DELTA DENTAL®

Summary Plan Description (SPD)

Delta Dental PPO

Lee's Summit R-7 School District

23442000 (Buy-Up Option)

HCR

DentaCare M

(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 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 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 non-covered charges, deductible and coinsurance amounts.

Eligibility
To be eligible for this 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 or the ERISA Information. 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, your coverage will not become effective until your group's next renewal date. 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), their coverage will not become effective until your group's next renewal date. During the benefit period, a member may only 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. Additional dues or service charges may apply to the change. If a member changes his or her membership type during the annual open enrollment, he or she must wait one-year in order to make another change in membership type (unless the member has a change in status identified above), and then only on your group's next renewal date.

Dependent Children
A dependent child (natural, stepchildren or legally adopted children of the member or the member's spouse) is eligible for coverage until the end of the calendar year 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 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 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. DDMO may recover benefit overpayments.

An enrollee's coverage will terminate for, among other things, the following: the enrollee no longer meets the eligibility requirements, the group's coverage 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 (includes all types)
- Dental prophylaxis (cleaning, scaling, and polishing), twice in any benefit period
- Periodontal maintenance visits limited to twice in any benefit period, subject to your prophylaxis frequency limitation
- Topical fluoride application for dependent children under age 19, once in any benefit period
- Bitewing x-rays two sets per benefit period
- Periapical x-rays as required
- Full-mouth x-rays once in any 36 month period
- Space maintainers that replace prematurely lost teeth of eligible dependent children under age 19, Initial appliance only, except for accidental injuries
- Sealants: for dependent children under age 14, limited caries-free occlusal surfaces of the first and second permanent molars, once in 3 years
- Brush Biopsy to detect oral cancer

B: Basic Dental Services

- Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain)
- Restorative services using amalgam, synthetic porcelain, and plastic filling material. Composite fillings are a benefit on all teeth.
- Simple extractions
- Surgical extractions
- Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth)
- Non-surgical periodontics: treatment for gum diseases. Coverage for scaling and root planning are limited to once per 24 months
- Surgical periodontics: treatment of gum diseases and bone supporting the teeth, including periodontal splinting, covered only once in a 3 year period for the same site
- General anesthesia in conjunction with covered surgical procedures
- Oral surgery (excluding simple and surgical extractions)
- Prefabricated stainless steel crowns, when teeth cannot be restored with filling material, limited to once in 5 years
- Denture adjustments, repairs, rebase and relines to complete and partial dentures
- Repair or re-cementing of crowns, inlays, onlays, or bridgework

C: Major Dental Services

- Prosthetics: bridges, once in 5 years
- Prosthetics: 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
- Implants and implant abutments (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

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.
- 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.

- 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.
- If an existing bridge or denture cannot be made satisfactory, a replacement will be covered only once in 5 years.
- 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.

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, DDMO will be liable 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 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, 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, 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.

PPO

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

For members of: Lee's Summit R-7 School District

Group Number: 23442000 (Buy-Up Option)

Coverage Levels and Percentages:	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist**
Coverage A:	100%	80%	80%
Coverage B:	80%	50%	50%
Coverage C:	50%	50%	50%
Coverage D:	50%	50%	50%
Deductible:	$0	$0	$0
Applies to:	B Coverage	B Coverage	B Coverage
Family limit:	per person	per person	per person

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):	$1,750	$1,750	$1,750

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

Orthodontic Lifetime Maximum:	$1,000	$1,000	$1,000

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: 01/01/2024

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 30 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 last day of the month of employment.

In lieu of the benefits described in this SPD, your customized program is as follows:

- 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.
- Two additional cleanings per benefit period for participants who are pregnant, diabetic, have a suppressed immune system, or have a history of periodontal therapy. To be eligible for the additional cleaning coverage, you must submit a completed Self-Report form which can be obtained at www.deltadentalmo.com by clicking on the Healthy Smiles Healthy Lives Logo or by contacting customer service. If periodontal therapy has already been reported on your claims, the Self-Report form is not necessary.

How To File and Appeal A Claim

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 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.

You will be provided written notice if your claim for benefits under the Plan has been denied, setting forth the specific reasons for such denial, written in a manner to be understood by you. Additionally, if your claim for benefits has been denied, you will be afforded a reasonable opportunity for full review of the decision denying the claim, including appeals and requests for review.

DDMO has established a first-level and second-level review process for written complaints. A first-level review, whether related to an adverse benefit determination or for reasons other than an adverse benefit determination, must be submitted in writing to DDMO's Customer Service Department. You have 180 days to submit your written complaint after receiving the denial or the notice that gave rise to the complaint. DDMO shall allow 180 days from the date allowed to file the first level complaint or 180 days from the date DDMO sent notification to the person who submitted the complaint of DDMO's resolution of said first level complaint, whichever is later. Any complaint should be accompanied by documents or records in support of the complaint. You may review pertinent documents relating to the claim and submit issues and comments in writing for consideration.

