Delta Dental Insurance Company

BENEFITS ASSOCIATION, INC.
DENTAL FOR EVERYONE

GOLD PLAN

deltadentalins.com

Group No: 05604

Effective Date: December 1, 2009

Revised Date: January 1, 2013

DELTA DENTAL INSURANCE COMPANY
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DENTAL CERTIFICATE OF COVERAGE

Delta Dental PPO[SM] 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 Dental") and cannot modify the Contract in any way.

Anthony S. Barth
President

TABLE OF CONTENTS

GROUP HIGHLIGHTS

PLAN:
You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:	***1st Year***		***2nd Year***		***3rd Year and Thereafter***	
	In-Network	***Out-of Network***	***In-Network***	***Out-of Network***	***In-Network***	***Out-of Network***
Diagnostic & Preventive Benefits*:	60%	60%	80%	80%	100%	100%
Basic Benefits:*	50%	50%	65%	65%	80%	80%
Major Benefits:*	0%	0%	30%	30%	50%	50%
DEDUCTIBLE:	$50 per Enrollee each Calendar Year		$50 per Enrollee each Calendar Year		$50 per Enrollee each Calendar Year	
MAXIMUM AMOUNT:	$1,000 Per Enrollee each Calendar Year		$1,000 Per Enrollee each Calendar Year		$1,000 Per Enrollee each Calendar Year	

* Benefits will increase on the Primary Enrollee's anniversary date under this Contract.

WAITING PERIODS
Basic Benefits are limited to Enrollees who have been enrolled in this Contract for 6 consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage. Waiting periods are calculated for each Primary Enrollee from the effective date reported by the Contractholder for said Primary Enrollee.

Major Benefits are limited to Enrollees who have been enrolled in this Contract for 12 consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage. Waiting periods are calculated for each Primary Enrollee from the effective date reported by the Contractholder for said Primary Enrollee.

PREMIUMS:
You are required to contribute towards the cost of your coverage.
You are required to contribute towards the cost of your Dependent's coverage.

Delta Dental may cancel the Contract 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

NOTICE:
Since this information is being provided in electronic format, its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.

DEFINITIONS

Terms when capitalized in your certificate of coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Approved Amount -- the maximum amount a Dentist may charge for a Single Procedure.

Benefits (In-Network or Out-of-Network) -- the amounts that Delta Dental will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a Delta Dental PPO Dentist. Out-of-Network Benefits are those covered by the Contract but performed by a Delta Dental Premier® Dentist or Non-Delta Dental Dentist.

Claim Form -- the standard form used to file a claim or request Pre-Treatment Estimate for treatment.

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

Contract Allowance -- the maximum amount Delta Dental will use for calculating the Benefits for a Single Procedure. The Contract Allowance for services provided:

- by Delta Dental PPO Dentists and Delta Dental Premier Dentists is the lesser of the Dentist's submitted fee, the Delta Dental PPO Dentist's Fee, the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement or Maximum Plan Allowance; or
- by Non-Delta Dental Dentists is the lesser of the Dentist's submitted fee or the Delta Dental PPO Dentist's Fee.

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

Delta Dental PPO Dentist (PPO Dentist) -- a participating Delta Dental Dentist who agrees to accept Delta Dental's PPO fees as payment in full and comply with Delta Dental's administrative guidelines. All PPO Dentists are also Delta Dental Premier Dentists. All PPO Dentists must be contracted in the Delta Dental Premier network.

Delta Dental PPO Dentist's Fee (PPO Dentist's Fee) -- the fee for each Single Procedure that PPO Dentists have contractually agreed to accept as payment in full for treating PPO Enrollees.

Delta Dental Premier® Dentist (Premier Dentist) -- a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

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

Dependent Enrollee -- a dependent of a Primary Enrollee who is eligible for Benefits under the Contract.

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

Enrollee -- a Primary Enrollee or Dependent Enrollee enrolled to receive Benefits.

Maximum Plan Allowance (MPA) -- the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of network Dentist.

Non-Delta Dental Dentist -- a Dentist who is neither a Premier nor a PPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period -- the month of the year during which employees may change coverage for the next Contract Year.

Participating Dentist Agreement -- an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which services are provided.

Participating PPO Dentist Agreement (PPO Dentist Agreement) -- an agreement between a member of the Delta Dental Plans Association and a Dentist which establishes the terms and conditions under which covered services are provided under a PPO program.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee -- any employee or retiree eligible for Benefits under the Contract.

