MISSOURI STATE TROOPERS ASSOCIATION

INSURANCE BENEFITS

(insurance rates are per pay period & must be a payroll deduction)

	DENTAL (Delta Dental)	VISION (Delta Vision)
Member	$14.00	$5.50
Member + 1	$29.00	$8.00
Member + Family	$43.50	$10.00

DELTA DENTAL®

Welcome to Delta Dental of Missouri

Use this guide and **Smile.DeltaDentalMO.com** to help you learn about your dental benefits and get started on your way to a healthier smile.

DELTA DENTAL

Dental Benefits Summary

Missouri State Troopers Association	Delta Dental PPO℠ Network	Delta Dental Premier® Network	Out-of-Network
	Based on applicable PPO Maximum Plan Allowance - No balance billing	Based on applicable Premier Maximum Plan Allowance - No balance billing	Based on applicable Maximum Plan Allowance for Out-of-Network dentist - Balance billing is possible
Preventive Services • Bitewing x-rays, one set per benefit period; two sets for age 15 and under • Emergency palliative treatment • Full mouth x-rays, once in any 36 month period • Oral Examinations, twice in any benefit period • Periapical x-rays, as required • Periodontal maintenance, once in any benefit period (subject to your prophylaxis frequency limitation) • Prophylaxis (cleanings), twice in any benefit period • Space maintainers for dependent children under age 16, once in 5 years • Topical fluoride treatments for dependent children under age 19, once in any benefit period	**100%**	**100%**	**100%**
Basic Services • Endodontics • Fillings • General Anesthesia • Non-Surgical Periodontics • Oral surgery • Sealants for dependent children under age 19, once in 5 years • Simple extractions • Surgical extraction of impacted teeth • Surgical extractions • Surgical Periodontics	**80%**	**80%**	**80%**
Major Services • Crown repairs & recement • Crowns, Inlays, Onlays, once in 10 years • Stainless steel crowns, once in 10 years	**50%**	**50%**	**50%**
Orthodontia • Orthodontia for dependent children under age 19 (lifetime maximum)	**50% up to $750 No deductible**	**50% up to $750 No deductible**	**50% up to $750 No deductible**
Calendar Year Deductible (Applied to Basic and Major services)	**$50 individual Unlimited family**	**$50 individual Unlimited family**	**$50 individual Unlimited family**
Annual Maximum (Applied to Preventive, Basic and Major services)	**$1,000**	**$1,000**	**$750**

Dependent Age Limit: 26

Late entrant provisions

- 12 month waiting period applies to all Basic Services for late entrants.
- 24 month waiting period applies to all Major Services for late entrants.
- 24 month waiting period applies to all Orthodontia for late entrants. The waiting period must be satisfied prior to banding.

Monthly Premium Rates (1/1/22-12/31/23)

Coverage Tier	
Employee	$28.00
Two Party	$58.00
Family	$87.00

This is intended to be a summary only. If a discrepancy occurs the Summary Plan Document will govern. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions. Orthodontic treatment in progress may be covered. Benefits provided by the prior carrier will be subtracted from the lifetime maximum available from Delta Dental.

DELTA DENTAL®

Delta Dental PPO™ plan network options

Delta Dental gives you the freedom to visit the dentist of your choice and to 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 and the information below describes what you can expect depending on whether you receive services from a Delta Dental PPO™ dentist, a Delta Dental Premier® dentist or an out-of-network dentist.

Delta Dental PPO network

Comprised of a select panel of dentists, more than 300,000 dental offices participate in the Delta Dental PPO program. Delta Dental will provide the highest level of benefits for covered services when care is received from a Delta Dental PPO dentist. These dentists agree to:

- Accept payment based on a reduced fee schedule – reducing your out-of-pocket expenses – with **no balance billing** for charges that exceed the fee schedule.
- Submit dental claims for members and abide by Delta Dental's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

Your out-of-pocket expenses will be lowest when you see a Delta Dental PPO dentist.