DDMO will acknowledge receipt in writing within ten working days and will investigate the complaint within twenty working days after receipt of a complaint. If additional time is needed to complete the investigation, DDMO will notify you in writing on or before the twentieth working day with the investigation completed within thirty working days thereafter. DDMO will notify you in writing of the decision within five working days following the investigation. You have the right to request a second-level review, in which case, DDMO shall follow the same time frames as a first-level review except in the case of a request for an expedited review where life or health of an enrollee may be in jeopardy. *Any first-level complaint should be sent to*: Delta Dental of Missouri, Customer Service Department, 12399 Gravois Rd, St. Louis, MO 63127-1702. *Second-level appeals should be sent to:* Delta Dental of Missouri, Appeals Committee, 12399 Gravois Rd, St. Louis, MO 63127-1702. You have the right to file an appeal with the Director of the Missouri Department of Insurance at any time. For detailed information on filing an appeal with the Missouri Department of Insurance, (MDI), contact: Missouri Department of Insurance, ATTN: Consumer Affairs, PO Box 690, Jefferson City, MO 65102. The consumer hot line is 1-800-726-7390.

This document is a "summary plan description" (SPD) of your dental care coverage, which is more fully described in the Membership Certificate (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 Membership Certificate. Where there are conflicts or inconsistencies between the language of the SPD and the Membership Certificate, the language of the Membership Certificate governs. DDMO has the right to amend this SPD and the Membership Certificate and has discretion and authority to interpret the provisions and terms of this SPD and the Membership Certificate. In addition, your group 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.

ERISA Information

The following sections contain information to meet the requirements of the Employee Retirement Income Security Act (ERISA) of 1974, as amended. It does not constitute a part of the Plan, nor of any insurance policy issued in connection with it. All inquiries relating to the following material should be referred directly to your Plan Administrator.

Name of Plan: The Lee's Summit R-7 School District Dental Plan referred to herein as the Plan.

Plan Number: None Provided

Dental Plan for Members of: Lee's Summit R-7 School District

Group Address: 301 NE Tudor Rd.
Lee's Summit, Missouri 64086

Tax ID Number: 44-6004933

Type of Plan and Administration:
The Plan is a group dental plan. The Plan is administered by the Plan Administrator through an insured contract with DDMO. Certain functions are performed on behalf of the Plan by DDMO. These functions include, but are not limited to, administration and payment of claims, customer service assistance, and issuing of Summary Plan Descriptions.

Plan Administrator: Lee's Summit R-7 School District
Attention: Sara McMillin
301 NE Tudor Rd.
Lee's Summit, Missouri 64086
816-986-1048

Agent of Legal Service: Lee's Summit R-7 School District
301 NE Tudor Rd.
Lee's Summit, Missouri 64086

In addition, service of process may be made upon the Plan Administrator or Trustee.

Trustee: Lee's Summit R-7 School District
301 NE Tudor Rd.
Lee's Summit, Missouri 64086

Plan's Fiscal Year Ends: 12/31

Funding Is: Contributory
Contributions to the Plan are made by both the group and the member. The amount the group contributes to the plan will be determined at the group's discretion from time to time. This practice can be stopped or modified at any time without prior notice to the member.

If your Plan is subject to The Employee Retirement Income Security Act of 1974 (ERISA), the following applies. ERISA entitles you, as an enrollee in this program, to certain rights and protections. For more information, please contact your Plan Administrator's office. ERISA provides that all Plan enrollees shall be entitled to:

Receive Information About Your Plan And Benefits

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each enrollee with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan enrollees, ERISA imposes duties upon the people who are responsible for operating the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan enrollees and beneficiaries. No one, including your group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and may pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

Assistance With Your Questions

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

DELTA DENTAL OF MISSOURI
COVERAGE OF IN PROGRESS ORTHODONTIC SERVICES
RIDER TO MEMBERSHIP CERTIFICATE

This Rider is issued by Delta Dental of Missouri ("DDMO") for attachment to and inclusion as part of the Summary Plan Description ("SPD"), Number ASPD-PPO-DMDFD4-8, and Schedule of Benefits, and Membership Certificate ("Certificate"), Number MO-PPO-MC-08. The effective date of this Rider is January 1, 2024. Accordingly, all definitions, terms, limitations, exclusions and conditions of the SPD and Certificate apply to this Rider, unless superseded or modified by this Rider.

Coverage Of In Progress Orthodontic Services

A. Prior Coverage for Orthodontic Services.

Membership Benefits include orthodontic Dental Services provided to a Participant whose orthodontic treatment began prior to becoming a Participant when each of the requirements below are met.

1. Participant had prior coverage for orthodontic services.
2. Participant meets the criteria for coverage of orthodontic Dental Services, including any age limits.
3. After becoming a Participant, the orthodontic treatment continues and Participant incurs expenses under the payment plan entered into with the orthodontist for such treatment.
4. Proof of prior coverage and the total amount paid for orthodontic services before becoming a Participant is submitted to DDMO.

Membership Benefits are limited to the Orthodontic Lifetime Maximum shown in the Schedule of Benefits less the amount paid for orthodontic services under the Participant's prior plan.

