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Certificate of Coverage

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Introduction

This Certificate of Coverage (COC) is a guide to your dental plan. It is not the contract between Delta Dental of Tennessee (DDTN) and your group or any member of the plan. Should there be any conflict between the COC and the contract, the contract will prevail.

I. Eligibility and Enrollment of Subscribers and Dependents

Eligible subscribers include full-time employees who normally work at least 30 hours a week as well as part-time employees who normally work at least 24 hours a week. Coverage is effective the first day of the month following 60 days of employment. City Judge eligibility determined by group. Enrollment must be completed before the coverage effective date. Subscribers who have enrolled in this dental plan through their employer or other group sponsoring this plan may also enroll their dependents.

Dependents are defined as: current legal spouse or qualified same or opposite gender domestic partner (excluding a common law spouse); dependent child from birth up to age 26, who is the employee's, employee's spouse's or qualified domestic partner's natural child, legally adopted child (including children placed for adoption), step-child, or child for whom the employee, employee's spouse, or qualified domestic partner is the legal guardian or legal custodian, or a child of the employee, employee's spouse, or domestic partner for whom a Qualified Medical Child Support Order has been issued, or an incapacitated child of the employee, employee's spouse or qualified domestic partner.

Dependents in military service are not eligible.

Dependents who permanently reside outside the United States are not eligible for coverage. The plan's determination of eligibility under the terms of this provision shall be conclusive. The plan reserves the right to require proof of eligibility, including a copy of the marriage license, certified copy of any Qualified Medical Child Support Oder, birth certificate, and/or proof of court granted legal guardianship, legal custody and/or legal separation.

Dependents must enroll along with the subscriber or as soon as they become dependents. If dependents do not enroll at this time, they must wait until the next open enrollment period to enroll. Dependents may not be enrolled without the enrollment of the subscriber, but the subscriber may drop dependent coverage and maintain their coverage.

A subscriber or dependent who drops their coverage but who still meets all requirements of the plan, may re-enroll during the first open enrollment period after having been out of the plan for 12 consecutive months except in the event of a qualified life status change. Enrollment changes due to a qualified life status change must be made within 60 days of the event.

Coverage for any subscriber or dependent terminates on the last day of the month during which they are no longer eligible for benefits as a member of the group. Specific state and federal laws or group policies may allow an extension of membership for a limited time. You should speak to the administrator of your group to ee if an extension is available and for how long the benefits could be extended.

If a subscriber's coverage ceases because they are no longer employed but the subscriber becomes eligible through their employer again within 24 months after coverage ceased, the subscriber (and eligible dependents) can re-enroll

in this dental plan and be covered immediately.

DDTN will not pay for any services received by a patient who is not eligible at the time of treatment. Coverage for subscribers and dependents is only effective after DDTN receives the premium for the period to be covered. If DDTN does not receive the premium when it is due, we may stop paying claims until payment is received. If premiums have not been received within 30 days after the due date, DDTN may cancel the contract with the group. DDTN does not bill individuals for premiums.

This contract may be cancelled upon renewal by DDTN with 30 days prior written notice or by the Group with 60 days prior written notice.

II. Choosing a Dentist

DDTN does not directly provide dental services and therefore is not liable for a dentist's refusal to provide services. It has contracted with "Participating Dentists". These dentists are independent contractors who have agreed to accept certain fees for the service they provide to you. Dentists that have not contracted with Delta Dental are referred to as "Non-Participating Dentists". The fact that a dentist has or has not chosen to participate with DDTN should not be viewed as a statement about their qualifications.

Although you are free to choose any dentist, your out of pocket expenses may be less if you choose a participating dentist. Therefore, you should always ask your dentist if he is a participating dentist or verify with DDTN that your dentist is a participating dentist before receiving any dental services.

DDTN is not responsible for any injuries or damages suffered due to the actions of any dentist. DDTN shares in the public concern over the spread of infectious disease, but it cannot require a dentist to be tested for them. Information about the need for clinical precautions as recommended by recognized health authorities is provided to dentists. If you have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

III. General Provisions

A. Participating dentists will file your claim with DDTN. If you need a claim form for services provided by a non-participating dentist you may contact DDTN which will provide you with a claim form. To be considered for benefits, a claim must be filed within 15 months of the date of service.

B. If you require emergency dental care, you may seek services from any dentist. Your out of pocket expenses may be less if you choose a participating dentist.

