TRINITY UNIVERSITY

Group Number: 44-3628

Effective Date: June 1, 2003

Revised June 1, 2005
CERTIFICATE OF INSURANCE
OF YOUR GROUP DENTAL PROGRAM

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by Delta Dental Insurance Company ("Delta") and cannot modify the Contract in any way.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS’ COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS’ COMPENSATION SYSTEM.

Robert B. Elliott
President
Delta Dental Insurance Company
TEXAS NOTICE OF COMPLAINT

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Delta Dental Insurance Company’s toll free number for information or to make a complaint at

1-800-521-2651

You may also write to Delta Dental Insurance Company at

Delta Dental Insurance Company
1000 Mansell Exchange West
Building 100, Suite 100
Alpharetta GA 30022

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at

1-800-252-3439

You may write the Texas Department of Insurance at

P.O. Box 149104
Austin TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim, you should contact your agent or Delta Dental Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part of condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefon gratis de Delta Dental Insurance Company para informacion o para someter una queja al

1-800-521-2651

Usted tambien puede escribir a Delta Dental Insurance Company

Delta Dental Insurance Company
1000 Mansell Exchange West
Building 100, Suite 100
Alpharetta Ga 30022

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin TX 78714-9104
FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o Delta Dental Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para propuesto de informacion y no se convierte en parte o condicion del documento adjunto.
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GROUP HIGHLIGHTS

ELIGIBILITY:
Minimum number of hours/week: 20
Effective day of month: Date of hire

PLAN:
You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year Year.

DEDUCTIBLE:
The deductible for each Enrollee is $50.00.
The deductible for all family members is $150.00.

MAXIMUM:
The maximum amount payable each year for Benefits is $1,500.00 per Enrollee.
The maximum lifetime amount per Dependent Child Enrollee for Orthodontic Benefits is $1,000.00.

CONTRIBUTION:
You are required to contribute toward the cost of your coverage.
You are required to contribute toward the cost of your Dependents’ coverage.

DEFINITIONS
Terms when capitalized in this document, either in the section below or throughout the booklet, have defined meanings.

Approved Amount -- the total fee chargeable for a Single Procedure.

Attending Dentist’s Statement -- the form used to file a claim or request a Predetermination for proposed treatment.

Benefits -- the amounts that Delta will pay for dental services under the Contract.

Calendar Year -- the 12 months of the year from January 1st through December 31st.

Contract -- the written agreement under which Benefits are provided.

Contractholder -- the employer, association or other organization or group contracting to obtain Benefits.

Contract Allowance -- the maximum amount allowed for a Single Procedure. It is the least of the Dentist’s submitted fee, the Approved Amount as outlined in the terms of the Contracting Access Dentist Agreement, or the UCR fee.

Contract Term -- the period during which the Contract is in effect.
**Contract Year** -- the 12-month period starting on the Effective Date of the Contract and each 12-month period thereafter.

**Contracting Access Dentist** -- a Dentist who has executed a Contracting Access Dentist Agreement with Delta and who has agreed to provide services in accordance with the terms and conditions established by Delta. Contracting Access Dentists have agreed to charge no more than the Contract Allowance.

**Contracting Access Dentist Agreement** -- an agreement between Delta and a Dentist which establishes the terms and conditions under which covered services are provided under this program.

**Dentist** -- a person licensed to practice dentistry when and where services are performed.

**Dependent Enrollee** -- an Eligible Dependent enrolled under the Contract to receive Benefits.

**Effective Date** -- the date the Contract starts. This date is given on the booklet cover.

**Eligible Dependent** -- a dependent of an Eligible Person or domestic partner eligible for Benefits under the Contract.

**Eligible Person** -- any person defined in the Contract as eligible for Benefits under the Contract.

**Enrollee** -- an Eligible Employee ("Primary Enrollee") or Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits under the Contract.

**Non-Contracting Access Dentist** -- a Dentist who has not executed a Contracting Access Dentist Agreement with Delta and has not agreed to provide services in accordance with the terms and conditions established by Delta. A Non-Contracting Access Dentist may charge more than the Contract Allowance.

**Open Enrollment Period** -- the 31-day period of each year during which an Eligible Person may change coverage.

**Predetermination** -- Delta will estimate the amount of Benefits payable for proposed services to an Enrollee under the Contract.