B. No Prior Coverage for Orthodontic Services.

If a Participant began orthodontic treatment prior to becoming a Participant, but does not meet all of the criteria in Section A (e.g., Participant did not have prior coverage for orthodontic services, Participant cannot provide proof of the amount paid under prior coverage, etc.), no Membership Benefits for orthodontic Dental Services are available during the first 12 months after becoming a Participant ("No Prior Coverage Penalty").

Membership Benefits for orthodontic services begin after the expiration of the No Prior Coverage Penalty. Membership Benefits are limited to the Orthodontic Lifetime Maximum shown in the Schedule of Benefits less the amount paid by the Participant for orthodontic treatment under the payment plan entered into with the orthodontist for such treatment before becoming a Participant, as long as Participant meets the criteria for coverage of orthodontic Dental Services, including any age limits.

DELTA DENTAL®

Membership Certificate

Delta Dental PPO

HCR

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

MO-PPO-MC-08

DELTA DENTAL OF MISSOURI

A Not for Profit Corporation Organized under the Laws of the State of Missouri.

Membership Certificate

Delta Dental of Missouri (DDMO) hereby certifies that the holder (Group Sponsor) of this Membership Certificate as shown on the records of DDMO has been accepted for membership in this dental service plan. DDMO certifies that the enrollees of such Group Sponsor are entitled to Dental Care as provided herein, subject to the terms and conditions hereof, including continued payment of required dues or service charges.

This Membership Certificate includes the Schedule of Benefits, and Summary Plan Description, which are incorporated by reference.

In Witness Whereof, *Delta Dental of Missouri has caused this Membership Certificate to be duly executed effective as of the effective date of the Membership Agreement.*

DELTA DENTAL OF MISSOURI

BY

E. B. Rob Goren
President & CEO

MO-PPO-MC-08

SECTION I
DEFINITIONS

For purposes of the Membership Agreement, the following quoted terms have the meanings ascribed to them below when appearing in initial capital letters.

A. **"Accidental Injury"** means an injury to a tooth or teeth caused by a physical injury resulting from an incident not related to the normal function of the tooth or teeth. Some services, such as amalgam or crown replacement within a specified time period, are eligible for benefits if necessary due to an accidental injury.

B. **"Benefit Period"** means the time period described in the Schedule of Benefits for which dental benefits are provided to each Enrollee.

C. **"DDMO"** means Delta Dental of Missouri (a member of the Delta Dental Plan Association), and its successors and assigns.

D. **"Delta Dental Plan"** means a member of the Delta Dental Plans Association, including DDMO.

E. **"Delta Dental PPO" or "PPO"** means the preferred provider organization available from and through DDMO pursuant to the Membership Agreement.

F. **"Dental Services" or "Dental Care"** means those necessary services and care for which coverage and benefits are provided for under the terms and provisions of the Membership Agreement.

G. **"Dentist"** means a dentist duly licensed and legally qualified to practice dentistry at the time and place covered dental services are performed.

H. **"Dependent"** means, except as otherwise provided in the Summary Plan Description or Enrollment Agreement entered into by DDMO and the Group Sponsor, an "eligible dependent" of a Member for whom the applicable Member has made application for coverage to DDMO and for whom such application has been duly accepted for coverage by DDMO. For purposes hereof, an "eligible dependent" means (i) a Member's spouse, (ii) a Member's children (including a Member's stepchildren, legally adopted children, children required to be covered by reason of a "qualified medical child support order" as defined by Section 609 of ERISA and determined to be such by the Group Sponsor (or its plan administrator) (a copy of the procedures governing qualified medical child support orders may be obtained upon request)), until they reach the age or fail to satisfy the other eligibility requirements specified in the Schedule of Benefits and Summary Plan Description, or (iii) a Member's brothers and sisters who are wholly dependent upon the Member for support, until they reach the age specified in the Schedule of Benefits and Summary Plan Description. A child may

be covered as a dependent beyond the age specified in the Schedule of Benefits and Summary Plan Description if, and so long as, such child (a) is incapable of self-support due to physical or mental impairment which commenced prior to the specified age, and (b) is chiefly dependent upon the Member for support and maintenance. A special application must be completed by the Member and the dependent child's physician giving DDMO evidence satisfactory to it of such child's disability and dependency either (i) at least 31 days before reaching such age, or (ii) at the time of application for membership by the Member if such child is then over such specified age. DDMO may require proof of continued disability and dependence once each year thereafter.

I. **"Enrollee" or "Participant"** means a Member or Dependent.

J. **"Group"** means a group of Members which have been accepted and designated as such by DDMO, consisting of persons who are actively or formerly employed, associated or affiliated Members whose dues or service charges are remitted by the same Group Sponsor.

K. **"Group Sponsor"** means an individual, partnership, association, corporation, organization or other entity which agrees to sponsor a Group and to pay, or collect and remit to DDMO the dues or service charges payable by or with respect to the Members under this Membership Certificate, either by payroll reduction or otherwise and to receive any notice, card, certificate or rider from DDMO on behalf of such Members.

