

<p style="text-align: center;">TRUMAN STATE UNIVERSITY PLAN B (7620-2000)</p> <p style="text-align: center;">Benefit Summary¹</p>	<p style="text-align: center;">Delta Dental PPOSM Network</p>	<p style="text-align: center;">Delta Dental Premier[®] Network</p>	<p style="text-align: center;">Out-of-Network</p>
	<p style="text-align: center;">Based on applicable PPO Maximum Plan Allowance - No balance billing</p>	<p style="text-align: center;">Based on applicable Premier Maximum Plan Allowance - No balance billing</p>	<p style="text-align: center;">Based on applicable Maximum Plan Allowance for Out-of- Network dentist - Balance billing is possible</p>
<p>Preventive Services</p> <ul style="list-style-type: none"> Oral examinations, twice in any benefit period Prophylaxis (cleanings), twice in any benefit period Periodontal maintenance, twice in any benefit period (subject to the prophylaxis frequency limitations) Bitewing x-rays, one set per benefit period Sealants for dependent children under age 16, once in any 5 year period Space maintainers for dependent children under age 16, once in 5 years Topical fluoride treatments for dependent children under age 14, twice in any benefit period Emergency palliative treatment 	100%	100%	100%
<p>Basic Services</p> <ul style="list-style-type: none"> Periapical x-rays as required Full-mouth x-rays, once in any 36 month period Fillings: amalgam (silver) on posterior teeth and composite (white) on anterior teeth Simple extractions 	80%	80%	80%
<p>Major Services</p> <ul style="list-style-type: none"> Periodontics: treatment for diseases of the gums and bones supporting the teeth. Periodontal surgery is covered only once in a 3 year period for the same site. Coverage for root planing and scaling are limited to once per 24 months Endodontics: root canal filing and pulpal therapy Surgical extractions Oral surgery General anesthesia in conjunction with a covered surgical procedure Crowns, bridges, dentures, inlays, onlays, once in 5 years 	50%	50%	50%
<p>Orthodontic Services</p> <ul style="list-style-type: none"> Orthodontia treatment that begins <u>while covered on this plan (Plan B)</u>, for dependent children under age 19 	<p>1st Benefit Period: N/A 2nd Benefit Period: N/A 3rd Benefit Period: 50%</p>	<p>1st Benefit Period: N/A 2nd Benefit Period: N/A 3rd Benefit Period: 50%</p>	<p>1st Benefit Period: N/A 2nd Benefit Period: N/A 3rd Benefit Period: 50%</p>
<p>Subscriber Year Deductible (Applied to Basic and Major services)</p>	\$50 per person		
<p>Subscriber Year Maximum² (Applied to Preventive, Basic and Major)</p>	\$1,000 per person		
<p>Lifetime Orthodontic Maximum</p>	\$1,500 per eligible dependent		
<p>Dependent Age Limit: 26</p>			

¹ This is intended to be a summary only. Please refer to your Summary Plan Description (SPD) for a more complete listing of services, including plan limitations and exclusions. If a discrepancy occurs, the SPD will govern.

² Dental benefits are provided according to a subscriber year benefit period, which begins on the date of your DDMO membership is effective and continues for 12 consecutive months. A new benefit period renews on the first day of your anniversary month.