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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

As an enrollee in this plan, you may also enroll your dependents.

Dependents are defined as a lawful husband or wife or other relationship as defined by the group or child(ren) from birth to the Dependent Age Limit listed on the Benefit Summary Page. "Child" includes a natural child, stepchild, adopted child, foster child or child in the subscriber's legal custody. A child over the Dependent Age Limit may continue to be eligible. The child must not be able to support them self because of mental incapacity or physical handicap. Such disabling condition must have begun before reaching the Dependent Age Limit. Proof of these facts must be given to DDTN or the group within 31 days if requested. Proof will not be required more than once a year.

Dependents in military service are not eligible.

Your dependents must enroll along with you 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. Your dependents may not be enrolled without your enrollment, but you may drop dependent coverage and maintain your coverage.

If you or your dependents drop coverage but still meet all requirements of the plan, you 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.

Your or your dependent's coverage terminates when you 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 see if an extension is available and for how long the benefits could be extended.

DDTN will not pay for any services received by a patient who is not eligible at the time of treatment. Coverage for you and your 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 15 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.

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 pre-treatment Estimate. You may have your dentist send DDTN a claim form detailing the projected treatment and DDTN will give a pre-estimate of the benefits to be paid. A pre-treatment estimate 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 you or your covered dependent's rights to recover from the other person. You and your covered dependent would be required to help DDTN in making such a recovery.

E. This dental plan does not replace any workers' compensation coverage.

F. If you or your 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.

G. After a claim is processed, an Explanation of Benefits (EOB) will be made available to you. If any payment for services was denied, the EOB will give the reason why. If you disagree with the denial you must submit a request in writing asking that the claim be reviewed. Such request should include the reason why you believe the claim was wrongly denied. The request for your first level review must be received by DDTN within 180 days of your 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 you within 30 days after DDTN receives the request for review.
If you do not agree with the first level review decision, you may request a second level review. The manner in which to seek a second level review will be included with the letter informing you of our first level review decision.

The second level review decision will be made no later than 30 days from the date we receive your request. If you do not agree with the second level review decision, you may file civil action in court within one year of the final denial.

IV. Benefits

Not every dental procedure is a benefit of your dental plan, nor are they paid at the same level of co-insurance. 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 unless specifically listed as a benefit.
D. Services for congenital (hereditary), hypodontia 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 or attrition.
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 unless specifically listed as a benefit.
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.

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 recommend which treatment should be provided. It is a determination of benefits under the terms of your coverage. The dentist and you or your 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 you. 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

- All oral examinations and cleanings (prophylaxis).
  - Oral exams and cleanings, to include any combination of teeth cleanings (prophylaxes, periodontal maintenance procedures and scaling in the presence of inflammation), are limited to two times in any calendar year. Excludes full mouth debridement which is covered once per lifetime.
  - Members with high-risk health conditions may receive a total of four cleanings, to include periodontal maintenance procedures, in any calendar year. Eligible members include:
    - Diabetics with periodontal disease
    - Pregnant women with periodontal disease
    - Individuals with renal failure/dialysis
    - Individuals with suppressed immune systems (undergoing chemotherapy or radiation treatment, HIV positive, organ transplant patients, stem cell/bone marrow transplant patients)
    - Individuals at high risk for infective endocarditis (such as those with a history of infective endocarditis, certain congenital heart defects, artificial heart valves, heart valve defects, hypertropic cardiomyopathy, or mitral valve prolapse)
  - Members with special health care needs may be eligible for additional oral exams and may receive a total of four cleanings, to include periodontal maintenance procedures, in any calendar year.
    - Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.
  - Adult prophylaxis for members under 14 years of age is not allowed.
  - Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
- X-rays.
  - One set of bite-wing x-rays are covered in a calendar year.
  - Full mouth x-rays and/or panoramic x-rays are covered once within 3 years, unless special need is shown.
- Fluoride. Topical application of fluoride is covered for members up to 19 years of age once per calendar year.
- Space maintainers.
  - Space maintainers are covered for missing posterior primary teeth for members 14 years of age or under.
  - Distal shoe space maintainers are a benefit on first permanent molars, limited to children up to age 8. Charges for repairs and adjustments by the same dentist or dental office are not allowed.
  - Only one space maintainer is allowed per area per lifetime.
- Emergency Palliative Treatment to temporarily relieve pain.

