

UT SELECT Dental

2016-2017 SELF-FUNDED DENTAL PLAN GUIDE



A PUBLICATION OF
THE OFFICE OF EMPLOYEE BENEFITS

UT SELECT Dental Benefit Plan Guide

Self-Funded Dental Plan

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This booklet is a summary of the UT SELECT DENTAL benefits provided by The University of Texas System. The University of Texas System is responsible for funding this Plan.

The Benefits described in this booklet are administered by Delta Dental Insurance Company in accordance with an administrative agreement with The University of Texas System.

FOR INFORMATION CALL

(800) TX-DELTA

(800) 893-3582

Access the Delta Dental National Provider file at www.deltadentalins.com/universityoftexas.

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Definitions

For the purpose of this summary, the following definitions shall apply:

ALLOWED FEE means the fee determined to be the lower of the Maximum Plan Allowance charges or the amount submitted by the Dentist.

ANNUAL ENROLLMENT PERIOD means the annual period during which Primary Enrollees may change coverage for the next Plan Year. This period typically occurs in July of each year.

BENEFIT means the amounts paid for dental services under the terms of the Plan.

CLAIM FORM means the standard form used to file a claim or request a Predetermination for proposed treatment.

CONTRACT means the administrative agreement under which Benefits are provided, excluding any supplemental dental coverage The University of Texas System may provide.

CONTRACT ALLOWANCE means the maximum amount allowed for a Single Procedure. The Contract Allowance for services provided by:

- DPO Dentists is the lesser of the Dentist's submitted fee, the DPO Dentist's Fee or the approved amount as outlined in the terms of the Premier Dentist Agreement with Delta Dental.
- Premier Dentists (who are not DPO Dentists) is the lesser of the Dentist's submitted fee, the approved amount as outlined in the terms of the Premier Dentist Agreement with Delta Dental or the MPA.
- Non-Contracting Dentists is the lesser of the Dentist's submitted fee or the MPA.

CONTRACT TERM means the period during which this Contract is in effect.

CONTRACTING DPO DENTIST AGREEMENT (DPO DENTIST AGREEMENT) means an agreement between Delta Dental and a Dentist which establishes the terms and conditions under which covered services are provided under a DPO program.

CONTRACTING DENTIST AGREEMENT (PREMIER DENTIST AGREEMENT) means 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.

DPO DENTIST means a contracting Delta Dental Dentist who agrees to accept the fees listed in the DPO Dentist Agreement as payment in full and comply with Delta Dental's administrative guidelines.

DPO DENTIST'S FEE means the fee outlined in the DPO Dentist Agreement. DPO Dentists agree to charge no more than this fee for treating DPO Enrollees.

DELTA DENTAL PREMIER DENTIST (PREMIER DENTIST) means 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 DPO Dentists; however, all Premier Dentists agree to accept Delta Dental's MPA for each Single Procedure as payment in full.

DPO means a Dental Provider Organization.

DENTIST means a Doctor of Dentistry duly licensed at the time and place where services are performed.

DEPENDENT ENROLLEE means an Eligible Dependent enrolled in the Plan to receive Benefits.

EFFECTIVE DATE means the date the program commences.

ELIGIBILITY DATE means the date when an Eligible Person's Benefits become effective.

ELIGIBLE DEPENDENT means a Dependent of an Eligible Employee or an Eligible Retiree who is eligible for Benefits under the Plan.

ELIGIBLE EMPLOYEE means an Employee who is eligible for Benefits under the Plan.

ELIGIBLE PERSON means an Eligible Employee, an Eligible Dependent, an Eligible Retiree or a Surviving Dependent (spouse or child(ren)) of an Eligible Employee or Eligible Retiree.

ELIGIBLE RETIREE means a Retiree of The University of Texas System eligible for Benefits under the Plan.

ENROLLEE means an Eligible Person enrolled in the Plan to receive Benefits.

MAXIMUM PLAN ALLOWANCE (MPA) means 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 contracting Dentist.

NON-DELTA DENTAL DENTIST (NON-CONTRACTING DENTIST) means a Dentist who is neither a Premier nor a DPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

PLAN means the UT SELECT DENTAL benefits available to each Eligible Person of The University of Texas System under the terms of the Contract.

PLAN YEAR means the 12 month period commencing on September 1st of each year and ending August 31st of the following year.