L. **"Late Entrant"** means any Participant who elects coverage more than 31 days after first becoming eligible for enrollment in the plan. If a Late Entrant Penalty is included in your plan, Late Entrants can elect coverage at any time after the initial enrollment period; however, benefits may be limited as expressly provided in the Summary Plan Description or Schedule of Benefits.

M. **"Maximum Plan Allowance"** means the amount determined by the applicable Delta Dental Plan as the allowed amount for a particular procedure, service, or item for the particular Dentist or service provider. The allowed amount for a particular Dentist or service provider depends on its, his or her participation status (e.g., PPO Dentist, Premier Dentist or Non-Participating Dentist).

N. **"Member"** means, except as otherwise provided in the Summary Plan Description or Enrollment Agreement entered into by DDMO and the Group Sponsor, any individual who has made application to and has been duly accepted for coverage by DDMO, and who is actively employed, associated or affiliated by or with the Group Sponsor (or an affiliate of the Group Sponsor).

O. **"Membership"** means the following types of coverage, as applicable.

1. **"Individual Membership"** is comprised of the individual (one person) who has been duly accepted and is in good standing as a Member of DDMO.

2. **"Family Membership"** is comprised of a Member and one or more Dependents. There may be more than one type of Family Membership (e.g., Member and spouse, and Member and all Dependents, including the Member's spouse).

P. **"Membership Benefits"** means those benefits described in this Membership Certificate, the Schedule of Benefits and Summary Plan Description, which become applicable to an Enrollee, as evidenced by the records of DDMO, subject to the limitations, exclusions and other terms and conditions in this Membership Certificate, the Schedule of Benefits and Summary Plan Description. The Membership Benefits shall, in any case, be the ones for which dues or service charges are being charged and remitted at the time Dental Care is provided hereunder.

Q. **"Non-PPO Participating Dentist" or "Premier Dentist"** means a Dentist or service provider who has or participates under a participation agreement with a Delta Dental Plan for rendering the Dental Care provided by this Membership Certificate and to accept payment based on the applicable Maximum Plan Allowance for a Non-PPO Participating Dentist.

R. **"Non-Participating Dentist"** means a Dentist or service provider who does not have or participate under a participation agreement with a Delta Dental Plan for rendering the Dental Care provided by this Membership Certificate and who has not agreed to accept payment based on the applicable Maximum Plan Allowance for a Premier Dentist or PPO Dentist.

S. **"Participating Dentist"** means a Dentist or service provider who has or participates under a participation agreement with a Delta Dental Plan for rendering the Dental Care provided by this Membership Certificate and who has agreed to accept payment based on the applicable Maximum Plan Allowance for a Premier Dentist or PPO Dentist.

T. **"PPO Participating Dentist" or "PPO Dentist"** means a Dentist or service provider who has or participates under a participation agreement with a Delta Dental Plan for rendering the Dental Care provided by this Membership Certificate and to accept payment based on the applicable Maximum Plan Allowance for a PPO Participating Dentist.

U. **"Renewal Date" or "Anniversary Date"** means the date specified as such in the then current Enrollment Agreement between DDMO and Group Sponsor.

V. **"Schedule of Benefits"** means the document which sets forth the extent to which benefits will be provided an Enrollee under this Membership Certificate. Specific Group deductibles, coinsurance, and maximum amounts are included in the Group's Schedule of Benefits. Such Schedule of Benefits shall be the one in effect and for which dues or service charges are being remitted at the time Dental Care is provided hereunder.

W. **"Summary Plan Description" or "SPD"** means the document which summarizes the Dental Care, coverages and benefits provided under the Membership Agreement.

X. **"Treatment Plan"** means a written report showing the recommended treatment of any dental disease, defect or injury for an Enrollee prepared by a Dentist, as a result of any examination made by such Dentist, while membership under this Membership Certificate is in effect for the Enrollee.

SECTION II
MEMBERSHIP AGREEMENT AND PERIOD

A. The Membership Agreement consists of the Member's application, the DDMO enrollment regulations in force from time to time for the Group, the Enrollment Agreement entered into by DDMO and the Group Sponsor, the Schedule of Benefits, Summary Plan Description, this Membership Certificate and duly executed riders, if any, between DDMO and the Group Sponsor. These documents constitute the entire agreement between DDMO and the Group Sponsor regarding the Membership Benefits and coverage provided to Members.

B. A Member's coverage period ("Membership Period") begins on the date DDMO accepts the Member as reflected in DDMO's records ("Membership Effective Date"). The Membership Period continues, until this Membership Certificate or coverage under this Membership Certificate is terminated for any reason as provided herein.

C. Except as otherwise expressly provided in the Summary Plan Description or the Enrollment Agreement entered into by DDMO and the Group Sponsor, Enrollees must enroll within 31 days after first eligible. Failure to enroll within the specified time may postpone enrollment until the Group's Renewal Date.

