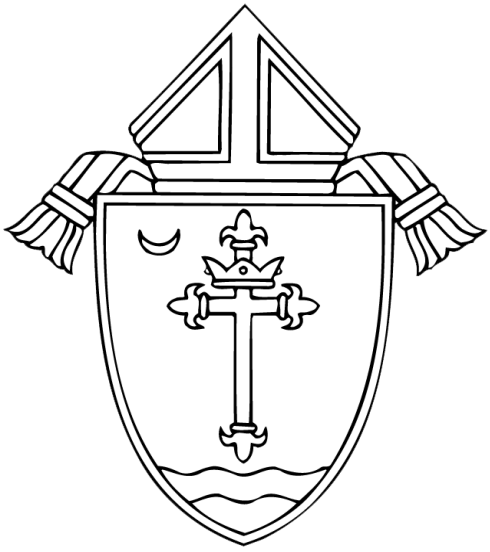
DELTA DENTAL®

Summary Plan Description (SPD)

Delta Dental PPO

Archdiocese of St. Louis

Effective 7/1/2011



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 under the Archdiocese of St. Louis Dental Plan utilizing the network and administrative services of 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 at www.deltadentalmo.com.

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 lesser of usual fees or 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 lesser of filed fees or 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 lesser of the dentist's billed charge or the applicable Maximum Plan Allowance. 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

You and your dependents can be eligible to receive benefits under this Plan on your first date of employment.

To be eligible, a participant must be:

- An active employee working at least 1,000 hours annually;
- A teacher with a ½ time or more contract;
- A religious employee on official assignment with the Archdiocese;
- A retired employee, as defined in the Early Retiree section, who was covered under this Plan on the date immediately prior to retirement;
- A Kenrick-Glennon Seminarian, studying for the Archdiocese of St. Louis priesthood, who is not eligible for other group coverage; or
- A Permanent Deacon who is not an employee or who is an active employee working less than 1,000 hours annually and who is providing services to an Employer, provided that the Deacon must pay 100% of the premium for coverage under the Plan (individual only, individual plus one dependent, or family coverage).

Eligible dependents are the Participant's legal Spouse or a married or unmarried child of the Participant or the Participant's Spouse who has not yet attained their 26th birthday, regardless of student status. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A foster child who resides in your household in a regular parent child relationship and qualifies as your exemption under the Internal Revenue Code.

The Participant must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions. A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A spouse is the person to whom the Participant is married as recognized by the laws of the Catholic Church or the laws of the State of Missouri. It is always understood for this purpose that the spouse is of the opposite sex.

A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

If both parents are covered under this Plan for personal benefits, either but not both may cover a child for dependent benefits. Any individual who is eligible for personal benefits is not a dependent.

WHEN COVERAGE BEGINS

For You

If you are eligible and wish to be covered under this Plan, you must complete the required enrollment forms and authorize any required contributions. Your coverage will begin as follows:

- If you enroll on or before the date eligible, coverage begins on the date eligible.
- If you enroll within 30 days of the date eligible, coverage will be effective on the date you are eligible.

If you do not enroll within 30 days of becoming eligible, you may enroll at a later time as a late enrollee, but only during the annual open enrollment period, unless you experience a change in family status as described in the Special Enrollment Section.

For Your Dependents

If you wish this Plan to provide coverage for your eligible dependents, you must enroll and authorize contributions for dependent benefits. Coverage for your dependents will begin as follows:

- If you enroll your eligible dependents (spouse and/or children) at the time you enroll, coverage for those dependents will begin on the date your coverage begins.
- If you delay enrollment but still enroll within 30 days of the date eligible, coverage will be effective on the date you are eligible.

If you fail to enroll eligible dependents within 30 days of eligibility, they may join the Plan at a later time, but only during an open enrollment period, unless there is a change in family status as described the Special Enrollments section.

Any dependents you acquire by marriage, birth, adoption or placement for adoption and date of foster child placement after the date you become eligible may be covered under the Plan, provided enrollment is in accordance with the special enrollment provisions. You and/or your dependents (if not previously enrolled in the Plan) may be enrolled when any of these events occur, provided enrollment is in accordance with the Plan's guidelines.

