DELTA DENTAL®

Summary Plan Description (SPD)

Delta Dental PPO
Dentacare M - ASC

Priests' Mutual Benefit Society

(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 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** 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

Unmarried dependent children (natural, stepchildren or legally adopted) are eligible for coverage until the end of the year in which they reach the dependent age limit (shown on your Schedule of Benefits) or until the date they marry, or until the end of the month in which the dependent ceases to be a full-time student (for plans with full-time student coverage), whichever occurs first. A dependent child is considered a full-time student if enrolled at an accredited educational institution with a minimum of 12 credit hours per semester (9 credit hours for graduate school); provided however, that a full-time student's coverage hereunder will not terminate due to a medically necessary leave of absence that is certified by the child's physician before the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which coverage would otherwise terminate under the Plan. DDMO requires proof of full-time student status each semester, and also requires proof of a certified medically necessary leave of absence. Unmarried dependent children who are incapable of self-support because of physical or mental impairments can continue to be protected under your membership regardless of age, if they become impaired before reaching age 19. A special application must be completed by you and your dependent child's physician at least 31 days before your child's 19th birthday. DDMO may require

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

B: Basic Dental Services

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

C: Major 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)
- Implants, as well as bone grafts, limited to once in 5 years per tooth

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 dependent children under 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.

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 composite resin fillings on molar teeth, in which case the benefits are based on the allowed amount for an amalgam (silver) filling; or 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 (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, or temporary appliances.
- 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 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.

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 M - 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:	Priests' Mutual Benefit Society
Group Number:	9169-1000 & -2000

Coverage Levels and Percentages:	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist**
Coverage A:	100%	80%	70%
Coverage B:	90%	80%	50%
Coverage C:	80%	80%	50%
Coverage D:	N/A	N/A	N/A
Deductible:	$75	$75	$75
Applies to:	B & C Coverage	B & C Coverage	B & C Coverage
Family limit:	N/A	N/A	N/A

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):	$2,500	$2,500	$2,500

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

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

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

Dependent Age Limit:	N/A
Effective Date of Program:	1/1/2021

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 is as follows:

- Two additional cleanings are covered per benefit period for patients who are pregnant, diabetic, have a suppressed immune system, or have a history of periodontal therapy. To be eligible for the additional cleaning benefits 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.
- Employee only benefit plan

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 Priests' Mutual Benefit Society Dental Plan referred to herein as the Plan.

Plan Number: None provided

Dental Plan for Members of: Priests' Mutual Benefit Society

Group Address: 20 Archbishop May Drive
St. Louis, MO 63119

Tax ID Number: 43-1158344

Type of Plan and Administration:
The Plan is a group dental plan. The Plan is self-funded. The Plan is administered by DDMO through a self-funded contract with the Plan Administrator. 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: Priests' Mutual Benefit Society
Attention: Gigi Henson
20 Archbishop May Drive
St. Louis, MO 63119
314-792-7034

Agent of Legal Service: Priests' Mutual Benefit Society
Attention: Gigi Henson
20 Archbishop May Drive
St. Louis, MO 63119

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

Trustee: N/A

Plan's Fiscal Year Ends: 6/30

Funding Is: Non-Contributory
Contributions to the Plan are made by the group. 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.

ERISA Information (Continued)

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.