**Premiums** -- the amounts payable monthly by the Contractholder as required in the Contract.

**Primary Enrollee** -- an Eligible Person enrolled under the Contract to receive Benefits.

**Procedure Code** -- the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.

**Qualifying Status Change** -- a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child’s birth or adoption; iii) a change in spouse’s employment; iv) a death in the family; or v) a court order requiring dependent coverage.

**Single Procedure** -- a dental procedure that is assigned a separate CDT number.

**UCR** -- **Usual, Customary and Reasonable**, which have the following meanings:

**Usual** -- A "usual" fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his usual fee. If more than one fee is charged for a given service, the fee determined to be usual will not exceed the lowest fee which is regularly charged or which is offered to patients.

**Customary** -- A fee is "customary" when it is within the range of usual fees charged and received by Dentists of similar training for the same service within the geographic area determined by Delta to be relevant. Customary fees may be determined on the basis of fees filed with Delta by Contracting Access Dentists. A Customary fee for a Contracting Access Dentist is that fee which is approved by Delta in the terms of the Contracting Access Dentist Agreement.
Reasonable -- A fee is "reasonable" if it is "usual" and "customary" or if it falls above "usual" or "customary" or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

Waiting Period -- the continuous period of time that you must be in an eligible group before you are eligible for coverage under the Contract.

We, Our, or Us -- Delta, and will be used without respect to capitalization.

You, Your, Yours -- the Primary Enrollee, and will be used without respect to capitalization.

CHOICE OF DENTIST

Delta offers you a choice of selecting a Dentist from our panel of Contracting Access Dentists, or you may choose a Non-Contracting Access Dentist.

A directory of Contracting Access Dentists is available from the Contractholder. You are responsible for verifying whether the Dentist you select is a Contracting Access Dentist. Dentists are regularly added to the panel so a Contracting Access Dentist may not yet be listed. Additionally, you should always confirm that a listed Dentist is still a Contracting Access Dentist.

You may choose to go to any Dentist. Even if you choose a Contracting Access Dentist from our panel, Delta cannot guarantee that a particular Dentist will be available.

There may be a difference in the out-of-pocket cost you pay if your Dentist is not a Contracting Access Dentist. A Contracting Access Dentist has contractually agreed not to charge you any amount for services above the Approved Amount. Delta pays your Benefits based on the Contract Allowance less any deductibles or maximums that may apply.

If a Dentist is not a Contracting Access Dentist, the amount charged to you may be above that charged by our Contracting Access Dentists. When Delta pays Benefits for services provided by Non-Contracting Access Dentists, Delta will allow the Customary fee or the fee which satisfies the majority of the Contracting Access Dentists. You will then be responsible for any extra amount charged by this Dentist over what Benefits Delta will pay in addition to any deductibles and maximums specified by the plan. This is called balance billing, that is, the Dentist may bill you for the balance after Delta’s payment is made.

WHO IS ELIGIBLE?

Eligibility for Enrollment

All retired employees and all present, permanent employees working the minimum number of hours per week shown on the Group Highlights page are eligible on the Effective Date. All future permanent employees will become eligible on the calendar day of the month shown on the Group Highlights page.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

Dependents are your:

a) Your lawful spouse or domestic partner named in the Contractholder’s Affidavit of Domestic Partnership.

b) Unmarried dependent children from birth to their 25th birthday. “Children” includes natural children, step-children, adopted children, children of your domestic partner, and foster children. Newborn infants are eligible from the moment of birth. An adopted child will be eligible from the moment the Eligible Person becomes a party in a suit to adopt the child. A newborn child or adopted child will automatically be covered for thirty-one (31) days. To continue coverage after thirty-one (31) days, notice of the birth or notice regarding the suit to adopt and additional Premium, if any, must be received within the thirty-one (31) day period.
c) unmarried grandchildren. "Grandchild" is a child of an unmarried dependent child who is less than 25 years of age and is financially dependent upon the Eligible Person. Coverage for said grandchild may not be terminated solely because the grandchild's parent is no longer dependent upon the Eligible Person for federal income tax purposes.

d) unmarried dependent children, including grandchildren, under 25 years of age for whom the Eligible Person is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in Texas. Said child may request to be covered under the Eligible Person's coverage.

e) an unmarried child, including grandchild, 25 years of age or older who is not self-supporting because of mental retardation or physical handicap and the child is chiefly dependent upon the Eligible Person for support and maintenance. Proof of these facts must be given to Delta within thirty-one (31) days of the child's attainment of age 25. Proof will not be required more than once a year after the child is 27.