After your coverage becomes effective, please notify your Employer promptly of new dependents or dependents who are no longer eligible due to a change in their status because of marriage, divorce, separation, age (of children), or mental or physical handicap qualifications.

ENROLLING

You are automatically enrolled into Delta Dental if you fill out the Archdiocesan Employee Benefits Information Form. This form will enroll you into the medical, dental, prescription and life insurance plan. You cannot enroll in only Delta Dental without enrolling into the other group insurance such as medical, prescription, and life. You must give your employer (parish/agency) a completed Employee Benefits Information Form within 30 days of becoming eligible for benefits. Benefits will take effect on the 1st day of work. For a teacher under contract, the effective date of health coverage is the earliest of either the first day students are expected to be in class or the first date of their paid employment contract. If you do not enroll during your first 30 days of eligibility, you may enroll later under either the special enrollment provision or the late enrollment provision.

SPECIAL ENROLLMENTS

- If you decline enrollment in the Plan (in writing as required) for yourself or your dependents due to other health coverage, you may enroll in this Plan at a later time if the other coverage is lost due to:
  - Separation
  - Divorce
  - Death
  - Termination of employment
  - Reduction of work hours
  - Employer contributions towards all family coverage have terminated
  - Termination of Cobra continuation or state continuation

  Or there is a change in family status due to:
  - Marriage
  - Birth of a child
  - Adoption or placement for adoption of a child
  - Foster child placement

  Enrollment must be made within 30 days after the coverage ends. Coverage will be effective on the day the other coverage ends.
- If you get married while eligible for coverage in the Plan, you may enroll your new spouse as well as yourself and any other eligible dependents not previously enrolled, provided enrollment is within 30 days of the marriage. Coverage for you, your spouse, and/or dependents will be effective on the date of the marriage.
- If you acquire a child while eligible for coverage in the Plan, you may enroll the child as well as yourself and any other eligible dependents not previously enrolled, provided enrollment is within 30 days of acquiring the new dependent child. Coverage for you and your dependents will be effective on the new dependent child's date of birth, date of adoption or date of placement for adoption and date of foster child placement.

LATE ENROLLMENTS

If you do not enroll for coverage within 30 days of the date eligible, you may enroll at a later time as a late enrollee, but only during the annual open enrollment period in May. Coverage will then become effective on July 1.

WHEN COVERAGE TERMINATES

Your coverage under this Plan will terminate on the date your employment terminates or if applicable, the following:

- On the date this Plan is discontinued; or
- On the date you are no longer eligible for coverage under this Plan; or
- On the date you begin active duty in the Armed Forces of any country; or
- On the date ending the period for which contributions (if required) have been paid.

In addition to the above, coverage for each dependent also terminates on the earliest date stated:

- On the date he/she ceases to be an eligible dependent; or
- On the date he/she becomes covered for personal benefits under this Plan; or
- On the date he/she begins active duty in the Armed Forces of any country; or
- On the date you request that coverage on your dependents be terminated.

If you cease active work, your coverage will terminate. However, if you cease active work for the following reasons your Employer may continue your coverage for a limited time, provided you make any required contributions:

- Injury, sickness or pregnancy - 6 months
- Temporary layoff - 3 months
- Approved leave of absence - 12 months

If you die while covered, benefits for dependents covered on the date of your death may be continued for 12 months, provided any required contributions are paid.

EARLY RETIREES

Employees and their dependents, who are enrolled in the Archdiocese Employee Benefits Plan, may continue full health coverage in the Plan until they are eligible for Medicare health insurance coverage if the following eligibility requirements are met by the participant:

- Age 55 or older.
- Not yet eligible for Medicare.
- Employee must either have been a half time or more teacher as defined by the Archdiocesan Policy or worked for 1,000 hours or more annually for ten of the prior twelve years to retirement.
- Employment must have been with a parish, school, or agency of the Archdiocese of St. Louis or a private Catholic organization with Archdiocesan health care coverage.

If covered, dependent spouses may continue coverage beyond the retired employee's date of Medicare eligibility under this early retiree health coverage provision until the earliest of five years from the date of retired employee's Medicare eligibility or their own (the spouse's) Medicare eligibility.