PREDETERMINATION means the estimated amount of Benefits payable under the Plan for the services proposed, assuming the Enrollee is covered under the Plan. A predetermination of benefits is not a guarantee of payment.

PRIMARY ENROLLEE means an Eligible Employee, an Eligible Retiree or a Surviving Dependent of an Eligible Employee or Eligible Retiree enrolled in the Plan eligible to receive Benefits.

PROCEDURE CODE means the Current Dental Terminology (CDT) number given to a Single Procedure by the American Dental Association.

SINGLE PROCEDURE means a dental procedure that is assigned a separate CDT number.

Eligibility

Eligibility for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan.

Your Eligibility Date will be determined by The University of Texas System in accordance with their established eligibility procedures. Please contact your Institution Benefits Office for your Eligibility Date.

EMPLOYEE ELIGIBILITY

If you are eligible to participate in the UT System uniform group insurance program under Chapter 1601 of the Texas Insurance Code, you are eligible for the Benefits described in this Benefit Booklet.

For purposes of this Plan, the term Eligible Employee will also include those individuals who are no longer an Employee of The University of Texas System, but who are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may apply for coverage for yourself (or for yourself and your Dependents) on or before your Eligibility Date, within 31 days of your Eligibility Date or during the Annual Enrollment period.

DEPENDENT ELIGIBILITY

If you are eligible for coverage, you may include your Dependents. If both you and your spouse are UT Employees, then your children may be covered as Dependents of either parent, but not both. In addition, a spouse that is a UT Employee may be covered as a Dependent only if the spouse's dental coverage as an Employee is waived.

The Plan defines a Dependent as:

- Your spouse;
- Your unmarried child under 25 years of age. This includes stepchildren, adopted children and children for whom you are named the legal guardian by a court;
- Your unmarried grandchild under 25 years of age provided the child meets the requirements which includes proof that you claim the child as your dependent for federal tax purposes; or
- Your unmarried child 25 years of age or older who has been determined by The University of Texas System to be medically incapacitated.

RETIREE ELIGIBILITY

You are eligible to receive the dental plan benefits described in this Benefit Booklet if you are a former UT Employee who meets all eligibility as determined by UT and has retired under the:

- Teacher Retirement System of Texas;
- Employees Retirement System of Texas; or
- Optional Retirement Program.

Changes in Your Status

Typically, Annual Enrollment is the only time you can make changes to your coverage. The only exception is when a qualified change in status occurs. Your Institution Benefits Office has a complete listing of all qualified changes in status. Examples of qualified changes in status include:

- Change in marital status, including marriage, divorce, annulment, or death of a spouse;
- Change in the number of Dependents caused by birth, adoption, medical child support order, or death;
- Change in residence if the change affects you and your Dependents' current plan eligibility;
- Change in employment status including starting or ending employment, and starting or returning from unpaid leave of absence;
- Change in Dependent eligibility; or
- Significant change in coverage or cost of another employer benefit plan available to you and your family.

You (the Employee) have 31 days from the date of a qualifying event to make the appropriate changes to your benefit designations. Application for changes must be made through your Institution Benefits Office. If you do not finalize the appropriate changes during the 31-day status change period, the changes cannot be made until the next Annual Enrollment Period. Please contact your Institution Benefits Office with questions or changes in status.

NOTIFY YOUR INSTITUTION BENEFITS OFFICE PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR:

When a child marries or reaches age 25, coverage under the Plan must be terminated. For additional information regarding requirements for continuation of group benefit coverage, see **Continuation of Group Coverage (COBRA)** in this Benefit Booklet. Once your Institution Benefits Office is notified, coverage is terminated and benefits for expenses incurred after termination will not be available. If benefits are paid prior to notification to Delta Dental, refunds will be requested.

Coverage for your spouse must be terminated upon divorce. In that event, please refer to the **Continuation of Group Coverage (COBRA)** subsection in this Benefit Booklet.

LOSS OF ELIGIBILITY

Coverage ends for any Enrollee on the earliest of the following dates:

- The date the Plan terminates;
- The last day of the month in which an Enrollee loses eligibility to participate in the Plan for any reason including failure to make full payment of premium due;
- The first of the month following your request to terminate coverage subject to any limitations as to when a plan change is permitted; e.g. annual enrollment or change of status event;
- The date of death of the Enrollee.