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

Qualifying Status Change -- a change in:

- legal marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Enrollee, spouse or dependent child);
- dependent child ceases to satisfy eligibility requirements (limiting age, student status or marital status);
- residence (Enrollee, dependent spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by IRC Section 125.

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

CHOICE OF DENTIST

Enrollees may choose a Dentist from Delta Dental's panel of PPO Dentists and Premier Dentists, or Enrollees may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at deltadentalins.com. Enrollees are responsible for verifying whether the selected Dentist is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, Enrollees should always confirm with the Dentist's office that a listed Dentist is still a participating PPO Dentist or Premier Dentist.

PPO Dentist
The PPO program potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Dentists will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

Premier Dentist
The Premier Dentist, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist. A Premier Dentist can balance bill for the difference between the PPO Dentist's Fee and the Premier Dentist's Approved Amount. This amount may be more than the charge accepted by a PPO Dentist.

Non-Delta Dental Dentist
If a Dentist is a Non-Delta Dental Dentist, the amount charged to Enrollees may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists can balance bill for the difference between the PPO Dentist's Fee and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the Dentist's submitted charge.

Additional advantages of using a PPO Dentist or Premier Dentist

- The PPO Dentist and Premier Dentist must accept assignment of Benefits, meaning PPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Dentist and Premier Dentist will complete the dental Claim Form and submit it to Delta Dental for reimbursement.

WHO IS ELIGIBLE?

Eligibility for Enrollment
Current and future Members of the Association residing in Alabama, California, Delaware, District of Columbia, Florida, Georgia, Louisiana, Maryland, Mississippi, Montana, Nevada, New York, Pennsylvania, Texas, Utah and West Virginia and all present and future permanent employees of an eligible Member of the Association in the above mentioned states/territories who: employs less than 5 employees; and has elected coverage under the Contract.

You will become eligible for coverage on the 1st day of the month following the submission of the completed Enrollment Form and first month premium to Delta Dental Insurance Company.

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

- Lawful spouse;
- Unmarried dependent children from birth to their 26th birthday, if a full-time student in an accredited school. "Children" includes natural children, step-children, adopted children, and foster children. The child must be dependent on you for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the moment of placement in the physical custody of the Eligible Person, as certified by the agency making placement.
- An unmarried child 26 years or older may continue to be eligible as a dependent if the child is not self-supporting because of mental incapacity or physical handicap that began before age 26 and the child is mostly dependent on the Primary Enrollee for support and maintenance. Proof of these facts must be given to Delta Dental or Contractholder within 31 days if it is requested. Proof will not be required more than once a year after the child is 28.

Dependents in military service are not eligible.

Enrollment Requirements

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

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees for coverage.
- You must pay Premiums in the manner elected by the Contractholder and approved by Delta Dental. If coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, you may not re-enroll except during an Open Enrollment Period.
- If you pay Premiums for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental until your dependents are no longer eligible or until you choose to drop dependent coverage and if coverage is dropped other than during an Open Enrollment Period, your dependents may not be re-enrolled at any time, unless there is a court order requiring dependent coverage.
- 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.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

Loss of Eligibility

You will lose coverage on the first to occur:

- on the last day of the month you are no longer an active member of the Association or an employee of an active member of the Association;
- on the last day of the month you fail to make the required premium payment: or
- on the date this Contract is terminated.

Your dependents' coverage ends when your coverage ends or on the date when dependent status is lost.

Continuation of Benefits

Delta Dental will not pay for Benefits for any services received after your coverage ends. However, Delta Dental will pay for a Single Procedure incurred when you were covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- 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 Dependent Enrollees will resume as follows:

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

Coverage will resume the first day of the month after you return to work, provided you submit to Delta Dental an enrollment card requesting that coverage be reactivated.

*You 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.

If you are rehired within the same Calendar Year, deductibles and maximums will resume as if you were never gone.

Continued Coverage Under USERRA
As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date you fail to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under (COBRA)
COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for employees and their Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

DEDUCTIBLE

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

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

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.

BENEFITS, LIMITATIONS & EXCLUSIONS

Delta Dental will pay the Benefits for the types of dental services as described below. Delta Dental will pay Benefits only for covered services. These services must be provided by a Dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside the state of Mississippi, the Dentist will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of this Contract**.**

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under the Contract. Even if the Dentist bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

Enrollee Coinsurance
Delta Dental's provision of Benefits is limited to the applicable percentage of Dentist's fees shown on the Group Highlights page. You are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". Your group has chosen to require Enrollee Coinsurances under this program 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 Enrollee Coinsurance to the Enrollee, Delta Dental 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.

BENEFITS
Delta Dental will pay or otherwise discharge the percentage of Contract Allowance shown on the Group Highlights page for covered services.

Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Dentist in choosing required dental treatment.
- Preventive: Cleaning (periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Major Benefit) for payment purposes), topical application of fluoride solutions.

Basic Benefits:

- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- 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.
- Restorative: amalgam, synthetic porcelain, plastic fillings and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Other Basic Benefits: space maintainers.

Major Benefits:

- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.
- Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth.
- Crowns,Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.

Note on additional benefits during pregnancy **-** When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted**.**

LIMITATIONS
Limitations on Diagnostic and Preventive Benefits:

- Routine oral examinations and cleanings (including periodontal cleanings) are provided no more than twice in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Major Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Full-mouth x-rays and panoramic x-rays are limited to once every three (3) years while the person is an Enrollee under any Delta Dental program.
- Bitewing x-rays are provided twice each Calendar Year for each Enrollee.
- Topical application of fluoride solutions is limited to Enrollees under age 19.

Limitations on Basic Benefits:

- Sealants are limited as follows:
  1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
  2) Sealants do not include repair or replacement of a sealant on any tooth within two (2) years of its application.
- Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic fillings or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.
- Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.
- Space maintainers are limited to the initial appliance only and to Enrollees under age 14.

Limitations on Major Benefits:

- Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional benefits during pregnancy.
- Delta Dental will not pay to replace any crowns, inlays/onlays, or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the Contractholder.
- Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.
- The initial installation of a prosthodontic appliance is not a Benefit unless the prosthodontic appliance, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was eligible under a Delta Dental program.
- Delta Dental limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e. the implant supported crown or denture.

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 crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used;
- an inlay/onlay instead of an amalgam restoration; or.
- a composite restoration instead of an amalgam restoration on posterior teeth.

If you receive Optional Services, 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 Dental does not pay Benefits for:

- treatment of injuries or illness covered under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

- cosmetic surgery or dentistry for purely cosmetic reasons.

- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, 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 cleft lip or cleft palate.

- treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment.

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

- prescribed drugs, medication, pain killers or experimental procedures.

- 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 general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.

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

- treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

- charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.

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

- treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.

- the initial placement of any prosthodontic appliance, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under this Contract or was covered under any dental care program with Delta Dental. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such Prosthodontic appliance or implant must include the replacement of the extracted tooth or teeth.

- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws).

- services for any disturbances of the temporomandibular (jaw) joints.

COORDINATION OF BENEFITS

Delta Dental matches the Benefits under this program with your Benefits under any other group prepaid program or Benefit plan including another Delta Dental 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 Dental will not reduce Benefits, but if the other program is the primary one, Delta Dental 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 the Contract (see Benefits and Limitations).

- How does Delta Dental determine which Plan is the "primary" program?
  (1) If the other Plan is not primarily a dental plan, this Plan is primary.
  (2) If the other Plan is a dental program, the following rules are applied:
    a) the Plan covering the Enrollee as an employee is primary over a Plan covering the Enrollee as a dependent.
    b) the Plan covering the Enrollee 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:
      i) secondary to the Plan covering the insured person as a dependent and
      ii) 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.
  (3) Except as stated below, when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
    a) 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
    b) 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.

c) However, if the other Plan does not have the birthday rule described above, 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.

d) In the case of a dependent child of legally separated or divorced parents, the Plan covering the Enrollee 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 Enrollee 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 (3) a) through (3) c).

(4) 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 is ignored.

(5) 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:
   a) First, the benefits of a Plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
   b) 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.

(6) 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.

AUTOMATED INFORMATION LINE

You may access Delta Dental's automated information line on a regular business day to obtain Enrollee eligibility and Benefits, group Benefit or claim status information or to speak to a Customer Service Representative for assistance.
(800) 521-2651

CLAIMS

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

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

PRE-TREATMENT ESTIMATES

A Dentist may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will predetermine the amount of Benefits payable under the Contract for the listed services. Benefits will be processed according to the terms of the Contract when the treatment is performed. Pre-Treatment Estimates are valid for 60 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date the Enrollee's coverage ends; or
- the date the PPO Dentist's or Participating Dentist's agreement with Delta Dental ends.

CLAIMS APPEAL

Delta Dental will notify the Primary Enrollee if Benefits are denied for services submitted on a Claim Form, 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 Dental giving reasons why the denial was wrong. The Enrollee may also ask Delta Dental to examine any additional information he/she includes that may support his/her appeal.

Delta Dental will make a full and fair review within 60 days after Delta Dental receives the request for appeal. Delta Dental 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 judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Delta Dental 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.