If covered, dependent children may continue coverage beyond the retired employee's date of Medicare eligibility under this provision until the earliest of: five years from the date of the retired employee's Medicare eligibility or the date that they reach 26 years of age.

Should a retiree obtain dependents and wish to convert from individual coverage to family coverage, she/he would have thirty (30) days from the event (marriage/adoption/birth) to change coverage from single to family.

The employee will be responsible for paying 100% of the then current premium, plus any regular future premium increase, on a monthly basis unless they are eligible for Medicare. They will be responsible for the then current dependent premiums, plus any regular premium increase, on a monthly basis as long as the dependent(s) are eligible for coverage. The employee and/or their dependents would remain in the Plan and make premium payments through the parish or agency from which they retired. The employee should contact their employer for the necessary paperwork to enroll in the early retiree provision. Those employees covered under an HMO option would be eligible also for this retiree coverage.

If a participant of the early retiree provision terminates coverage, he will not be eligible to enroll back into the plan at a later date.

If a retiree's former employer terminates participation with the Archdiocese Health Care Plan, the retiree's coverage with the Archdiocese will also terminate.

The eligibility requirements, availability, and the terms of the early retiree health care provisions are subject to change by the Archdiocese of St. Louis.

CONTINUATION OF COVERAGE PROVISION

You can continue *medical, dental, and prescription* benefits that are in force for you and/or your dependents upon the occurrence of certain events that would normally result in termination of coverage under the Plan.

Who May Continue Coverage, When, and for How Long?

Any individual who has been covered under this plan for *3 months or longer* may elect to continue coverage. Anyone who is covered under another group health care plan or Medicare is not eligible for this continuation of coverage. You may continue medical, dental, and prescription coverage under the Plan for yourself and your dependents for up to 18 months if your coverage terminates for any of the following reasons:

- If your employment terminates for any reason other than your gross misconduct; or
- If your working hours are reduced and you are no longer considered eligible for coverage under the Plan.

Continuation coverage may extend from 18 months to 29 months for a participant and/or dependent who is disabled (as defined by the Social Security Administration) at the time of termination or reduction of hours, provided that such participant and/or dependent has given notice of the disability within 60 days of the Social Security determination and requested the extended continuation period before the end of the first 18 months.

Your dependents' coverage may be continued for up to 36 months if their coverage terminates for any of the following reasons:

- If you should die; or
- If you become divorced or legally separated from your spouse; or
- If you are no longer an active employee and you become eligible for Medicare; or
- If your dependent child no longer meets the definition of an eligible dependent child under the Plan.

When Continued Coverage Ends

The continued coverage will end for any person when:

- The cost of continued coverage is not paid on or before the date it is due; or
- That person becomes entitled to Medicare; or
- That person is covered or becomes covered under another group health care plan that does not have a pre-existing condition limitation; or
- The Plan terminates for *all* employees; or
- That person has been in the continued coverage plan for the applicable maximum time frame.

Notice Responsibilities

Within 60 days of termination or the qualifying event, it is your responsibility to notify the Archdiocesan Office of Human Resources of whether or not you intend to enroll in the continued coverage provision plan.

It is your responsibility or that of your spouse to notify the Archdiocesan Office of Human Resources if you become divorced or legally separated. It is your responsibility or that of your covered child to notify your employer if your dependent child no longer qualifies as a covered dependent under the Plan. *If you, your spouse, or child, fail to properly notify the Archdiocesan Office of Human Resources within the 60 day period, you or your dependents will be unable to purchase continued coverage*.

Cost of Continued Coverage

Any person who chooses to continue coverage under the Plan will be required to pay the entire cost of that coverage (including any portion you now pay and any portion the Archdiocesan Office of Human Resources now pays). The cost will be slightly higher than the total premium for active employees/dependents. Your payments for continued coverage must be made within 30 days after the initial election, and thereafter by the 18th of each month within the current billing month or your coverage will end. The individual must submit payment via automatic withdrawal for all premium charges on a timely basis.

Schedule of Benefits for Continued Coverage

Medical, Dental, Life, and Prescription benefits will remain the same as the coverage in force for active employees.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA).

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons For Taking Leave:

Unpaid leave must be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage during the leave period just as though the employee had continued working.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Please contact your employer for additional special information and whether or not you qualify for the Family and Medical Leave Act of 1993.