Continuation of Group Coverage (COBRA)

ELIGIBILITY FOR COBRA

An Enrollee may be entitled to continue coverage under this program following the occurrence of certain "Qualifying Events," at his/her expense. The continued coverage can remain in effect for a maximum period of either 18, 29 or 36 months depending on the reason eligibility terminated.

Eligible "Qualifying Events" include:

- a) the Primary Enrollee's termination of employment, other than for gross misconduct, or a reduction in work hours to less than the minimum required to be eligible under this program;
- b) the Primary Enrollee's death;
- c) a divorce or legal separation from the Primary Enrollee; or
- d) a Dependent Enrollee child's loss of eligibility as a Dependent.

Primary Enrollees and their Dependent Enrollees may continue coverage for 18 months following Qualifying Event "a." However, if the Enrollee was disabled at the time Qualifying Event "a" occurred, that person's coverage may be continued for a total of 29 months provided:

- i) there is a determination under Title II or Title XVI of the Social Security Act that the disabled person was disabled at the time Qualifying Event "a" occurred; and
- ii) notice of the Title II or Title XVI determination is provided during the initial 18 months of continued coverage and within 60 days of the date of the determination.

Extended coverage under i) and ii) ends on the first day of the month that begins more than 30 days after the date of the final determination that the Enrollee is no longer disabled. The Enrollee must notify the COBRA Administrator within 30 days of any such determination.

Dependent Enrollees who have continued coverage for 18 months because of Qualifying Event "a" and who then experience a second Qualifying Event ("b", "c" or "d") during the first 18 months of continued coverage may choose to continue coverage for up to a total of 36 months after the first Qualifying Event.

CONTINUING COVERAGE UNDER COBRA

If an Enrollee wishes to continue coverage, it is necessary to notify the appropriate Institution Benefits Office of The University of Texas System within 31 days after a Qualifying Event. Otherwise, the option of continued coverage based on one of these events will be lost.

Once The University of Texas System has been made aware of a Qualifying Event, it will notify the affected persons about their right to continue their coverage. This notice will include the amount of monthly payments necessary to continue coverage, as allowed by law. If an Enrollee wishes to continue coverage, the COBRA administrator must be notified within 60 days after the Primary Enrollee receives notice, or within 60 days after losing coverage because of the Qualifying Event, whichever is later. An Enrollee will then have 45 days to pay the initial cost of coverage, which must include the payment for each month since the Qualifying Event. Payment must be fully paid by the Enrollee and includes a 2% administrative fee.

Continued coverage will be the same as what the Enrollee would have received if still eligible under the Plan. If The University of Texas System changes coverage for regular Employees, continued coverage will change as well.

Continued coverage will end at the end of the month in which any of the following events first occurs:

- a) the allowable number of consecutive months of continued coverage is reached;
- b) the dental program ends;
- c) payments are not paid as required; or
- d) the Enrollee becomes covered for standard dental benefits under another group health plan (as an Employee or a Dependent) which does not contain any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this program.

Once continued coverage ends, it cannot be reinstated.



Deductible

Before Benefits are provided, every Enrollee must pay a deductible for coverage each Plan Year. The deductible amount is \$25.00 for each Enrollee except for services for which no deductible is required. There is no deductible for Diagnostic, Preventive or Orthodontic Benefits. Only the Dentist's Allowed Fee for covered Benefits will count toward the deductible.

Maximum Amount

The Maximum Amount payable each Plan Year for each Enrollee for all Benefits except Orthodontic Benefits is \$1,250.00.

The Maximum Lifetime Amount for Orthodontic Benefits is \$1,250.00.

Payment

The Primary Enrollee is responsible for payment of the full monthly premium. If the Primary Enrollee elects to cover Dependents, the Primary Enrollee will also be responsible for payment of the premium for the Dependents' coverage.

Benefits Provided

Subject to limitations and exclusions hereinafter set forth, the Plan will pay Benefits when provided by a Dentist and when necessary and customary, as determined by the standards of generally accepted dental practice.