Delta Dental Premier® Network

Comprised of more than 363,000 participating dental offices, Delta Dental Premier offers you greater access to dentists while still offering the advantages of a network. These dentists have participating agreements with Delta Dental which require them to:

- Accept payment based on applicable Delta Dental contractual agreement – which means **no balance billing** for charges that exceed the contracted amount.
- Submit dental claims for members and abide by Delta Dental's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

If your dentist is not a Delta Dental PPO dentist but is a Delta Dental Premier dentist, your benefit will be based on the Premier benefit level; however, you will receive the cost control and claims filing advantages noted above.

Out of Network

If you receive services from an out-of-network dentist (does not participate in either Delta Dental network) benefits for covered services are based on the Delta Dental maximum plan allowance and:

- You may be responsible for filing your own claim forms.
- Delta Dental's benefit payment will be made directly to you.
- You will be responsible for the difference between the dentist's charge and the maximum plan allowance.

Your out-of-pocket expenses may be more when you use an out-of-network dentist.

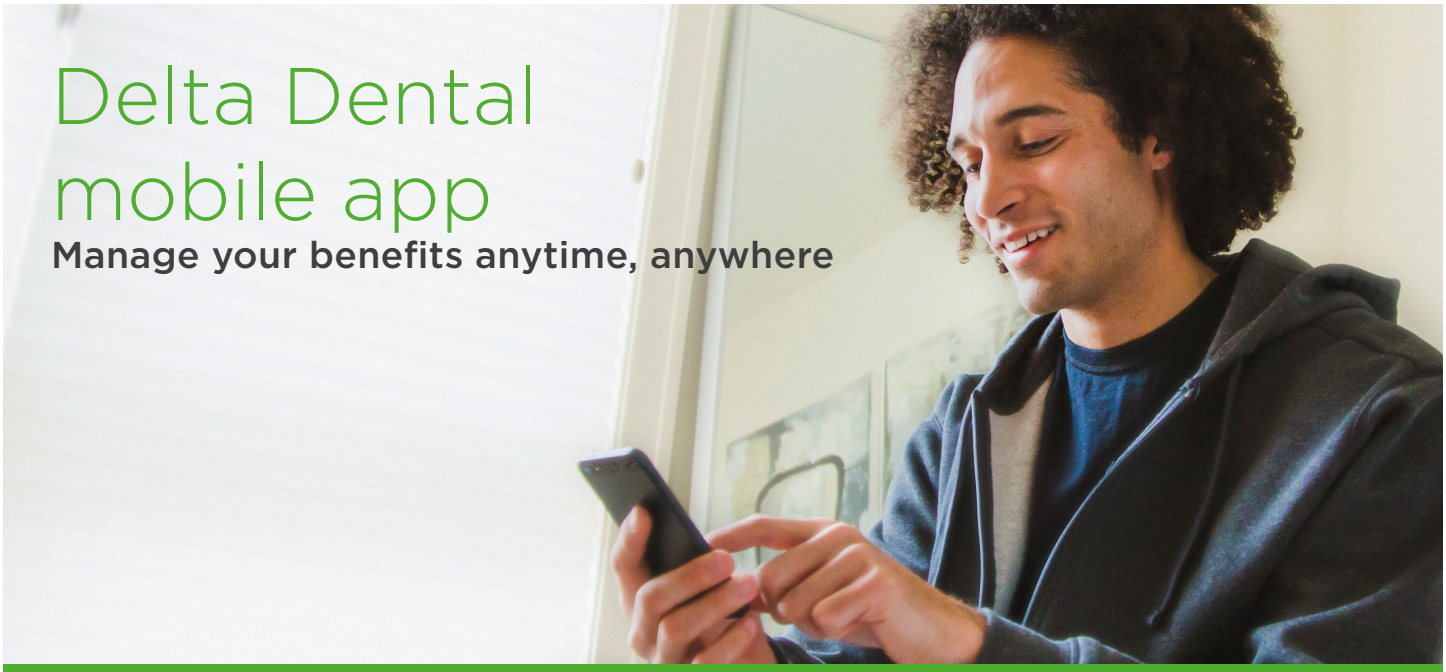
Locating a Participating Dentist

To determine if your dentist participates with Delta Dental or to select a participating dentist in your area:

- Search on-line at DeltaDentalMO.com
- Call Delta Dental Customer Service at 1-800-335-8266 or,
- Scan the image to search for a Delta Dental PPO or Delta Dental Premier participating dentist.