C. You may get an estimate of the cost of certain dental procedures before they are done. This estimate is referred to as a predetermination. You may have your dentist send DDTN a claim form detailing the projected treatment and DDTN will give an estimate of the benefits to be paid. A predetermination is not a guarantee of payment. Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums.

D. If you or your covered dependent receive an injury requiring dental treatment because of the action or fault of another person, and if DDTN is unaware of other coverage, DDTN may pay benefits but would assume the subscriber's or covered dependent's rights to recover from the other person. The subscriber and covered dependent would be required to help DDTN in making such a recovery. This dental plan does not replace any workers' compensation coverage.

E. If a subscriber or covered dependent has two dental coverages, DDTN will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
   1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.
   2. Where the patient is a dependent child, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the

coverage of the custodial parent's spouse (i.e. stepparent) will be primary.

3. If there is a court decree stating that one parent has financial responsibility for a child's dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.

F. After a claim is processed, an Explanation of Benefits (EOB) will be sent to the subscriber. If any payment for services was denied, the EOB will give the reason why. If the subscriber disagrees with the denial he or she must submit a request in writing asking that the claim be reviewed. Such request should include the reason why the subscriber believes the claim was wrongly denied. The request must be received by DDTN within 180 days of the subscriber's receipt of the EOB. DDTN will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after DDTN receives the request for review.

   If the subscriber does not agree with the first level review decision, he or she may refer the request for review to the Professional Relations Advisory Committee of DDTN. This second level review request must be in writing and received by DDTN within a reasonable time after the subscriber receives the first level review decision. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after DDTN receives the request for second level review.

   If the subscriber does not agree with the second level review decision, he or she may file civil action in court.

IV. Benefits

Not every dental procedure is a benefit of your dental plan nor are they paid at the same level of co-payment. The Schedule of Benefits in this COC reflects the procedures that DDTN will cover as well as certain limitations and exclusions for these covered benefits. These services will be covered when a dentist or an employee of a dentist who is licensed to perform the service provides them. These services must be necessary and must be provided in accordance with generally accepted dental practice standards. Some allowable procedures are subject to deductibles, maximums, and copayments as described on the Benefit Summary Page.

In addition to the limitations and exclusions shown in the Schedule of Benefits section, DDTN does not pay for the following:

General Limitations and Exclusions

A. Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
B. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
C. Cosmetic surgery or procedures for purely cosmetic reasons.
D. Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate, or upper and lower jaw malformations. This does not exclude those services provided under Orthodontic benefits, if covered.
E. Treatment to restore tooth structure lost from wear.
F. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
G. Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
H. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
I. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.
J. Services by a dentist beyond the scope of his or her license.
K. Dental services for which the patient incurs no charge.
L. Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
M. DDTN will apply the limitations and exclusions of this benefit plan based upon the member's complete and prior history as reflected in DDTN's records.

In the event a member transfers from one dentist to another during the course of treatment, payment by DDTN will be limited to the amount that would have been paid had only one dentist rendered the service.

V. Optional Services

In cases where alternate or optional methods of treatment exist, DDTN will pay for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of the subscriber's coverage. The dentist and subscriber or dependent should decide the course of treatment. If the treatment rendered is other than the covered benefit, the difference between DDTN's allowance and the dentist's fee, up to the approved amount, for the actual treatment rendered is due from the subscriber. For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, DDTN will pay for only the cost of the amalgam.

VI. Schedule of Benefits

In addition to the limitations and exclusions listed in the Schedule of Benefits, the **General Limitations and Exclusions** found in Section IV of this Certificate of Coverage also apply.

A. Diagnostic & Preventive Benefits, Limitations & Exclusions

- Oral examinations and cleanings (prophylaxis). Oral exams and cleanings are limited to one time in any calendar year.
- Members with high risk health conditions may receive a total of four cleanings in any calendar year. Eligible members include diabetics and pregnant women with periodontal disease, those with renal failure, those with suppressed immune systems such as those undergoing chemotherapy/radiation treatment, HIV positive or organ or stem cell transplant patients or those at high risk for infective endocarditis.
- Periodontal maintenance procedures will be considered optional services.
- Adult prophylaxis for members under 14 years of age are not allowed.
- Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
- X-rays. Full mouth x-rays (which include bitewing x-rays) or a panorex are payable once in any three year period. One set of bite-wing x-rays is covered in a calendar year.
- Fluoride. Topical application of fluoride is covered for members up to 19 years of age.