The Plan shall pay or otherwise discharge the following percentage of the Contract Allowance for these services:

DIAGNOSTIC AND PREVENTIVE BENEFITS (100%)	
DIAGNOSTIC	procedures to assist the Dentist in determining required dental treatment
PREVENTIVE	prophylaxis (regular cleanings and periodontal cleanings); topical application of fluoride solutions (to age 19); and space maintainers (to age 14)
SEALANTS	topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing decay (through age 15)
BASIC BENEFITS (80%)	
ORAL SURGERY	extractions and certain other surgical procedures, including pre and post-operative care
ANESTHESIA	when administered by a Dentist for a covered Oral Surgery, or for gingivectomy, gingivoplasty or osseous surgery
ENDODONTIC	treatment of the tooth pulp
PERIODONTIC	treatment of gums and bones supporting teeth
RESTORATIVE BENEFITS (80%)	
RESTORATIVE	amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth surface resulting from the process of dental decay)
DENTURE REPAIRS (80%)	
DENTURE REPAIRS	repairs to partial or complete dentures
CROWNS, JACKETS AND CAST RESTORATIONS (50%)	
CROWNS, JACKETS AND CAST RESTORATIONS	for treatment of carious lesions (visible destruction of the hard tooth structure resulting from the process of dental decay) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations and prefabricated stainless steel restoratives
PROSTHODONTIC BENEFITS (50%)	
PROSTHODONTIC	procedures for construction of fixed bridges and partial or complete dentures and repair of fixed bridges
OTHER SERVICE	occlusal guard
ORTHODONTIC BENEFITS (50%)	
ORTHODONTIC	procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions

Limitations

LIMITATIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

1. The Plan will not pay for more than 2 oral examinations done in any Plan Year while the patient is an Enrollee under any dental program provided by The University of Texas System.
2. The Plan will not pay for more than 2 regular cleanings or 4 periodontal cleanings done in any Plan Year while the patient is an Enrollee under any dental program provided by The University of Texas System.
3. Full mouth x-rays will be provided when required by the Dentist, but not more than once each 5 years will be paid by the Plan. Bitewing x-rays are limited to twice each Plan Year.
4. Topical application of fluoride is limited to Enrollees under age 19.

LIMITATIONS ON SEALANTS

1. Sealants are a Benefit limited to Dependent Enrollees through age 15.
2. Benefits are limited to application on permanent posterior molar teeth with no caries (decay), without restorations and with the occlusal surface intact.
3. Benefits do not include repair or replacement of a sealant on any tooth within 2 years of its application.

LIMITATIONS ON ORAL SURGERY

Removal of impacted teeth for preventive purposes is not covered.

LIMITATIONS ON DENTURE REPAIRS

Denture relines are limited to once every 6 months.

LIMITATIONS ON PERIODONTIC TREATMENTS

1. Scaling and root planing services are limited to once in any 24 month period for each quadrant.
2. Osseous surgery is limited to once in any 36 month period for each quadrant.

LIMITATIONS ON CROWNS, JACKETS AND CAST RESTORATIONS

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



LIMITATIONS ON PROSTHODONTIC BENEFITS

1. The Plan will not pay to replace any bridge or denture that the Enrollee received in the previous 5 years. An exception will be considered if the bridge was defective at the time of placement, and the Plan can establish that, the Plan will permit a replacement bridge within the 5 year window following its insertion. If the bridge has, since its insertion, been damaged and cannot be made satisfactory or acceptable, the Plan will also permit a replacement bridge within the 5 year window following its insertion.
2. The Plan limits payment for implants (artificial teeth implanted into or on bone or gums.) The Plan will credit the cost of a 3-unit bridge benefit towards the cost of an implant and related services. The Plan credit will be applied per tooth but limited to replacement received in the previous 5 years. Removal of implants is not covered.
3. The Plan limits Benefits for dentures to a standard partial or complete denture. A "standard" denture means a removable appliance to replace missing teeth that is made from acceptable materials by conventional means.

LIMITATIONS ON ORTHODONTIC BENEFITS

1. All payments shall be on a monthly basis. The Plan will make periodic payments for an Orthodontic treatment plan begun on or after the Eligibility Date of the Enrollee. The Plan will pay Orthodontic Benefits in progress for a new Enrollee.
2. The obligation of the Plan to make periodic payments for Orthodontic treatment shall terminate on the next payment due date following the date the Enrollee loses eligibility or upon termination of the Contract, whichever shall occur first.
3. The Plan will not make any payment for repair or replacement of an Orthodontic appliance furnished, in whole or in part, under this program.