Dependents in military service are not eligible.

**Enrollment Requirements**

If the Contractholder is paying all premiums for you or your dependents, everyone is automatically enrolled.

If you are paying all or a portion of premiums for yourself or your dependents then:

a) You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.

b) All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.

c) If you elect dependent coverage, you must enroll all of your Eligible Dependents.

d) If you pay Premiums for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta until your dependents are no longer eligible or until you choose to drop dependent coverage, coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.

e) If both you and your spouse are Eligible Persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.

f) **A minimum percentage of Primary Enrollees** with dependents, as shown on the Group Highlights Page, must enroll all of their Eligible Dependents. Dependents covered by any other group are not counted toward this requirement.

**Dual Coverage**

You have a choice between dental coverage under this Delta plan and one or more alternate programs of the Contractholder. You may exercise that choice as follows:

a) All eligible employees that enroll will be enrolled as Primary Enrollees under this Delta plan unless they elect an alternate plan.

b) Except for new employees, enrollment may be filed with the Contractholder only during the Open Enrollment Period.

c) New employees may enroll within thirty days of employment which will be effective until the next Open Enrollment Period.
Parallel Enrollment
You and your dependents who enroll in the Contractholder’s medical plan are required to enroll under this dental plan. Eligibility for coverage under this dental plan begins on the date eligibility under the medical plan begins provided that the Eligible Enrollee has met the eligibility period requirements.

Loss of Eligibility
Your coverage ends on the day you stop working for the Contractholder, or immediately when this program ends. Your dependents’ coverage ends when your coverage ends, or as soon as they are no longer dependents as defined in this booklet.

Continuation of Benefits
Delta does not pay Benefits for services received after your coverage ends. But Delta will pay for Single Procedures incurred when the patient was covered if such procedure is completed within 30 days of the date coverage ends. A dental service is incurred as follows:

a) for an appliance (or change to an appliance), at the time the impression is made;
b) for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
c) for root canal therapy, at the time the pulp chamber is opened; and
d) for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence
You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993*.

Benefits for you and your eligible dependents will resume as follows:

a) if coverage is reactivated in the same Calendar Year, deductibles and maximums will resume as if you were never gone; or
b) if coverage is reactivated in a different Calendar Year, new deductibles and maximums will apply.

Coverage will resume the date you return to work provided you submit to Delta an enrollment card requesting that coverage be reactivated.

*Your and your dependents' coverage is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred. Important: The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

Optional Continuation of Coverage (COBRA)
When the Eligible Persons of an employer are covered under the Consolidated Omnibus Budget Reconciliation Act of 1986, then in consideration of the premium payments, Delta agrees to provide Benefits to Enrollees who elect continued coverage pursuant to this section.

a) Right to Continue. Coverage may continue in accordance with the following provisions when:

(i) you or your Dependent Enrollee becomes ineligible for coverage under the Contract due to a Qualifying Event shown below; (A domestic partner and his or her Dependent Enrollee will not be eligible for COBRA continuation unless the Primary Enrollee elects COBRA continuation.); and

(ii) the Contract remains in force.

“Qualifying Event” means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary’s loss of coverage under this Contract:
your termination of employment.
your death.
divorce or legal separation from you.
you becoming entitled to Medicare benefits.

* a dependent child ceasing to meet the description of a dependent child.
• a bankruptcy proceeding under Title 11, United States Code with respect to the employer, which results in a substantial elimination of coverage (within one year before or one year after the date of commencement of the proceeding) of a retired Primary Enrollee (who retired on or before the date of substantial elimination of coverage), or of a Dependent Enrollee of a retired Primary Enrollee.

“Qualified Beneficiary” means you and any of your Dependent Enrollees who are entitled to continue coverage under the Contract, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:
• is acquired during your 18 or 29 month continuation period; and
• is enrolled for coverage in accordance with the terms of the Contract.