CANCELLATION OF CONTRACT

Delta Dental may cancel the Contract only:

- on an anniversary of the Effective Date upon 60 days written notice; or
- if your employer does not pay the monthly premiums upon 31 days written notice; or
- if your employer does not provide a list of who is eligible upon 60 days written notice; or
- if less than the minimum number of Primary Enrollees required under the Contract are reported eligible for three (3) months or more, upon 15 days written notice.

GENERAL PROVISIONS

Clinical Examination
Before approving a claim, Delta Dental 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 Dental, in or near his community or residence. Delta Dental will in every case hold such information and records confidential.

Notice of Claim Forms
Delta Dental will give any Dentist or Enrollee, on request, a standard Claim Form 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 Enrollee is a minor) and submitted to Delta Dental.

If the form is not furnished by Delta Dental 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 Dental, 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.

Written Notice of Claim/Proof of Loss
Delta Dental 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 Dental within 6 months 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 25 days after receipt of due written proof of such loss where claims are submitted electronically, or
- within 35 days after receipt of due written proof of such loss where claims are submitted in paper format.

If any additional information is needed to pay and/or further review the claim, Delta Dental will notify the Enrollee and his/her Dentist within the applicable timeframe. The Enrollee and/or his/her Dentist will have 45 days to provide the requested information. Delta Dental will process the claim within 20 days of receipt of the additional information. If the additional information is not received within the 45 day timeframe, 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.

Claims not paid or denied within the applicable time frame of due written proof of loss are subject to a charge of 1½ percent interest per month. If this time frame is not met, damages may be sued for.

To Whom Benefits are Paid
PPO Dentists and Premier Dentists will be paid directly. Any other payments provided by the Contract will be made to the Primary Enrollee, unless the Enrollee requests 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 the Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the 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 three (3) years from expiration of the time within which proof of loss is required by the Contract.

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

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.

NOTICE OF PRIVACY PRACTICES

CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

This notice is required by law to tell you how Delta Dental Insurance Company and its affiliates ("Delta Dental"), and its third party administrator, Morgan-White Administrators ("MWA"), protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's health care history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental and MWA receive, use and disclose your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI is prohibited.

We must follow the privacy practices that are described in this notice. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice from the privacy official at the plan headquarters that provides your benefits (refer to the Contact section at the end of this notice). You should receive a copy of this notice at the time of enrollment in a Delta Dental program, and we will notify you of how you can receive a copy of this notice at least once every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer, we may provide PHI to your employer for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Delta Dental and MWA in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Delta Dental or MWA in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.

For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your dentist.

- Uses and/or disclosures of PHI for payment.

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.

For example, Delta Dental or MWA may use and disclose your PHI to bill you or your plan sponsor.

- Uses and/or disclosures of PHI for health care operations.

For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of dentists.

Disclosures Delta Dental and MWA Must Make Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Delta Dental and MWA must disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations

Disclosures Delta Dental and MWA Make With Your Authorization

Delta Dental and MWA will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Delta Dental, MWA or by a person requesting your PHI from Delta Dental or MWA.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting Delta Dental or MWA at the addresses listed below. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Delta Dental and MWA may charge a reasonable fee for providing you copies of your PHI. Delta Dental and MWA will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental and MWA do not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental or MWA at the addresses listed below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact Delta Dental or MWA at the addresses listed below if you have questions about amending your PHI.

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.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to Delta Dental or MWA at the addresses listed below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact Delta Dental or MWA at the addresses listed below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Delta Dental or MWA have violated your privacy rights. You may file a complaint with us by notifying Delta Dental or MWA at the addresses listed below. We will not retaliate against you for filing a complaint.

Contact

You may contact Delta Dental or MWA at the addresses and telephone numbers listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental Insurance Company
Contracts and Compliance
Attn: Privacy Contact
1130 Sanctuary Parkway
Suite 600
Alpharetta, Georgia 30009
(800) 521-2651

Morgan-White Administrators
Attn: Privacy Officer
Post Office Box 14067
Jackson, MS 39236
(800) 800-1397

This notice is effective on and after July 1, 2006.

NOTICE OF PROTECTION PROVIDED BY
MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies.

The maximum amount of protection with respect to any one (1) life, regardless of the number of policies or contracts, is:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender and net cash withdrawal values

Health Insurance

- $500,000 in basic hospital, medical and surgical or major medical benefits
- $300,000 in disability benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in net cash surrender and net cash withdrawal values

The Association may not cover this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Mississippi. You should not rely on coverage by the Association when selecting an insurer.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life and Health Insurance
Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

Mississippi Insurance Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.