LIMITATION ON ALL BENEFITS - OPTIONAL SERVICES

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 where a standard denture could be used;
- c) an inlay instead of a restoration; or
- d) a composite restoration instead of an amalgam restoration on posterior teeth.

If optional services are received, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the optional service. The Enrollee will be responsible for the remainder of the Dentist's fee.

Exclusions

The following services are not covered Benefits:

- a) Services for injuries or conditions which are compensable under worker's compensation or employer 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 DJ-1, Vernon's Texas Civil Statutes). The Plan shall reimburse the Texas Department of Human Services for the cost of services paid for by the Department under said Act to the extent such costs are for services which are Benefits under the Plan;
- b) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations other than for newborn children. Such malformations include, but are not limited to: cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), and fluorosis (a type of discoloration of the teeth) ;
- c) Services for restoring tooth structure lost from wear, 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, or periodontal splinting;
- d) Prescribed drugs, medication, analgesia, vitamins or dietary supplements (however, benefits may be provided under an Enrollee's medical plan);
- e) Procedures that are experimental, nonstandard or not recommended or approved by the Plan;
- f) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility;
- g) Charges for anesthesia, including IV sedation, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services or gingivoplasty or gingivectomy or osseous surgery (these services may be covered under an Enrollee's medical plan);
- h) Extraoral grafts (grafting of tissues from outside the mouth to oral tissues);
- i) Services with respect to any disturbance of the temporomandibular joint (jaw joint);*
- j) Services performed by any person other than a Dentist or auxiliary personnel legally authorized to perform services under the direct supervision of a Dentist;
- k) Broken appointments;
- l) Duplicate dentures, prosthetic devices or other appliances; or
- m) Lost, missing or stolen dentures or appliances.

*Although this Plan will not provide coverage in regard to hospitalization, an Enrollee's medical plan may. See your medical plan description or contact your Institution Benefits Office for more information.

Predetermination

Predetermination may be requested at the option of the Enrollee. An Enrollee may obtain a Predetermination by requesting that a Dentist file an Attending Dentist's Statement with Delta Dental before treatment, showing the services to be provided to an Enrollee.

Delta Dental will Predetermine the amount of Benefits payable under this Plan for the listed services. Predeterminations are valid for sixty (60) days from the date of the Predetermination but not longer than the Contract's term nor beyond the date the Enrollee's eligibility ends.





Choice of Dentist

Delta Dental offers you a choice of selecting a Dentist from our panel of DPO Dentists and Premier Dentists or you may choose a Non-Contracting Dentist.

A list of the Delta Dental Dentists can be obtained by accessing the Delta Dental National Provider file at www.deltadentalins.com/universityoftexas. You are responsible for verifying whether the Dentist you select is a DPO Dentist or a Premier Dentist. Dentists are regularly added to the panel so a DPO Dentist or a Premier Dentist may not yet be listed. Additionally, you should always confirm with Delta Dental that a listed Dentist is still a contracted DPO Dentist or a Premier Dentist.

You have the freedom to visit any dentist worldwide. If you choose a dentist outside the United States, you must pay for your treatment at the time of service. Delta Dental coverage outside the United States is the same as Delta Dental out-of-network coverage within the United States.

DPO Dentist

The DPO Program allows you the greatest reduction in your out-of-pocket expenses, since this select group of Dentists in your area will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the DPO Dentist. These charges are generally lower than those charged by the majority of Dentists in the same area.

Premier Dentist

The Premier Dentist has not agreed to the features of the DPO Program; however, you may still receive dental care at a lower cost than if you use a Non-Contracting Dentist. A Premier Dentist (who is not a DPO Dentist) has agreed to accept no more than the lesser of: 1) their submitted fee, 2) the approved amount as outlined in the terms of the Premier Dentist Agreement, or 3) the Maximum Plan Allowance. This amount may be more than the charge accepted by a DPO Dentist.

Non-Contracting Dentist

If a Dentist is a Non-Contracting Dentist, the amount charged to you may be above that charged by the DPO or Premier Dentists. When Benefits are payable for services provided by Non-Contracting Dentists, Delta Dental will allow the lesser of the submitted fee or the Maximum Plan Allowance. You will then be responsible for any extra amount charged by this Dentist over Benefits we 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 Dental's payment is made.