But it does not include your new spouse, stepchild or foster child acquired during the continuation period; whether or not the new Dependent is enrolled for coverage.

b) Continuation Periods. The maximum period of continued coverage for each Qualifying Event will be as follows:

(i) Termination of Employment. When eligibility ends due to your termination of employment; then coverage for you and any of your Dependent Enrollees may be continued for up to 18 months from the date employment ended. Termination of employment includes a reduction in hours or retirement.

EXCEPTIONS:
• Misconduct. If your termination of employment is for gross misconduct, coverage may not be continued for you or any of your Dependent Enrollees.
• Disability. “Disability” or “Disabled” as used in this section will be as defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration. If you:
  1) become disabled by the 60th day after your employment ends; and
  2) are covered for Social Security disability benefits;
then coverage for you and any of your Dependent Enrollees may be continued for up to 29 months from the date your employment ended.

If your Dependent Enrollee:
  1) becomes disabled by the 60th day after your employment ends; and
  2) is covered for Social Security Disability income benefits;
then coverage for that Dependent Enrollee, for you and for any other Dependent Enrollees may be continued for up to 29 months, from the date your employment ended. However, in the case of a newborn child or an adopted child, the 60 day period as stated above will begin on the date of birth or on the date of placement in the home.

You must send the Contractholder a copy of the Social Security Administration’s letter:
  1) within 60 days after they find that you or your Dependent Enrollee is disabled, and
  2) before the 18 month continuation period expires; and again
  3) within 30 days after they find that he or she is no longer disabled.

Subsequent Qualifying Event. If your Dependent:
  1) is a Qualified Beneficiary; and
  2) has a subsequent Qualifying Event during the 18 or 29 month continuation period;
then coverage for that Dependent Enrollee may be continued for up to 36 months, from the date your employment ended.

(ii) Loss of Dependent Eligibility. If a Dependent Enrollee’s eligibility ends, due to a Qualifying Event other than your termination of employment; then that Dependent Enrollee’s coverage may be continued for up to 36 months, from the date of the event. Such events may include:
• your death, divorce, legal separation, or Medicare entitlement; and
• a child reaching the age limit, getting married or ceasing to be a full-time student.
You must notify the Contractholder within 60 days of a divorce, a legal separation, or a child ceasing to be an eligible Dependent (as defined by the Contract). One or more subsequent Qualifying Events may occur during the Dependent Enrollee’s 36 month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first event.

(iii) Medicare Entitlement. If your eligibility under the Contract ends when you become entitled to Medicare benefits; then coverage may not be continued for yourself. But coverage may be continued for any of your Dependent Enrollees for up to 36 months, from your Medicare entitlement date.

If your eligibility under the Contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement; then any of your Dependent Enrollees may continue coverage for up to:
- 36 months from your Medicare entitlement date; or
- 18 months from the date your employment ended (whichever is later).

c) Election. To continue coverage, you must notify the Contractholder of such election within 60 days from the later of:
(i) the date of the Qualifying Event;
(ii) the date of loss of coverage; or
(iii) the date the Contractholder sends notice of the right to continue.

Continued coverage elected under this section will be effective on the first day following the applicable Qualifying Event provided:
(1) you notify the Contractholder within the applicable time period stated above and
(2) you remit the initial premium for continued coverage within 45 days after such notification.

d) Termination. Continued coverage will end at the earliest of the following dates:
(i) the end of the maximum period for continued coverage shown above;
(ii) the date the Contract terminates;
(iii) the last day of the period for which Premium has been paid, if any Premium is not paid when due;
(iv) the date after the date of the initial election to continue coverage on which you or your Dependent Enrollee:
  - first becomes covered under any other group dental plan; or
  - first becomes eligible for benefits for Medicare.

Once continued coverage ends, it cannot be reinstated.

DEDUCTIBLE

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amount is listed on the Group Highlights page.

Only the Dentist’s fees you pay for covered Benefits will count toward the deductible.

You do not have to pay a deductible for Diagnostic and Preventive Benefits or Orthodontic Benefits.