Delta Dental mobile app

Manage your benefits anytime, anywhere



Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, check claims and coverage, view ID cards and more, right on your mobile device.

Getting started

Delta Dental's mobile app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental.

Mobile ID card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.

My coverage and my claims

View information on your plan and coverage details, and check the status of claims for you and your family. Easily add your dependents to your account so you can access the whole family's coverage in one spot

Find a dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.

Dental Care Cost Estimator*

Find out what to expect with our Dental Care Cost Estimator. Our easy-to-use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.

LifeSmile™ Score

Do you know how your smile scores? Learn more about your personal oral health risk profile by taking our simple risk assessment survey.

*Feature not available in all geographic areas and is subject to dentist participation.

24/7 Online access to benefits and service

Register today

Visit **DeltaDentalMO.com/Members/Register** to receive electronic delivery of your benefit information. Once registered, log into your account online or with the Delta Dental mobile app.

You have access to important plan information

- Review and print your dental plan's coverage levels, deductibles, maximums, age limits and limitations
- Verify your eligibility
- Request or download a claim form
- Order or print an ID card
- View your Explanation of Benefits (EOB)
- Get answers to frequently asked questions

Log in to view your benefits

Visit www.DeltaDentalMO.com, and click on one of the **Member** or **Sign In** links. To register, follow the steps under **Member Sign In**.

Customer service

We are here to help every Monday through Friday from 7 am to 5 pm CT.

- **800-335-8266**
- **Service@DeltaDentalMO.com**

We make finding a dentist easy

Finding a dentist is easy using any of the methods below.

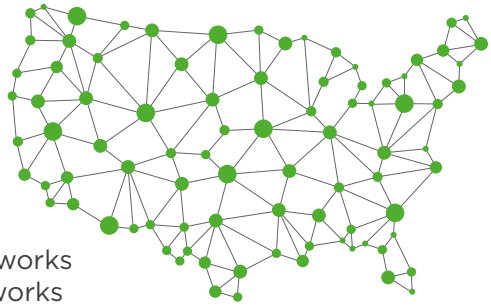
Online
Visit DeltaDentalMO.com and click on "Find a Dentist"

Mobile app
To download, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental.

Customer service
Our customer care team can assist via phone at 800-335-8266 or via email at service@deltadentalmo.com.

DELTA DENTAL®

Smile.
Delta Dental's Network Provides You Cost Savings and Choice.



The Advantages of the Delta Dental Networks

- Our networks give you choice and help control costs
- Delta Dental is proud to offer both the Delta Dental PPO℠ and Premier® networks
- 95% of all practicing dentists in Missouri participate in the Delta Dental networks
- Delta Dental participating dentists accept our allowed amount
- Non-participating dentists don't accept our allowed amount and balance billing is possible
- You will receive the maximum cost savings when you select a dentist in the Delta Dental PPO℠ network

Example Savings for a Common Procedure

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Your Plan	Amount Your Plan Pays	Amount Dentist can Balance Bill	Total Amount You Pay	Your Total Cost Savings
Delta Dental PPO℠	$1,200	$750	50%	$375	$0	$375	$450
Delta Dental Premier®	$1,200	$975	50%	$487.50	$0	$487.50	$225
Out-Of-Network	$1,200	$750	50%	$375	$450	$825	$0

Know Before You Go

With Delta Dental, your dentist is likely to be in either our Delta Dental PPO℠ or Delta Dental Premier® network. There are four easy ways to be sure:

- Check with your dentist
- Visit our website at www.DeltaDentalMO.com
- Download the Delta Dental mobile app
- Contact Delta Dental Customer Service at 800-335-8266

Delta Dental of Missouri

DeltaDentalMO.com | @DeltaDentalMO | Facebook.com/DeltaDentalMO

DDMO-181206-1331

DELTA DENTAL®

Summary Plan Description (SPD)