NOTICE OF PRIVACY PRACTICES FOR THE ARCHDIOCESE OF ST. LOUIS HEALTH PLAN AND DENTAL PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: April 14, 2003.

1. Introduction

The use and disclosure of your Protected Health Information ("PHI") by the Plans is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). This Notice of Privacy Practices ("Notice") is intended to summarize the HIPAA regulations ("Regulations"). You may find these Regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164. If there is any difference between this Notice and the Regulations, the Regulations will control.

PHI includes all individually identifiable health information (health information about you that also identifies you) created, received, sent to other people or companies, or maintained by the Plans, regardless of form (oral, written, or electronic).

2. Information About Uses and Disclosures of Your PHI

a. In General

Except as otherwise indicated in this Notice, uses and disclosures will be made *only with your written authorization*, subject to your right to revoke such authorization.

b. Required PHI Uses and Disclosures

To You. Upon your request, the Plans are required to give you access to certain PHI in order for you to inspect and copy it.

To The Secretary. The Secretary of the Department of Health and Human Services ("Secretary of HHS") may require the Plans to Use and Disclose your PHI in order for the Secretary of HHS to investigate or determine whether the Plans are complying with the Regulations.

c. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Plans and their business associates (companies who help the Plans provide you with your benefits, such as outside administrators) will use PHI without your consent, authorization, or opportunity to agree or object to carry out three activities: treatment, payment, and health care operations. The Plans will also disclose PHI to the Plan Administrator, the Archdiocese of St. Louis, for purposes related to those activities. The Plan Administrator has amended the plan documents to protect your PHI as required by federal law.

(1) Treatment

The Plans may disclose PHI to your health care providers (such as physicians and hospitals) to assist in diagnosis and treatment. However, PHI that consists of psychotherapy notes will not be used or disclosed without your written authorization, even if for treatment purposes, unless it is necessary to defend the Plans in litigation filed by you.

For example, a Plan may disclose to a treating specialist the name of your general practitioner so that the specialist may ask for your treatment records from the general practitioner.

(2) Payment

The Plans may use or disclose your PHI in determining who is covered under the Plans and when the Plans are making a payment. These activities include billing, managing claims, subrogation, plan reimbursement, preauthorizations, and treatment reviews.

For example, a Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

(3) Health Care Operations

The Plans may use or disclose PHI for activities associated with making sure the Plans can provide you with affordable, quality health care. These activities include quality assessment and improvement, reviewing the competence of a health care professional, underwriting, disease or case management, arranging for legal services, auditing, business planning, development, management, and general administrative activities.

For example, a Plan may use information about your claims to refer you to a disease management program, project future benefit costs, or audit the accuracy of the way it processes claims.

d. Uses and Disclosures That Require That You Be Given an Opportunity to Agree or Object

Disclosure of your PHI to the following persons is allowed if you have either agreed to the disclosure or have been given the opportunity to object and have not objected: (1) your family members or close personal friends if the information is directly relevant to the family member's or friend's involvement with your care or payment for that care; or (2) disaster relief organizations for purposes of notifying friends and family members involved in your care of your location or condition in the event of an emergency. If you are not present to voice your agreement or objection, a Plan may also disclose PHI to such persons that is relevant to their involvement with your care if the Plan determines it is in your best interests.

e. Uses and Disclosures For Which Consent, Authorization, or Opportunity to Object is Not Required

The Plans are allowed to use and disclose your PHI *without* your consent, authorization, or opportunity to object under the following circumstances:

(1) When Required By Law. For example, when needed to comply with Medicare regulations.

(2) Public Health Activities. When permitted for purposes of public health activities such as preventing or controlling disease, or reporting disease or infection exposure.

(3) Abuse and Neglect. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities, if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence.

(4) Public Oversight. Where requested by a public oversight agency for oversight activities authorized by law.

(5) Legal Proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met.

(6) Law Enforcement. When required for law enforcement purposes including for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, subject to conditions contained in the Regulations.

(7) Coroner, Medical Examiner, or Funeral Director. When required to be given to a coroner or medical examiner to identify a deceased person or determine a cause of death. The Plans may also disclose PHI to funeral directors to carry out their duties with respect to a deceased person.