MAXIMUM AMOUNT

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the patient loses coverage, if treatment is stopped, or if the Contract with the Contractholder is canceled.
COINSURANCE AND OPTIONAL SERVICES

Delta will pay the Benefits for the types of dental services as described below. Delta will pay Benefits only for covered services.

**Patient Coinsurance**

Delta's provision of Benefits is limited to the applicable percentage of Dentist’s fees specified below. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the “Patient Coinsurance”. The Contractholder has chosen to require Patient Coinsurance under the Contract as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees.

If the Dentist discounts, waives or rebates any portion of the Patient Coinsurance to the Enrollee, Delta will be obligated to provide as Benefits only the applicable percentages of the Dentist’s fees reduced by the amount of such fees that is discounted, waived or rebated.

**Limitations on All Benefits - Optional Services**

That are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures. For example:

a) a crown where a filling would restore the tooth;

b) a precision denture/partial where a standard denture/partial could be used;

c) an inlay/onlay instead of an amalgam restoration; or

d) a composite restoration instead of an amalgam restoration on posterior teeth.

If you receive Optional Services, your Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

**EXCLUSIONS**

**Delta does not pay Benefits for:**

a) services for injuries or conditions which are compensable under workers’ compensation or Contractholders’ liability laws; services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision except for services covered by the Medical Assistance Act of 1967, as amended (Article 695j-1, Vernon's Texas Civil Statutes). Delta will reimburse the Texas Department of Human Services for the cost of services paid by the Department under the said Act to the extent such costs are for services which are Benefits under this Contract.

If the Texas Department of Human Services is paying benefits pursuant to Chapters 31 and 32 of the Human Services Code (financial and medical assistance programs administered pursuant to the Human Services Code) and a parent who is covered by the group policy has possession or access to a child pursuant to a court order, or is entitled to access or possession of a child and is required by the court to pay child support, then all benefits paid on behalf of the child or children under the Contract must be paid to the Texas Department of Human Services.

b) services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration) of the teeth, and anodontia (congenitally missing teeth), except those services provided to newborn children for congenital defect or birth abnormalities or services that may be provided under Orthodontic Benefits.
c) services for restoring tooth structure lost from wear, erosion, or abrasion, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to: equilibration, periodontal splinting, occlusal adjustment.

any Single Procedure started prior to the date the person became covered for such services under this program.

e) prescribed drugs, medication or analgesia.

f) experimental procedures.

g) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.

i) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

j) services with respect to any disturbance of the temporomandibular joint (jaw joint).

k) services performed by any person other than a Dentist or auxiliary personnel legally authorized to perform services under the direct supervision of a Dentist.

l) charges incurred for oral hygiene instruction, a plaque control program or dietary instruction.

m) broken appointments.

n) services or supplies covered by any other health plan of the Contractholder.

o) treatment rendered by a person who ordinarily resides in the Primary Enrollee’s household or who is related to the Primary enrollee (or to the Primary enrollee’s spouse) by blood, marriage or legal adoption.

**BENEFITS AND LIMITATIONS**

Delta will pay or otherwise discharge the following percentage of the Contract Allowance for covered services.

**Diagnostic and Preventive Benefits 100%:**

Diagnostic: procedures to assist the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning; periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Basic Benefit) for payment purposes); topical application of fluoride solutions; space maintainers.

**Limitations on Diagnostic and Preventive Benefits:**

a) Routine oral examinations and cleanings, including periodontal cleanings, are not provided more than twice in any 12 month period while the patient is an Enrollee under any Delta or any prepaid dental care program provided by the Contractholder.

b) Full mouth x-rays or panographic x-rays will be provided when required by the Dentist, but not more than one x-ray each 5 years will be paid by Delta.

c) Bitewings are limited to 2 bitewing procedures each 12 months when provided to Enrollees under age 18 and 1 bitewing procedure each 12 months for Enrollees age 18 and over.

d) Delta will not pay for topical application fluoride for anyone 19 years or older.
e) Space maintainers are limited to the initial appliance only and to Enrollees under age 14.