Delta Dental PPO

Missouri State Troopers' Association

01201141

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

Dependent Children
A dependent child (natural, stepchildren or legally adopted children of the member or the member's spouse) is eligible for coverage until the end of the month in which he or she reaches the dependent age limit (shown on your **Schedule of Benefits**). Unmarried dependent children who are incapable of self-support because of physical or mental impairments ('handicapped dependent') can continue to be protected under your membership regardless of age, if they become impaired before reaching the applicable dependent age limit shown on the **Schedule of Benefits**. An unmarried dependent child who was covered as a handicapped dependent under your Group's previous dental plan may be enrolled at the time of initial enrollment, regardless of 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 once 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 are limited to one set per benefit period. Dependent children age 15 and under will be allowed two sets per benefit period
- Periapical x-rays as required
- Full-mouth x-rays once in any 36 month 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 any 5 years, except for accidental injuries

B: Basic Dental Services

- Restorative services using amalgam, synthetic porcelain, and plastic filling material
- Sealants: for dependent children under age 19, limited caries-free occlusal surfaces of the first and second permanent molars, once in 5 years
- 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)

C: Major Dental Services

- Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes and when teeth cannot be restored with a filling material, once in 10 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 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.
- 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.
- 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 10 years, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

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

Late Entrant Penalty - Any Participant who elects coverage more than 31 days after first becoming eligible for enrollment in the plan is a Late Entrant. Late Entrants can elect coverage at any time after the initial enrollment period. Benefits will be limited and Late Entrants must be enrolled in the plan as follows before becoming eligible for certain benefits.

- A 12 month waiting period applies to all Coverage B services for Late Entrants. Late Entrants must be enrolled for 12 months in this plan before becoming eligible for Coverage B benefits.
- A 24 month waiting period applies to all Coverage C services for Late Entrants. Late Entrants must be enrolled for 24 months in this plan before becoming eligible for Coverage C benefits.
- A 24 month waiting period applies to all Coverage D services for Late Entrants. Late Entrants must be enrolled for 24 months in this plan before becoming eligible for Coverage D benefits.

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

Delta Dental of Missouri - Schedule of Benefits

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: Missouri State Troopers' Association

Group Number: 01201141

Coverage Levels and Percentages:	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist**
Coverage A:	100%	100%	100%
Coverage B:	80%	80%	80%
Coverage C:	50%	50%	50%
Coverage D:	50%	50%	50%
Deductible:	$50	$50	$50
Applies to:	B & C Coverage	B & C Coverage	B & C 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):	$1,000	$1,000	$750

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

Orthodontic Lifetime Maximum:	$750	$750	$750

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: 01/01/2020

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 member of the group or a designated affiliate. "Active" means the member meets the participation requirements set by your group, which have been approved by DDMO.

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.

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 Missouri State Troopers' Association Dental Plan referred to herein as the Plan.

Plan Number: None provided

Dental Plan for Members of: Missouri State Troopers' Association

Group Address: 1729 East Elm Street
Jefferson City, Missouri 65101

Tax ID Number: 43-1253773

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: Missouri State Troopers' Association
Attention: Kemp Shoun, Executive Director
1729 East Elm Street
Jefferson City, Missouri 65101
573-635-5500

Agent of Legal Service: Missouri State Troopers' Association
Attention: Tim VanRonzelen
231 Madison Street
Jefferson City, Missouri 65101

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

Trustee: N/A

Plan's Fiscal Year Ends: 4/30

Funding Is: Contributory
Contributions to the Plan are made by 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, 2020. 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.

If a waiting period or Late Entrant Penalty applies, DDMO will only pay benefits for orthodontic services received after the date the Participant becomes eligible to receive orthodontic Dental Services. If a waiting period applies under the Membership Agreement, it does not apply to a Participant who had coverage for orthodontic services under the prior plan of the Group Sponsor on the day prior to the effective date of the Membership Agreement.

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").

The No Prior Coverage Penalty will begin after the end of any waiting period or Late Entrant Penalty for orthodontic services. The No Prior Coverage Penalty will be measured from the date a Participant would have become eligible to receive orthodontic Dental Services.

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.