D. Except as otherwise expressly provided in the Summary Plan Description or the Schedule of Benefits, at the time of initial enrollment, a Member must select one of the Membership types offered (e.g. Individual Membership or Family Membership). During the Benefit Period, a Member may only 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 change in status (if any) expressly permitted under the Enrollment Agreement. Additional dues or service charges may apply to the change.

If a Member changes his or her Membership type during the annual open enrollment, he or she must wait one-year in order to make another change in Membership type (unless the Member has a change in status identified above), and then only on the Group's Renewal Date.

SECTION III
DENTAL SERVICES AVAILABLE

To the extent provided in the applicable Schedule of Benefits and Summary Plan Description, and subject to the limitations, exclusions and other terms and conditions contained therein and in this Membership Certificate, Membership Benefits will be provided for Dental Services when rendered by a Dentist (or other appropriate service provider) in compliance with generally accepted standards of dental practice, as determined by DDMO.

A. **Covered Dental Services.** Coverage is provided for one or more of the following levels of Dental Service. The Schedule of Benefits and Summary Plan Description set forth in detail the applicable coverage levels and the types of services and items covered by each level of coverage.

1. COVERAGE A: Preventive Dental Services
2. COVERAGE B: Basic Dental Services
3. COVERAGE C: Major Dental Services
4. COVERAGE D: Orthodontic Dental Services

B. **Payment for Dental Services**

1. Membership Benefits will be available for the Dental Services provided and described in this Membership Certificate, the Schedule of Benefits, and the Summary Plan Description.

2. When Dental Care is received from a Dentist or service provider who has or participates under an agreement with a Delta Dental Plan for the applicable program of the Enrollee, the Dentist or service provider will usually submit a claim for such Dental Care directly to DDMO and DDMO will make payments directly to such Dentist or service provider. When Dental Care is received from a Dentist or service provider who does not have or participate under an agreement with a Delta Dental Plan for the applicable program of the Enrollee, the Member is responsible to submit a claim for payment to DDMO on forms prescribed by DDMO. DDMO shall not be obligated to pay claims submitted after the end of the calendar year following the year in which services were rendered. If a claim is denied due to a Participating Dentist's failure to make timely submission, the Enrollee is not liable to such Participating Dentist for

the amount which would have been payable by DDMO, provided that the Enrollee advised the Participating Dentist of his eligibility for Membership Benefits at the time of treatment.

3. **For Dental Services rendered by a PPO Dentist or a Premier Dentist,** DDMO will pay to such Dentist an amount equal to the applicable Maximum Plan Allowance for such Dentist, subject to the benefit maximum, coinsurance, and deductible, if any, as specified in the applicable Schedule of Benefits and Summary Plan Description. The PPO Dentist or Premier Dentist may bill the Enrollee for the deductible, coinsurance, non-covered services, and the amount exceeding the benefit maximum, if any, and the Enrollee is responsible for payment of such billed amount.

4. **For Dental Services rendered by a Non-Participating Dentist**, DDMO will determine the applicable Maximum Plan Allowance for such Non-Participating Dentist. The Enrollee is responsible for payment of all charges in excess of the Maximum Plan Allowance and for payment of the portion of the Maximum Plan Allowance that represents the coinsurance, deductible, or any amount above the benefit maximum, if any, as specified in the Schedule of Benefits. The Enrollee is also responsible for making full payment to the Non-Participating Dentist if DDMO pays any portion of the Maximum Plan Allowance to the Member. DDMO's usual practice is to pay the Member directly; however, DDMO reserves the right to pay a Non-Participating Dentist as determined necessary or appropriate by DDMO (such as a qualified medical support order).

5. In the event the Dentist submits a statement at the commencement of a period of **orthodontic services** which shows a charge for the entire treatment, Membership Benefits will be paid under this Membership Certificate, subject to the applicable Schedule of Benefits, Summary Plan Description, and eligibility requirements, and until this Membership Certificate or coverage hereunder is terminated for any reason as provided herein. Such payment will be spread out over the course of treatment. Orthodontic cases that begin prior to the Member's Membership Period are not a benefit unless specifically covered in the Schedule of Benefits and/or Summary Plan Description.

SECTION IV
PROVISION OF SERVICE BENEFITS

A. An Enrollee must advise the provider of Dental Care of the Enrollee's DDMO Membership when Dental Care is provided. If the Enrollee fails to advise the provider of Dental Care of the Enrollee's DDMO Membership and have his DDMO Membership verified at the time Dental Care is provided, DDMO is only obligated to pay for such Dental Care on the basis set forth in Section III.B.4 above in full discharge of DDMO's obligation under this Membership Certificate.

B. Before this Membership Certificate will be validly issued or effective, or before Membership Benefits will be approved, the Member agrees that any Dentist, physician, or other person or institution, is authorized to provide to DDMO all information, records or copies of records relating to dental treatment or to any health condition, history, diagnosis, treatment or care of any Enrollee covered by this Membership Certificate. The Member agrees that DDMO is authorized to release to others any information relating to Dental Care, other services or care and Membership Benefits furnished under this Membership Certificate when necessary for the administration of this Membership Certificate. The Member agrees to provide to DDMO any information it may require to determine its obligations under this Membership Certificate. With respect to the foregoing agreements and authorizations, those are made by the Member on behalf of himself and Dependents.