**Basic Benefits 80%:**

- **Oral Surgery:** extractions and certain other surgical procedures (including pre-and post-operative care).
- **General Anesthesia:** when administered by a Dentist for a covered oral surgery procedure.
- **Endodontics:** treatment of the tooth pulp.
- **Periodontics:** treatment of gums and bones supporting teeth.
- **Palliative:** treatment to relieve pain.
- **Sealants:** topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

**Limitations on Sealant Benefits:**

- a) They are available only to Enrollees under the age of 15.
- b) They are limited to application topermanent molars with no caries (decay), without restorations and with the occlusal surface intact.
- c) They do not include the repair or replacement of a sealant on any tooth within 3 years of its application.

**Restorative Benefits 80%:**

Restorative: amalgam, synthetic porcelain, plastic fillings and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure).

**Denture Repairs 80%:**

Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.

**Crowns, Jackets and Cast Restorations 50%:**

Crowns and Cast Restorations: for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations or prefabricated stainless steel restorations.

**Limitations on Crowns, Jackets and Cast Restorations:**

Delta will not pay to replace any crown, jacket or cast restoration which the patient received in the previous 5 years.

**Prosthodontic Benefits 50%:**

Procedures to construct or repair fixed bridges and construction of partial or complete dentures.

**Limitations on Prosthodontic Benefits:**

- a) Delta will not pay to replace any bridge or denture that the patient received in the previous 5 years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.
- b) Delta limits Benefits for dentures to a standard partial or complete denture. A "standard" denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
c) Delta will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Delta will credit the cost of a standard complete or partial denture that would have been allowed under this plan toward the cost of an implant and related services (coinsurance applies).

**Orthodontic Benefits 50%:**
Orthodontia: procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malocclusion of teeth and/or jaws which significantly interferes with their functions.

**Limitations on Orthodontic Benefits:**

a) All payments will be on a monthly basis. The obligation of Delta to make periodic payments for an Orthodontic treatment plan begun prior to the date the patient becomes covered will commence with the first payment due following the date the patient’s coverage is effective.

b) The obligation of Delta to make periodic payments for Orthodontic treatment will terminate on the payment due date next following the date the Dependent Enrollee or the Primary Enrollee loses coverage, or upon termination of the Contract, whichever will occur first.

c) Delta will not make any payment for repair or replacement of an Orthodontic appliance furnished, in whole or in part, under this program.

d) Orthodontic Benefits are limited to Dependent Enrollee children under age 25.

**COORDINATION OF BENEFITS**

Delta matches the Benefits under this program with your Benefits under any other group prepaid program or Benefit plan including another Delta plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that your combined coverage does not exceed the Dentist’s fees for the covered services. If this is the “primary” program, Delta will not reduce Benefits. But if the other program is the primary one, Delta will reduce Benefits otherwise payable under this program. The reduction will be the amount paid for or provided under the terms of the primary program for services covered under this program (see BENEFITS, LIMITATIONS).

**Definitions:**

a) “Plan” means any plan providing Benefits or services for or by reason of medical or dental care or treatment, which Benefits or services are provided by:
   (i) group, blanket or franchise insurance coverage;
   (ii) service plan contracts, group practice, individual practice and other prepaid coverage;
   (iii) any coverage under labor-management trusted plans, union welfare plans, Contractholder organization plans, or employee benefits organization plans, and
   (iv) any coverage under governmental program, and any coverage required or provided by any statute.

The term “Plan” will be construed separately with respect to each policy, contract, or other arrangement for Benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the Benefits or service of other Plans into consideration in determining its Benefits and that portion which does not.

b) “This Plan” means this policy.

c) “Allowable Expense” means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides Benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Allowance Expense and a Benefit paid.

d) “Claim Determination Period” means the Contract Year, as defined on the Definitions page.
How does Delta determine which is the "primary" program?

a) If the other plan is not primarily a dental plan, this plan is primary.

b) If the other plan is a dental program, the following rules are applied:
   (i) The plan covering the patient as an employee is primary over a plan covering the patient as a dependent.
   (ii) The plan covering the patient as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
       • secondary to the plan covering the insured person as a dependent and
       • primary to the plan covering the insured person as other than a dependent (e.g. a retired employee),
     then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
   (i) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
   (ii) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in a) on the previous page, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

In the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (iii).

The benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (vi) is ignored.