The advantages of using a DPO Dentist or Premier Dentist:

a) The DPO Dentist and Premier Dentist must accept assignment of Benefits, meaning DPO 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; and

b) The DPO Dentist and Premier Dentist will complete the dental claim form and submit it to Delta Dental for reimbursement.

Below is an example of how Benefits are payable to 3 different types of Dentists, assuming the service is covered, there is an 80% coinsurance, the deductible has been met, and the maximum benefit has not been exceeded.

	DPO DENTIST	PREMIER DENTIST	NON-CONTRACTING DENTIST
DENTIST SUBMITTED AMOUNT:	\$150	\$150	\$150
DELTA APPROVED AMOUNT:	\$104	\$135	\$150
DELTA ALLOWED AMOUNT:	\$104	\$135	\$135
PLAN PAYMENT:	\$83.20	\$108	\$108
PATIENT PAYMENT*:	\$20.80	\$27	\$42

* The difference between the Approved Amount and the Plan Payment.

Coordination of Benefits

The Plan reviews and coordinates the Benefits under this program with benefits under any other group benefit plan of the Enrollee. (This does not apply to a blanket school accident policy.) Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist's fees for the covered services. If this is the "primary" program, the Plan will not reduce Benefits. But if the other program is the primary program, the Plan 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 AND LIMITATIONS).

How does the Plan determine which program is the "primary" program?

- i) If the other plan(s) primarily covers services or expenses other than dental care, then this Plan shall be primary.
- ii) If the other coverage is by a dental plan, the plan covering the Enrollee as an Employee shall be primary over the plan covering the Enrollee as a Dependent; the plan covering the Enrollee as a Dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the Enrollee as a Dependent of a person whose date of birth occurs later in the calendar year provided, however, that 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 Dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the Enrollee as Dependent of the parent without legal custody.
- iii) Notwithstanding subparagraph (i) and (ii), 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 shall be determined before the benefits of any other plan which covers the child as a Dependent child.
- iv) When primary coverage cannot be determined according to (i) and (ii) above, the program which has covered the Enrollee for the longer period of time shall be primary.

If the coverage under this Program is "primary" as provided above, the Plan shall provide Benefits without regard to any other plan. If the coverage under this Contract is not "primary," the Plan shall provide Benefits only to the extent that services which are Benefits provided by this Plan are not fully paid for or provided under the terms of such other plan.



Claims

Delta Dental shall furnish to any Dentist, or to an Enrollee, on request, a standard claim form (Attending Dentist's Statement) to make a claim for payment for services covered by the Contract. In order to make a claim for payment, the Attending Dentist's Statement (ADS), duly completed in accordance with the terms thereof and signed by the Dentist who performed the services and by the Enrollee (or the Enrollee's parent or guardian if such Enrollee is a minor) shall be submitted to Delta Dental at the address stated below.

Any Enrollee or Dentist may obtain claim forms or other information about Benefits from:

Delta Dental Insurance Company

P.O. Box 1809

Alpharetta, Georgia 30023

(1-800-893-3582)

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 by writing to Delta Dental giving reasons why the denial should be re-evaluated. The Enrollee may also ask Delta Dental to examine any additional information he/she includes that may support his/her appeal.

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.

Delta Dental 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 Dental. If the form is not furnished by Delta Dental within fifteen (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 proof of loss, or written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Delta Dental must be given written proof of loss (typically the date of service) 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 date of service (unless the claimant was legally incapacitated).

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

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 this 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.

Enrollees have a right to appeal any denied claim through The University of Texas System. Requests for appeals should be sent to The University of Texas System, Office of Employee Benefits, 210 West 6th Street, Suite B.140E, Austin, Texas, 78701.

Claims payable under the Contract for any loss other than Orthodontic services will be paid within 30 days after receipt of due written proof of such loss. Delta Dental will notify the Primary Enrollee and his/her dentist of any additional information needed to process the claim within the 30 day period. Delta Dental 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 written proof of loss, all accrued indemnities for Orthodontic services will be paid monthly.



General Provisions of the Plan

DPO Dentists and Premier Dentists shall be paid directly by Delta Dental for services provided under the Plan. The Enrollee may request in writing when filing proof of loss for payment to be made directly to a Non-Contracting Dentist who provided the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except if the person is a minor or otherwise not competent to give a valid release, in such event, Benefits may be made payable to his parent, guardian or other person actually supporting him.