C. As an option to the Enrollee, a treatment plan may be submitted in writing to DDMO by the attending Dentist for any of the Dental Services described herein. The Dentist will determine what treatment is needed and could submit a treatment plan to DDMO for predetermination of benefits. This estimate will allow the Enrollee to determine in advance how much of the cost of the treatment will be paid by DDMO and how much of the cost the Enrollee will be responsible for paying, until this Membership Certificate or coverage hereunder is terminated for any reason as provided herein.

SECTION V
LIMITATIONS

A. If an Enrollee transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist (or other service provider) renders services for one dental procedure, (including but not limited to prosthetics, orthodontics, and root canal therapy), DDMO will not be liable for, or obligated to pay, more than the amount that it would have paid if the services had been provided by only one Dentist.

B. Whenever there are optional techniques of treatment carrying different fees, DDMO is liable only for the treatment carrying the lowest fee.

C. No benefits will be payable for services rendered after this Membership Certificate terminates.

D. A prosthetic appliance that replaces an existing appliance will not be provided more often than the time specified in the Summary Plan Description and/or Schedule of Benefits, and then only in the event that the existing appliance is not, and cannot be repaired.

Crowns, jackets, labial veneers, inlays, and onlays, and space maintainers provided under this Membership Certificate, will not be provided more often than the time period specified in the Schedule of Benefits and/or Summary Plan Description (except for Accidental Injury) and then only in the event that the existing restoration or appliance is not, and cannot be, repaired.

The applicable time period will be measured from the date on which the existing appliance, or restoration was last supplied, whether under this Membership Certificate or under any other prior dental agreement between, or involving as signatories, any of the parties to this Membership Agreement. The term "existing", as used in this paragraph, includes appliance, or restoration that was placed at the inception of the aforesaid time period but which, for whatever reason, is no longer in the possession of the Enrollee.

E. Unless required due to Accidental Injury, charges for replacement of filling restorations are only covered once within the time period specified in the Schedule of Benefits and/or Summary Plan Description, regardless of the number or combinations of restorations placed on a surface.

F. Sealants are limited to caries-free occlusal surfaces of the first and second permanent molars, unless specified otherwise in the Schedule of Benefits and/or Summary Plan Description.

G. **Orthodontic Limitations (if applicable)**

1. If this Membership Certificate or coverage provided hereunder is terminated before completion of a DDMO approved orthodontic treatment for any reason, all Membership Benefits provided under this Membership Certificate for such approved treatment will cease with payment through the end of the month in which the effective date of such termination occurs.

2. Any charges for the replacement or repair of any orthodontic appliance furnished under the treatment plan will not be paid by DDMO or constitute a "Dental Service" under this Membership Certificate.

3. Unless stated otherwise in the Schedule of Benefits or the Summary Plan Description, Membership Benefits for orthodontic Dental Services are limited to children who are Dependents and such Membership Benefits will terminate when the Dependent child reaches the specified age limit for orthodontic Membership Benefits.

4. After the completion of orthodontic Dental Services as set forth in a DDMO approved treatment plan, no further orthodontic Membership Benefits will be provided unless the lifetime maximum has not been reached.

SECTION VI
COORDINATION OF BENEFITS AND EXCESS INSURANCE

All Membership Benefits, and payments therefor, under this Membership Certificate are subject to the following Coordination of Benefits provisions.

A. For purposes of this Section VI:

1. "plans" means all group programs providing benefits for care, including, but not limited to service plan programs, group or blanket insurance coverage, group practice and other prepayment group programs, labor-management trusteed plans, union welfare plans, excess-type plans, government programs, including any coverage required or provided by statute, and group and individual no-fault auto programs;

2. "allowable expenses" means a necessary item of expense for care that does not exceed the Maximum Plan Allowance when expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable expenses do not include expenses for care which is covered neither under this Membership Certificate nor under such other group program. An allowable expense to a secondary plan includes the value or amount of any deductible amount or coinsurance percentage or amount of otherwise allowable expenses which were not paid by the primary or first paying plan; and

3. "benefits" means Membership Benefits, or payments made therefor, under this Membership Certificate, and payments made for care by another plan under its group program.

B. This Section applies where there are two or more plans providing benefits to an Enrollee and the sum of all benefits which would be provided by the plans involved, absent this Section, exceed the allowable expenses incurred by an Enrollee.

C. Total benefits to be provided by all plans for care shall not exceed allowable expenses incurred by the Enrollee for that care, whether or not claim has been duly made therefor under all such plans.

D. In no event shall DDMO provide payments for benefits by application of this Section in an amount which is in excess of the amount which would be provided under this Membership Certificate without application of this Section.

E. When the other plan does not have a Coordination of Benefits provision, by whatever name called, then that plan will determine its benefits first, and DDMO will provide benefits, subject to Section VI.D., for the remaining allowable expenses incurred by the Enrollee.