(8) Organ Donation. For assisting organizations involved in procuring, banking, or transplanting organs or tissue for the purpose of facilitating organ or tissue donation and transplantation.

(9) Research. For research purposes, subject to conditions contained in the Regulations.

(10) National Security. Where necessary to prevent a serious and imminent threat to the health or safety of a person or the public or for national security or intelligence purposes, if the disclosure is consistent with applicable law and standards of ethical conduct.

(11) Workers' Compensation. When authorized by and to the extent necessary to comply with workers' compensation or similar laws.

f. Disclosures to the Plan Sponsor

The Plans may disclose PHI to the Archdiocese of St. Louis, the Plan Sponsor, to assist the Plans in providing you with your benefits.

3. <u>Your Rights</u>

a. Right to Request Restrictions on PHI Uses and Disclosures

You may request that a Plan restrict uses and disclosures of your PHI to carry out treatment, payment, or health care operations. You may also request that a Plan restrict disclosures to a disaster relief organization, or to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, the Plans are not required to agree to your request. You or your personal representative will be required to request restrictions on these uses and disclosures in writing.

b. Right to Request Confidential Communications

The Plans will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you clearly state to the Plans that the disclosure could endanger you. For example, you may request that your PHI be sent to your office address instead of your home address, if you feel that someone at your home who might receive your PHI through the mailing could threaten your safety.

c. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI from a Plan that is used to make decisions about your benefits, such as enrollment, billing, claims, or medical management records. If access is denied, you or your personal representative will be provided with a written denial setting forth the reason for the denial, a description of how you may exercise your review rights, and a description of how you may complain to the Secretary of HHS. The Plan will respond to your request within the time required by state or federal law. Your request for access must be in writing.

d. Right to Amend PHI

You have the right to request that a Plan amend your PHI if you believe it is inaccurate or incomplete. If your request is denied in whole or in part, the Plan must provide you with a written denial that explains the reason for the denial. You or your personal representative may then submit a written statement disagreeing with the denial. Your statement will be included with any future disclosures of your PHI. The Plan will respond to your request within the time required by state or federal law. Your request for an amendment must be in writing. You must also include a reason to support your requested amendment.

e. Right to Receive an Accounting of PHI Disclosures

Upon your written request to a Plan, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting does not need to include PHI disclosures made:

- prior to the effective date of this Notice;
- to carry out Treatment, Payment, or Health Care Operations;
- to you about your own PHI;
- incident to a use or disclosure otherwise permitted by the Regulations; or
- based on your written authorization.

The Plan will respond to your request within the time required by state or federal law. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

f. The Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain an additional paper copy of this Notice.

g. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you.

4. Your Right to File a Compliant With the Plan or the Secretary of HHS

You may file a complaint with the Secretary of the HHS at the following address:
Region VI, Office for Civil Rights, U.S. Department of HHS
601 East 12th Street; Room 248
Kansas City, Missouri 64106
The Plans will not retaliate against you for filing a complaint.

5. The Plans' Duties

The Plans are required by law to maintain the privacy of PHI and to provide participants with notice of its legal duties and privacy practices.

This Notice is effective beginning April 14, 2003, and the Plans are required to comply with the terms of this Notice. However, the Plans reserve the right to change their privacy practices and to apply the changes to all of the PHI they maintain. If a privacy practice is changed in a way that affects you, a revised version of this Notice will be provided within 60 days.

6. Who You Can Contact at the Plans to Exercise Your Rights or for More Information

If you wish to exercise any of your rights described in this Notice or have any questions regarding this Notice or the subjects addressed in it, you may contact the following person:

Michael Puetz
Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, Missouri 63119
(314) 792-7540

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

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.

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.