No action at law or in equity shall be brought to recover on the Plan prior to expiration of sixty (60) days after proof of loss has been filed in accordance with requirements of the Plan, nor shall such action be brought at all unless brought within two (2) years from expiration of the time within which proof of loss is required by the Plan.

The Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.



Termination

All Benefits shall terminate for any Enrollee in the event that the Plan is terminated or such person ceases to be eligible under terms of the Contract. Delta Dental shall not be obligated to provide continuation of Benefits to any such person in such event, except for completion of Single Procedures commenced while the Plan was in effect or for services with respect to which Delta Dental has issued a prior Predetermination, and which are completed within 31 days of termination.

In the event of termination of the Plan for any cause, Delta Dental shall not be required to Predetermine services beyond the termination date.

COMPLAINT NOTICE: Should any dispute arise about the cost of coverage or about a dental claim filed, write to Delta Dental Insurance Company, 1130 Sanctuary Parkway, Suite 600, Alpharetta, Georgia 30009. If the problem is not resolved, the Enrollee may also write to The University of Texas System, Office of Employee Benefits, 210 West 6th Street, Suite B.140E, Austin, Texas, 78701; (512) 499-4616; or email to benefits@utsystem.edu.

Institution Contacts

UT ARLINGTON

Office of Human Resources
(817) 272- 5554
Fax: (817) 272-5798
benefits@uta.edu

UT AUSTIN

Human Resource Services
(512) 471-4772 or
Toll Free: (800) 687-4178
Fax: (512) 232-3524
HRSC@austin.utexas.edu

UT DALLAS

Office of Human Resources
(972) 883-2221
Fax: (972) 883-2156
benefits@utdallas.edu

UT EL PASO

Human Resources
(915) 747-5202
Fax: (915) 747-5815
benefits@utep.edu

UT HEALTH SCIENCE CENTER HOUSTON

Employee Benefit Services
(713) 500-3935
Fax: (713) 500-0342
benefits@uth.tmc.edu

UT HEALTH SCIENCE CENTER

SAN ANTONIO
Office of Human Resources
(210) 567-2600
Fax: (210) 567-6791
ben-admin@UTHSCSA.EDU

UT HEALTH SCIENCE CENTER TYLER

Office of Human Resources
(903) 877-7784
Fax: (903) 877-5394
benefits@uthct.edu

UT MD ANDERSON CANCER CENTER

Human Resources Benefits
(713) 745-6947
Fax: (713) 745-7160
hrbenefits@mdanderson.org

Physicians Referral Service (PRS)
(713) 792-7600
Fax: (713) 794-4812
prsfacbensrvs@mdanderson.org

UT MEDICAL BRANCH AT GALVESTON

Employee Benefits Services
(409) 772-2630, Option "0"
Toll Free: (866) 996-8862
Fax: (409) 772-2754
benefits.services@utmb.edu

UT PERMIAN BASIN

Human Resources
(432) 552-2751
Fax: (432) 552-3747

UT RIO GRANDE VALLEY

Brownsville
Human Resources
(956) 882-8205
Fax: (956) 882-6599
hr@utrgv.edu

Edinburg
Human Resources
(956) 665-2451
Fax: (956) 665-3289
hr@utrgv.edu

UT SAN ANTONIO

Human Resources
(210) 458-4250
Fax: (210) 458-7890
benefits@utsa.edu

UT SOUTHWESTERN MEDICAL CENTER

Human Resources/Employee
Benefits Division
(214) 648-9830
Fax: (214) 648-9881
benefits@utsouthwestern.edu

UT SYSTEM ADMINISTRATION

Office of Employee Services
(512) 499-4660
Fax: (512) 499-4380
esc@utsystem.edu

UT TYLER

Office of Human Resources
(903) 566-7480
Fax: (903) 565-5690
aclem@uttyler.edu



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benefits@utsystem.edu

Office of Employee Benefits | The University of Texas System
210 W. 6th Street, Suite B.140E | Austin, TX 78701

UT SELECT DENTAL

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

(800) 893-3582

M-F 6:15 AM-6:30 PM CT

www.deltadentalins.com/universityoftexas

The Office of Employee Benefits (OEB) leads in designing, implementing and administering high quality, cost-effective benefit programs for employees and retirees of The University of Texas System.

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