If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
   (i) first, the benefits of a plan covering the insured person as an employee, member or subscriber (or as that insured person's dependent);
   (ii) second, the benefits under the continuation coverage.
If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that insured person for the shorter term.
Effect on Benefits

a) This Coordination of Benefits section will apply in determining the Benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of (1) the Benefits that would be payable under this Plan in the absence of this Coordination of Benefits section; and (2) the Benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this Coordination of Benefits section would exceed such Allowable Expenses.

b) As to the Claim Determination Period with respect to which this Coordination of Benefits section is applicable, the Benefits that would be payable under this Plan in the absence of this Coordination of Benefits section for the Allowable Expenses incurred as to such person during such Claim Determination Period will be reduced to the extent necessary so that the sum of such reduced Benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the Benefits that would have been payable had the claim been duly made therefore.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits section of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, with the consent of the insured person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming Benefits under this Plan will furnish to the insurer or service plan such information as may be necessary to implement this Coordination of Benefits Section.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this Coordination of Benefits section have been made under any other Plan, Delta will have the right, exercisable alone in its sole discretion, to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this Coordination of Benefits section and amounts so paid will be deemed to Benefits paid under this Plan and, to the extent of such payments, Delta will be fully discharged from liability under this Plan.

Right of Recovery

Whenever payments have been made by Delta with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, Delta will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as Delta will determine: any persons to or for or with respect to whom such payments were made, any other insurers, services plans or any other organizations.

CLAIMS

Claims for Benefits must be filed on a standard Attending Dentist Statement which you or your Dentist may obtain from:

Delta Dental Insurance Company
P.O. Box #1809
Alpharetta, Georgia 30023
(800) 521-2651
AVA (800) 336-8264

PREDETERMINATIONS

A Dentist may file an Attending Dentist’s Statement before treatment, showing the services to be provided to an Enrollee. Delta will Predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract’s term nor beyond the date the patient’s coverage ends.
CLAIMS APPEAL

Delta will notify the Primary Enrollee if Benefits are denied for services submitted on an Attending Dentist’s Statement, in whole or in part, stating the reason(s) for denial. The Enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta giving reasons why the denial was wrong. The Enrollee may also ask Delta to examine any additional information he/she includes that may support his/her appeal.

Delta will make a full and fair review within 60 days after Delta receives the request for appeal. Delta may ask for more documents if needed. In no event will the decision take longer than 60 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgement in applying the terms of this Contract, Delta shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Delta by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

If the Enrollee believes he/she needs further review of said claim, he/she may contact his/her state insurance regulatory agency if applicable or bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if the Contract is subject to ERISA.

TERMINATION OF PROGRAM

Delta may terminate the program only:

a) on an anniversary of the Effective Date; or
b) if the Contractholder does not pay the monthly premiums; or
c) if the Contractholder does not provide a list of who is eligible; or
d) if less than the minimum number of Primary Enrollees required under the Contract reported eligible for 3 months or more.

WRITTEN NOTICE OF CLAIM/PROOF OF LOSS

Before approving a claim, Delta will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist’s care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Delta, in or near his community or residence. Delta will in every case hold such information and records confidential.

Delta will give any Dentist or Enrollee, on request, a standard Attending Dentist’s Statement to make claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Delta. If the form is not furnished by Delta within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Delta must be given written proof of loss within 90 days after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta within 90 days of the termination of the Contract.
TIME OF PAYMENT

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be paid within 30 days after receipt of due written proof of such loss. Delta will notify the Primary Enrollee and his/her dentist of any additional information needed to process the claim within 15 days of receipt of the claim. Delta will process the claim within 15 days of receipt of the additional information. If the requested information is not received within 45 days, the claim will be denied. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid monthly.

TO WHOM BENEFITS ARE PAID

It is not required that the service be provided by a specific Dentist. Payment for services provided by a Contracting Access Dentist or any of Delta's Contracting Dentists will be made directly to the Dentist. Any other payments provided by this Contract will be made to you, unless you request when filing a proof of loss claim that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist will be payable to you, or to your estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or other person actually supporting him.

LEGAL ACTIONS

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within 3 years from expiration of the time within which proof of loss is required by the Contract.

THIS CERTIFICATE OF INSURANCE CONSTITUTES ONLY A SUMMARY OF DENTAL SERVICE INSURANCE CONTRACT. THE COMPLETE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.