Levels of Coverage

A: Preventive Services

- Periodic oral examinations (evaluations), twice per calendar year
- Dental x-rays. (Full-mouth x-ray not more than once in any calendar year)
- Dental prophylaxis including cleaning, routine scaling and polishing, twice per calendar year
- Topical fluoride application for dependent children under age 19, twice per calendar year

B: Basic Services

- Space maintainers for eligible dependent children (excluding Orthodontics.)
- Emergency palliative treatment (minor procedures to temporarily reduce or eliminate pain) and emergency examinations.
- Fillings
- Periodontics limited to: Acute periodontal management; Gingivectomy and gingivoplasty; Gingival curettage.
- Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth)
- Simple extractions not requiring flap or bone removal.
- Crowns (not part of a bridge.)
- Oral surgery which is not covered under the patient's medical plan. (**SEE SCHEDULE OF BENEFITS)** Only specific procedures listed are covered and are not subject to the annual maximum.)

C: Major Services

- Partial or full removable dentures.
- Fixed or removable bridgework (including inlays and crowns as abutments.)
- Replacement of an existing full denture, but only if the existing denture was installed at least 5 years prior to its replacement and cannot be made serviceable.

D: Orthodontic Services

- Orthodontia benefits limited to dependent children under age 19 and not to exceed the lifetime maximum shown in the Schedule of Benefits. Necessary services related to an active course of orthodontic treatment, including but not limited to tooth extractions, cephalometric x-rays and other required x-rays. Initial and subsequent, if any, installation of orthodontic appliances for an active course of orthodontic treatment. Adjustment of active orthodontic appliances.

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.
- 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 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 or implants, in which case the benefits may be based on the cost of a removable partial denture or full dentures.

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, temporary appliances, or implants and related procedures.
- Services or supplies covered under a terminal liability, extension of benefits, or similar provision, of a program being replaced by this program.
- Services or supplies rendered by a dental or medical department maintained by or on behalf of a group, a mutual benefit association, union, trustee or similar person or group.
- Services or supplies provided or paid for by or under any governmental agency or program or law, except charges which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act, as amended).
- Services rendered beyond the scope of a dentist's or service provider's license, or experimental or investigational services/supplies.
- Services or supplies that a dentist determines for any reason, in his professional judgment, should not be provided.
- Instructions in dental hygiene, dietary planning, or plaque control.
- Missed appointments or claim form completion.
- Infection control, including sterilization of supplies and equipment.

How To File and Appeal A Claim

Your claims must be filed 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 <u>summary</u>, 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.

December 20, 2011

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: Archdiocese of St. Louis

Group Number: 1873-1000

Coverage Levels and Percentages:	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist**
Coverage A:	100%	100%	100%
Coverage B:	90%*	80%*	80%*
Coverage C:	60%	50%	50%
Coverage D:	50%	50%	50%
Deductible:	$50	$50	$50
Applies to:	B & C Coverage	B & C Coverage	B & C Coverage
Family limit:	$100	$100	$100

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:	$1,500 per person	$1,500 per person	$1,500 per person
	$3,000 per family	$3,000 per family	$3,000 per family

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

Orthodontic Lifetime Maximum:	$1,500	$1,500	$1,500

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

Dependent Age Limit: 26

Effective Date of Program: 7/1/2011

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

*The following oral surgery procedures are covered under Coverage B and are not subject to the annual maximum:

- Excision of impacted teeth.
- Excision of tumors or cysts from the mouth.
- Cutting procedures on the gums and mouth tissues for treatment of disease.
- Treatment of fractures of facial bones (excluding TMJ procedures).
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary gland or ducts.

Eligibility: Qualified new employees and their dependents become eligible for this coverage on the date of employment. Coverage begins on the first date of active work (for teachers under contract, the effective date of health coverage is the earliest of either the 1st date of school or the start date of their contract) if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the date the Eligible Person becomes eligible to enroll. Coverage ends on the day employment terminates unless the participant enrolls into either the Early Retiree Plan or Continuation of Coverage Plan at which time the coverage terminates at the conclusion of the Plans.

Plan Information

Name of Plan: The Archdiocese of St. Louis Dental Plan referred to herein as the Plan.

Plan Number: None Provided

Dental Plan for Members of: Archdiocese of St. Louis

Group Address: Office of Human Resources
20 Archbishop May Drive
St. Louis, MO 63119

Tax ID Number: 43-0653244

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: Archdiocese of St. Louis
Office of Human Resources
20 Archbishop May Drive
St. Louis, MO 63119
314-792-7540

Agent of Legal Service: Archdiocese of St. Louis
Office of Human Resources
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: 06/30

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