason, in his professional judgment, should not be provided.
- Instructions in dental hygiene, dietary planning, or plaque control.
- Missed appointments or claim form completion.
- Infection control, including sterilization of supplies and equipment.

How To File and Appeal A Claim

Your claims must be filed within 12 months of the date 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 Premier 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.

If a claim for benefits is denied, either in whole or in part, you will receive written notification explaining the reason for denial. Within 180 days after receiving the denial, you may submit a written request for reconsideration of the claim to addressee set forth below. 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. A decision with regard to the claim appeal will be made and you will be notified in writing of the decision within 60 days after your appeal is received.

In the case of an appeal involving medical judgment, a health care professional who has training and experience in the field involved in the medical judgment will be consulted. 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. The consultant whose advice was obtained by or on behalf of the Plan will be identified, 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 document is a "summary plan description" (SPD) of your dental care coverage, which is more fully described in the Plan Document. Because this document is a summary, it does not contain a complete explanation of each and every provision or term contained within the more comprehensive Plan Document. Where there are conflicts or inconsistencies between the language of the SPD and the Plan Document, the language of the Plan Document governs. Your employer (or Plan Administrator) has the right to amend this SPD and the Plan Document, and has discretion and authority to interpret the provisions and terms of this SPD and the Plan Document. In addition, your employer (or Plan Administrator) reserves the right to change or terminate its dental care Plan at any time. This SPD is not a guarantee of employment or an employment contract.

Delta Dental of Missouri - Schedule of Benefits
PPO - Dentacare E - ASC

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

For members of:	CSD Insurance Trust (Wright City – Standard PPO)		
Group Number:	9199-1410, -1411, -1412		
Coverage Levels and Percentages:	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist**
Coverage A:	100%	100%	10%
Coverage B:	80%	70%	10%
Coverage C:	50%	40%	10%
Coverage D:	50%	50%	10%
Per Visit Co-Pay Amount:	$10	$10	$10
Deductible:	N/A	N/A	N/A
Applies to:	N/A	N/A	N/A
Family limit:	N/A	N/A	N/A
Benefit Maximum:			
Coverage A, B, and C (if applicable):	$1,000	$1,000	$1,000
Amounts paid by Delta are applied to all benefit maximums (PPO, Premier, and Non-Participating Dentist).			
Orthodontic Lifetime Maximum:	$1,500	$1,500	$1,500
Amounts paid by Delta are applied to all orthodontic benefit maximums (PPO, Premier, and Non-Participating Dentist).			
Dependent Age Limit:	26		
Effective Date of Program:	3/1/2019		

Renewal Date may sometimes be referred to as Anniversary Date.

Benefit Period: Dental benefits are provided according to a calendar year benefit period. The calendar year benefit period begins on the Effective Date and ends on December 31st of the year in which the Effective Date occurs. A new calendar year benefit period begins each year on January 1st.

Eligibility: To be eligible for this coverage, you must be an active full-time employee of the group or a designated affiliate. "Active" means an employee regularly working at least the number of hours in the normal work week set by your group (but not less than 20 hours). You must be actively at work, unless your group was enrolled in another DDMO program prior to changing to this program. If coverage is dropped at any time, members or their dependents may not reenroll until the first open enrollment following one year.

New members and their dependents become eligible for this coverage on the date assigned by your group. Coverage ends on the date assigned by your group.

In addition to the benefits described in this SPD, your customized program includes:

- MAX*Advantage*[SM] Benefit Option is included in this program. Benefits paid for exams, cleanings, x-rays, and fluoride treatments do not apply towards your annual maximum.
- Per visit co-pay applies to Coverage A, B & C services.

THERE ARE TWO BENEFIT OPTIONS AVAILABLE TO YOU – BE SURE YOU ARE REVIEWING THE BENEFITS FOR THE PLAN IN WHICH YOU ARE ENROLLED (SEE REVERSE SIDE FOR ADDITIONAL OPTION).

Delta Dental of Missouri - Schedule of Benefits
PPO - Dentacare E - ASC

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

For members of:	CSD Insurance Trust (Wright City – Enhanced PPO)		
Group Number:	9199-1400, -1401, -1402		
Coverage Levels and Percentages:	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist**
Coverage A:	100%	100%	100%
Coverage B:	90%	80%	80%
Coverage C:	60%	50%	50%
Coverage D:	N/A	N/A	N/A
Deductible:	$50	$50	$50
Applies to:	B & C Coverage	B & C Coverage	B & C Coverage
Family limit:	$150	$150	$150

Amounts paid by Member towards the deductible apply to all deductible categories (PPO, Premier, and Non-Participating Dentist).

Benefit Maximum:

Coverage A, B, and C (if applicable):	$1,500	$1,500	$1,500

Amounts paid by Delta are applied to all benefit maximums (PPO, Premier, and Non-Participating Dentist).

Orthodontic Lifetime Maximum:	N/A	N/A	N/A

Amounts paid by Delta are applied to all orthodontic benefit maximums (PPO, Premier, and Non-Participating Dentist).

Dependent Age Limit: 26

Effective Date of Program: 3/1/2019

Renewal Date may sometimes be referred to as Anniversary Date.

Benefit Period: Dental benefits are provided according to a calendar year benefit period. The calendar year benefit period begins on the Effective Date and ends on December 31st of the year in which the Effective Date occurs. A new calendar year benefit period begins each year on January 1st.

Eligibility: To be eligible for this coverage, you must be an active full-time employee of the group or a designated affiliate. "Active" means an employee regularly working at least the number of hours in the normal work week set by your group (but not less than 20 hours). You must be actively at work, unless your group was enrolled in another DDMO program prior to changing to this program. If coverage is dropped at any time, members or their dependents may not reenroll until the first open enrollment following one year.

New members and their dependents become eligible for this coverage on the date assigned by your group. Coverage ends on the date assigned by your group.

In addition to the benefits described in this SPD, your customized program includes:

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

THERE ARE TWO BENEFIT OPTIONS AVAILABLE TO YOU – BE SURE YOU ARE REVIEWING THE BENEFITS FOR THE PLAN IN WHICH YOU ARE ENROLLED (SEE REVERSE SIDE FOR ADDITIONAL OPTION).