

Summary Plan Description (SPD)

Delta Dental Premier

MARCIT

Dentacare M - ASC

(For Customer Service and Benefit Information)

(314) 656-3001

(800) 335-8266

www.deltadentalmo.com

Delta Dental of Missouri

PO Box 8690, St. Louis, MO 63126-0690

About Your Coverage

About Delta Dental

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

Your Membership Card

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

Selecting Your Dentist

You may visit the dentist of your choice. Participating dentists have the necessary forms needed to submit your claim. If you go to a non-participating dentist you are responsible for paying the dentist and filing your claim. Obtain a claim form from your personnel office or from DDMO.

Participating Dentists

Delta Dental has unique "participating agreements" with nearly 108,000 practicing dentists nationwide, and more than 90 percent of the practicing dentists in Missouri. Participating dentists will 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 receive, at no cost, a list of participating providers in your area. Delta Dental participating dentists are reimbursed based on the dentist's usual, customary and reasonable (UCR) charge for services. Participating dentists accept the amount that Delta Dental determines to be the UCR charge as payment in full. You are not responsible for paying the dentist any amount that exceeds the UCR charge. You are only responsible for any noncovered charges, deductible and coinsurance amounts.

Non-Participating Dentists

If you go to a non-participating dentist in Missouri, DDMO will make payment directly to you based on the dentist's fee charged or the prevailing fee, whichever is less. If you go to an out-of-state non-participating dentist, DDMO will make payment directly to you on the same basis as the local Delta Dental reimburses its non-participating dentists. It will be your obligation to make full payment to the dentist and file your own claim.

Claim Filing Deadline

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

Eligibility

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

Enrolling

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

Dependent Children

Dependent children are eligible for coverage until the end of the month 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 on a full-time basis with a minimum of 12 credit hours per semester (9 credit hours for graduate school). DDMO requires proof of full-time student status each semester. A copy of a current report card, letter from accredited educational institution, or class registration identifying full-time student status is required to be submitted to DDMO for each semester of eligibility along with your child's name, date of birth, and the member's social security number. This information can be submitted at time of claim filing or immediately following enrollment at an accredited educational institution. Send to: Delta Dental of Missouri, Attn: Information Research, PO Box 8690, St. Louis, MO 63126.

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 30 days before your child's 19th birthday. Delta Dental may require proof of continued disability and dependence once a year thereafter.

Explanation of Benefits

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

Coordination of Benefits

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

Conversion of Coverage

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

Claim Predetermination

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

Benefit Outline

Your Schedule of Benefits included in this SPD will show 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 cost 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.) Benefit payments are based on the UCR charge for a particular service. Your dental benefits are provided according to a benefit period, which begins on the date your group's DDPM coverage initially became effective. **A new benefit period begins each year on July 1.**

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

Levels of Coverage

<p style="text-align: center;">A: Preventive Services</p> <ul style="list-style-type: none"> • Oral examinations (evaluations), twice in any benefit period (includes all types) • Bitewing and periapical x-rays as required • Full-mouth x-rays, once in any 36 consecutive months • Dental prophylaxis (cleaning, scaling, and polishing including periodontal maintenance visits), twice in any benefit period • Topical fluoride application for patients under age 19, once in any benefit period • Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain) • Space maintainers that replace prematurely lost teeth of eligible dependent children under age 16, once in 5 years 	<p style="text-align: center;">B: Basic Services</p> <ul style="list-style-type: none"> • Restorative services using amalgam, synthetic porcelain, and plastic filling material • Periodontics: treatment for diseases of the gums and bone supporting the teeth • Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth) • Simple and surgical extractions • Sealants: for dependent children under age 19, limited to caries-free occlusal surfaces of the first and second permanent molars, once in 5 years
<p style="text-align: center;">C: Major Services</p> <ul style="list-style-type: none"> • Prosthetics: bridges and dentures • Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes • Oral surgery (except for extractions under coverage B) 	<p style="text-align: center;">D: Orthodontic Services</p> <ul style="list-style-type: none"> • Orthodontic care: treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position. Applies to all employees and their eligible dependents.

Coverage Limitations

- Under Coverage A**
- If an existing space maintainer cannot be made satisfactory, a replacement will be covered only once in five years, except for accidental injuries.

- Under Coverage B**
- Sealants are limited to caries-free occlusal surfaces of the first and second permanent molars only once in five years.

- Under Coverage C**
- If an existing bridge or denture cannot be made satisfactory, a replacement will be covered only once in five years, but not during the first year of Coverage C benefits unless previously covered by MARCIT.

- Under Coverage C (Continued)**
- 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 five years, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

- Under Coverage D**
- 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 for the same procedure, benefits will not exceed what would have been paid for one dentist for that procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy). If alternative treatments are available, DDMO will be liable for the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of an amalgam (silver) filling; or fixed bridges, in which case the benefits may be based on the cost of a removable partial denture.

Implants are not a covered benefit, however, effective 7/1/2007 the plan will provide benefits up to the maximum plan allowance that would have been allowed for a covered alternative treatment such as a permanent bridge, partial denture, or full denture.

Dental Services Not Covered

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

How To Appeal A Claim

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

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

Any request for reconsideration should be sent to:

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

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

Delta Dental of Missouri

Schedule of Benefits

For employees of: Participating MARCIT Members

Group Number: 5226 (all sublocations)

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

PROGRAM FEATURES

BENEFITS

Coverage Levels: A, B, C, & D

Deductible: \$50
Applies to: B, C, & D Coverage
Family limit: \$150

Covered Percentages:
Coverage A: 100%
Coverage B: 80%
Coverage C: 50%
Coverage D: 50%

Benefit Maximum:
Coverage A, B, and C: \$1,250
Orthodontic Lifetime Maximum: \$1,250

Dependent Age Limit: 19; full-time students covered to age 25

Effective Date of Program: 07/01/2007

For all participants of MARCIT, benefits are provided according to a benefit year which renews each July 1. Orthodontic benefits are limited to a lifetime maximum of \$1,250.

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 MARCIT Dental Plan referred to herein as the Plan.

Dental Plan for Employees of: Participating MARCIT Members

Employer Address: 300 Rivergate Center
600 Broadway
Kansas City, MO 64105-1536

Employer ID Number: 43-1297967

Type of Administration:

The Plan is administered by the Plan Administrator through a self funded 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, premium billing, customer service assistance, and issuing of Summary Plan Descriptions.

**Plan Administrator
and Agent of Legal Service:** MARCIT
300 Rivergate Center
600 Broadway
Kansas City, MO 64105-1536

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

Trustee: N/A

Plan's Fiscal Year Ends: 06/30

Funding Is: Contributory

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

Eligibility Provisions:

Contact your benefit administrator.

Delta Dental of Missouri

ERISA Information (Continued)

The Employee Retirement Income Security Act (ERISA) of 1974 entitles you, as a participant in this program, to certain rights and protections. For more information, please contact your employer.

ERISA provides that all Plan participants 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 Pension and Welfare Benefits 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 participant 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 enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, 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 participants and beneficiaries. No one, including your employer, 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

09/02