F. When the other plan has a Coordination of Benefits provision, by whatever name called, then the order of determination of benefits shall be the first of the following rules applicable.

1. The benefits of a plan which covers the person on whose expense the claim is based other than as a dependent will be determined before the benefits of a plan which covers such person as a dependent.

2. When a claim is made for a person as a dependent child and that child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. If the other plan does not have the rule set forth in this paragraph and this results in a situation wherein either each plan would determine its benefits before the other or each plan would determine its benefits after the other, this paragraph shall not apply and the rule set forth in the other plan shall determine the order of benefit determination. In the case of a person for whom claim is made as a dependent child:

a. when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody;

b. when the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers that child as a dependent of the

stepparent, and the benefits of a plan which covers that child as a dependent of the parent without custody; and

c. notwithstanding paragraphs a. and b. above, if there is a court decree which would otherwise establish financial responsibility for the expenses for care with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

3. The benefits of the plan which has covered the Enrollee, on whose expense is based, for the longer period of time will be determined before the benefits of the plan which has covered such Enrollee for the shorter period of time.

G. The plan which determines its benefits first shall not consider the benefits of the other plan in its determination of benefits. When under the preceding order of determination, the other plan determines its benefits first, DDMO will provide benefits, subject to Section VI.D., for the remaining allowable expenses incurred by an Enrollee.

H. When the other plan would determine its benefits first under Section VI.F. but for the fact it has an excess-type insurance provision, by whatever name called, which by its terms provides benefits only for allowable expenses remaining unpaid after all other plans have paid, then DDMO will provide benefits as excess coverage. When benefits are provided as excess coverage under this Membership Certificate, DDMO will provide benefits, subject to Section VI.C. and D., equally with the other plans providing excess-type benefits.

SECTION VII
SERVICES NOT INCLUDED

This Membership Certificate does not provide Membership Benefits or any payments or coverage for the charges described below:

A. 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;

B. services or supplies for which coverage is available under workers' compensation or employers' liability laws;

C. services or supplies performed for cosmetic purposes or to correct congenital malformations, except newborns with congenital dental defects;

D. 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);

E. services or supplies related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws);

F. services or supplies not specifically identified as Dental Services for which coverage is provided in the Summary Plan Description or Schedule of Benefits (including hospital or prescription drug charges);

G. replacement of dentures and other dental appliances which are lost or stolen;

H. diseases contracted or injuries or conditions sustained as a result of any act of war;

I. denture adjustments for the first six months after the dentures are initially received. Separate fees may not be charged by Participating Dentists;

J. 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;

K. analgesia, including Nitrous Oxide, duplication of radiographs, temporary appliances or, except as otherwise expressly provided in the Summary Plan Description or Schedule of Benefits, implants and related procedures;

L. services or supplies covered under a terminal liability, extension of benefits, or similar provision, of a program being replaced by the coverage provided under this Membership Certificate;

M. 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;

N. 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);

O. services rendered beyond the scope of a Dentist's or service provider's license, or experimental or investigational services or supplies;

P. services or supplies that a Dentist determines for any reason, in his professional judgment, should not be provided;

Q. instructions in dental hygiene, dietary planning, or plaque control;

R. missed appointments or claim form completion;

S. infection control, including sterilization of supplies and equipment;

T. orthodontics, except as otherwise expressly provided in the Summary Plan Description or Schedule of Benefits;

U. complete occlusal adjustments, crowns for occlusal correction, athletic mouthguards, nightguards, bruxism appliances, and bite therapy appliances, except as otherwise expressly provided in the Summary Plan Description or Schedule of Benefits; and

V. consultations, except as otherwise expressly provided in the Summary Plan Description or Schedule of Benefits.

W. Services incurred prior to satisfying any applicable waiting period or Late Entrant Penalty;

SECTION VIII
DUES, PAYMENT AND GRACE PERIOD

A. DDMO shall have the sole right and authority to determine the dues and service charges applicable to this Membership Certificate. All such dues and service charges shall be due and payable in advance, and the initial charges must be paid on or before the Membership Effective Date under this Membership Certificate.

B. DDMO may increase or decrease dues or service charges as provided in the Enrollment Agreement with the Group Sponsor.

C. A grace period of thirty-one (31) days within which to pay dues and service charges will be allowed from the due date of each payment after the initial payment.

SECTION IX
TERMINATION

A. The Membership Agreement, and Membership Benefits and coverage under this Membership Certificate, terminate upon the earliest of the following dates:

1. the date on which the Enrollment Agreement with the Group Sponsor terminates for any reason;

2. the date designated by DDMO if the Group Sponsor violates the terms or conditions of the Membership Agreement, commits fraud or makes a material misrepresentation, or if determined necessary or appropriate by DDMO to comply with federal, state, or local law;

3. the date on which Group Sponsor fails to pay or remit, in full, the dues or service charges when due or within the grace period; or

4. the date on which Group Sponsor does not comply with DDMO's minimum contribution or participation requirements.

