

SUMMARY PLAN DESCRIPTION

OF

BAYLOR UNIVERSITY

DIRECT REIMBURSEMENT DENTAL PLAN

Plan Name:	Baylor University Reimbursement Dental Plan
Plan Number:	503
Plan Year:	January 1 – December 31
Effective Date:	January 1, 2003
Revision Effective Date:	January 1, 2004
Plan Sponsor, Plan Administrator, Named Fiduciary, and Agent For Service of Legal Process:	Baylor University (physical delivery) 700 S. University Parks Dr., Suite 200 Waco, TX 76706 Mailing address: PO Box 97052, Waco, TX 76798
Employer Taxpayer Identification Number:	74-1159753
Third Party Claims Administrator:	DR Administrative Services, Inc. 88 Sunnyside Blvd. Suite 203 Plainview, NY 11803 (888) 791-3737

This Summary Plan Description summarizes the key features of the dental care coverage provided through your employer’s Dental Reimbursement Plan (the “Plan”), which is governed by the Plan Document. If there are any discrepancies between the general information contained in this Summary Plan Description and the provisions of the Plan Document, the Plan Document will control.

PURPOSE OF PLAN

Baylor University has established the Plan to provide financial assistance to employees and their families for payment of dental expenses.

Baylor University cares and is concerned about the health of all employees and their families. This Plan encourages you to seek dental care that can improve your overall health, morale and productivity. The key to good dental care is regular visits to your dentist for oral examinations and cleaning of teeth. Major dental problems can often be avoided by preventive care and individual daily practice of good dental hygiene.

PARTICIPATION IN PLAN

Eligibility requirements

The Plan is available to full-time Baylor University employees (30 hours/week or .75 full-time equivalent) and their dependents. Eligibility Group A: Full-time faculty (tenure, tenure-track, and lecturers) and staff with executive benefits may enroll in employee only and dependent coverage in the dental plan for coverage to be effective upon employment. The University pays for employee only coverage. Eligibility Group B: Regular full-time staff with staff benefits may enroll in the plan by: 1) paying the employee and employer contributions (for dependant coverage, if applicable) during a 90-day waiting period for coverage effective upon employment, or 2) waiting for coverage to begin for employee only and dependent coverage (if applicable) at the completion of the 90-day period when the University begins to pay the employee only coverage contribution. The definition of eligible dependents is listed under the Baylor University dental insurance personnel policy.

End of participation

You will cease to be a Participant as of the earliest of (a) the date on which Baylor University terminates the Plan, or (b) the end of the month in which you cease to be an eligible Employee eligible due to termination of employment or change of status to part-time employment. If your participation terminates, your benefit to receive reimbursements of qualifying expenses under the Plan is automatically revoked as of the end of the month in which you terminate. Reimbursement for qualifying expenses incurred prior to your termination of participation may be received provided that you apply for reimbursement within 90 days after the close of

the Plan year.

Continuation of Coverage

If your participation in the Plan ceases, participants have the opportunity to continue benefits. Separating employees and their dependents that have been covered may apply for continued coverage for up to 18 months subject to the following conditions:

- Participants must apply within 30 days of separation for extended coverage.

Separated participants must pay the employee (if applicable) and employer contributions in order to continue coverage.

Effect of re-employment

If you terminate employment and are later rehired by Baylor University you may become a Participant again when you fulfill the eligibility requirements of the Plan.

CONTRIBUTIONS FOR THE PLAN

As an employee of Baylor University, you are a Participant of the plan after satisfying the eligibility requirements. Participation may require employee contributions to pay for the cost of the plan.

BENEFITS UNDER THE PLAN

The Plan will pay for qualifying dental and orthodontia expenses not covered under the medical plan as follows. These amounts may be changed each year and you will be notified of any changes.

Dental Benefits

100% of the first \$150.00 of any dental expenses; a \$50 deductible is applied to the next \$50 of any dental expenses; then 50% of remaining dental expenses are reimbursed up to the annual maximum of \$1500.00 per covered participant and dependent. All dental expense limits are applied on the basis of the Plan Year.

Covered Dental Expenses

All dental procedures, with the exclusion of cosmetic treatment (bleaching, laminates and implants), are covered dental expenses if provided by, or under the direction of, a dentist licensed to practice by the state in which he or she practices. The Plan's liability is subject to the subrogation and coordination of benefits rules explained under the Claims Procedure section below.

Orthodontia Benefits

Eligible participant and dependent expenses for orthodontia services will be reimbursed using the dental benefits formula up to a lifetime maximum benefit of \$1,000.00. Orthodontia benefits are tracked separately from dental expenses. Should you or your dependents need orthodontic care, remember that orthodontics is a highly specialized area of dentistry. Because the process takes a significant commitment on your part in terms of time and personal expense, we suggest that you seek the service of a specialist in orthodontics.

CLAIMS PROCEDURES

To receive payments under the Plan all claims must be received within 90 days after the end of a plan year to be eligible for reimbursement.

Assignment of Benefit to the Dental Provider

Payment can be made directly to the dental provider, if the member signs the claim form on the line stating the member is authorizing payment of the dental benefits otherwise payable directly to the below named entity. If this line is not signed, the third party administrator does not have permission to pay the provider and payment will go to the member.

Coordination of Benefits (Non-Duplication of Payment)

The Plan has been designed to help all employees meet the cost of dental treatment. Because it is not intended that you receive more in benefits than the actual amount of your dental expenses, the amount of benefits payable under the Plan will take into account any coverage you or a family member has under other "plans". The benefits under the Plan will be coordinated with the benefits of the other plans.

The Plan will be secondary to any other coverage that is available to your spouse or your dependents. In the event that the other policy states the same, the "Birthday Rule" will apply. The "Birthday Rule" states that the coverage of the parent, whose birthday is earlier in the year, will be the primary coverage for the dependents. The Plan will pay benefits only to the extent that any covered expense is not payable by the other plan. The Plan will always pay either its regular benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses, which includes deductibles and co-insurance not paid by other plans or programs. The explanation of benefits from the primary insurer is required in order to process a claim as secondary coverage.

Another "plan" for this purpose means any plan under which medical or dental benefits or services are provided by group insurance, self-insured plans, school or other educational institution, governmental programs, or coverage required or provided by any statute, or any similar plan or program.

Subrogation Rights of Plan

If a third party may be liable for a dental expense that you incur, the Plan will require that you subrogate the Plan to any claim that you have against the third party. The Plan would be paid back from the recovery against the third party for any expenses that the Plan had paid.

Claim Denial and Appeal Procedure

In the event of the denial of a claim, you have the right to file a written request for a review of the denial with the Plan Administrator within 60 days after you receive written notice of the denial. The Plan Administrator will conduct a full and fair review of the claim for benefits. The Plan Administrator will deliver to you or the beneficiary a written decision on that claim within, 30 days after the receipt of the request for review, except if there are special circumstances (such as the need to hold a hearing) requiring an extension of time for processing.

AMENDMENT AND TERMINATION OF PLAN

Baylor University has the right to amend the Plan by written action or approval of written action by the Board of Regents, Executive Council, or the Vice President for Human Resources if it determines that it is necessary or desirable to do so. Further, although Baylor University intends to continue the Plan indefinitely, it reserves the right to terminate the plan. In addition, Baylor University or the Plan Administrator may adopt any procedures and rules necessary to administer the Plan.