B. An Enrollee's Membership Benefits and coverage under this Membership Certificate terminate upon the earliest of the following dates:

1. the date on which the Enrollee ceases to be eligible (e.g., fails to meet underwriting guidelines, ceases to be in a classification of eligible persons, dies, is no longer associated with Group, a Dependent reaching the limiting age, etc.);

2. the date designated by DDMO if the Member fails to pay or remit, in full, any required contribution toward the dues or service charges when due or within the grace period, if any;

3. the date on which the Group Sponsor fails to pay or remit, in full, the dues or service charges when due or within the grace period; or

4. the date on which the Membership Agreement or Enrollment Agreement with the Group Sponsor terminates for whatever reason;

5. the date on which DDMO terminates a Member's Membership by giving at least thirty-one (31) days prior written notice to the Member for the following reasons:

   a. for fraud or a material misrepresentation in applying for this Membership Certificate or for Membership Benefits hereunder, for any breach of the Membership Agreement or in order to comply with federal, state, or local law; or

   b. for refusal to transfer to another program if the class of Membership or type of program to which this Membership Certificate belongs is discontinued.

A termination of the Member's Membership also terminates the Membership and coverage of all Dependents of that Member.

C. Termination of coverage shall be made without prejudice to any claim originating prior to the effective date of termination.

SECTION X
MISCELLANEOUS PROVISIONS

A. DDMO shall determine the nature and extent of the benefits and services to be furnished under this Membership Certificate. DDMO has the right to amend any provision of this Membership Certificate, the Summary Plan Description or the Schedule of Benefits by giving written notice thereof to the Group Sponsor. Any such change shall become effective on dates determined by DDMO. No broker or agent, and no employee of DDMO, except an authorized employee, has the authority to modify or waive any provisions of the Membership Agreement.

B. Under no circumstances does DDMO agree to select or secure a Dentist or other service provider for any Enrollee.

C. DDMO contracts with Dentists to provide Dental Care to Enrollees; however, DDMO in no way guarantees treatment by a provider or that any specific care will be available.

D. DDMO is not liable for any Dentist's or service provider's act or omission or for any act or omission by any agent or employee of the Dentist or service provider. DDMO also is not liable for any act or omission of any Group Sponsor or representative of a Group. The Group Sponsor or representative is the agent of the Member for all purposes under this Membership Certificate. DDMO is not liable for any claim, injury, demand or judgment arising out of or in connection with any dental care whether or not provided under this Membership Certificate.

E. If DDMO pays for an Enrollee's Dental Care to which the Enrollee was not entitled under the Membership Agreement, the Member must promptly reimburse DDMO on demand for the amount of such payment.

F. Any notice required or permitted to be given by DDMO hereunder to the Group Sponsor or one or more Members is sufficient if it is mailed to the Group Sponsor, or personally delivered to the Group Sponsor, at the address appearing on DDMO's records. With respect to any notice to be given to one or more Members, the Group Sponsor shall receive all notices from DDMO on behalf of such Members and communicate the information to such Members. Alternatively, DDMO may, at its option, give any such notice directly to the Member. Any such notice given by DDMO directly to a Member is sufficient if it is mailed to the Member, or personally delivered

to the Member, at the address appearing on DDMO's records. When practical, DDMO will give any notice required or permitted to be given by DDMO hereunder at least thirty-one (31) days prior to the notice's effective date.

G. This Membership Certificate and the right of the Enrollees to receive service or payments under this Membership Certificate are not assignable. This includes both before or after accrual of the Enrollee's right to receive such service or payments.

H. In the event of any conflict or inconsistency between the provisions of this Membership Certificate or the Summary Plan Description, the provisions of this Membership Certificate will govern and control. In the event of any conflict or inconsistency between the provisions of this Membership Certificate or the Schedule of Benefits, the provisions of this Membership Certificate will govern and control. In the event of any conflict or inconsistency between the provisions of this Membership Certificate or the Enrollment Agreement, the provisions of this Enrollment Agreement will govern and control.

I. This Membership Certificate supersedes any and all prior DDMO Membership Certificates that may have been issued.

J. This Membership Certificate, and Membership Agreement of which it is a part, are issued for delivery in the State of Missouri, for performance by DDMO and Group Sponsor in the State of Missouri, and to a Group Sponsor located in the State of Missouri. This Membership Certificate, and Membership Agreement of which it is a part, will be governed by the laws of the State of Missouri and any applicable federal laws.

K. In all matters with respect to the Membership Agreement, the Group Sponsor acts as agent of the Group and Enrollees, and not of DDMO. DDMO will not be liable for any act or omission of the Group Sponsor or its representatives, including any failure of the Group Sponsor or its representatives to timely remit to DDMO when due the dues and service charges required hereunder.

L. An Enrollee or any other claimant may not bring any action at law or in equity concerning a claim for service or payment until sixty days after written proof of claim for service or payment has been furnished in accordance with the requirements of this Membership Certificate. In no event may an Enrollee or any other claimant bring an action at law or in equity beyond five years of the date of service to which the action pertains.