B. Sealant Benefits, Limitations & Exclusions

- Sealants – resin filling used to seal grooves and pits on the chewing surface of permanent

molar teeth.

- A sealant is a benefit only on the unrestored, decay free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars.
- Sealants are only a benefit on members under 14 years of age.
- Only one benefit will be allowed for each tooth within a three-year period.
- Benefits include repair or replacement within 24 months by the same dentist or dental office.

C. Basic Benefits, Limitations & Exclusions

- Simple extractions.
- General Anesthesia & IV. Sedation is covered only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions. General anesthesia and IV sedation are limited to one hour. Any additional minutes are disallowed unless clinical documentation supports additional minutes.
- Anesthesia is payable for people with special health care needs.
  - Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.
- Minor Restorations – amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.
  - Restorative benefits are allowed once per surface in a 24-month period, regardless of the number or combinations of procedures requested or performed.
  - The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not allowed.
  - The replacement, by the same dentist or dental office, of a stainless-steel crown within 24 months of the initial placement is not allowed.
- Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.
- Denture Repairs - services to repair complete or partial dentures.

D. Oral Surgery Benefits, Limitations & Exclusions.

- Oral Surgery – complex extractions and other surgical procedures (including pre- and post-operative care). Some procedures are limited to once per lifetime. Excludes procedures that are considered medical procedures.

E. Endodontic Benefits, Limitations & Exclusions

- Endodontia - treatment of the dental pulp (root canal procedures).
  - Payment for root canal treatment includes charges for x-rays and temporary restorations.
  - Root canal treatment is limited to once in a 24- month period by the same dentist or dental office.
  - Post-operative procedures are considered part of the total fee.

F. Periodontic Benefits, Limitations & Exclusions

- Periodontia - treatment of the gums and bones that surround the natural tooth.
  - Payment for periodontal surgery shall include charges for three months post-operative care and any surgical re-entry for a three-year period.
  - Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.
  - Scaling and root planing procedures are allowed once within 24 months.
  - Localized delivery of antimicrobial agents is not a benefit.

G. Major Restorative Benefits, Limitations & Exclusions

- Cast Restorations. Crowns and onlays are benefits for the treatment of visible decay and

fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.

- Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, impression, temporary restoration and any re-cementation by the same dentist within a 12-month period.
- A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
- Procedures for purely cosmetic reasons are not benefits. Some procedures (ex. Veneers) may be made optional.
- Porcelain, gold or veneer crowns for children under 12 years of age are not a benefit.
- A prefabricated post and core in addition to crown is payable only on an endodontically treated tooth.

H. Prosthodontic Benefits, Limitations & Exclusions

- Prosthodontics. Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
  - Replacement of any fixed bridges or partial or complete dentures that the member received in the previous five years is not a benefit.
  - Payment for a complete or partial denture shall include charges for any necessary adjustment within a six-month period.
  - Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
- Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit. A temporary partial-stayplate denture is a benefit in children 16 years of age or under for missing anterior permanent teeth.
- A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
- Temporary partial dentures are a benefit during the healing period for missing upper anterior teeth.
- Temporary or provisional fixed prosthodontics are not separate benefits and should be included in the fee for the permanent prosthesis.
- Complete or Partial Denture Reline and Rebase procedures. Payment for a reline or rebase of a partial or complete denture is limited to once in a three-year period and includes all adjustments required for six months after delivery.

I. Implant Benefits, Limitation and Exclusions

- Implants. The surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered benefits.
  - Replacement of implants or abutments received in the previous five years is not a benefit.
  - The removal of an implant is allowed once per lifetime.
  - Specialized techniques are not benefits (ie. bone grafts, guided tissue regeneration, precision attachments, etc.)
  - Implants are not a benefit for patients under 19 years of age.
  - Implant maintenance procedures are allowed once in a 12-month period.

J. Orthodontic Benefits, Limitations & Exclusions (Buy-Up Plan Only)

- Orthodontics. Procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a benefit.
  - Orthodontic benefits are limited to members shown on the Benefit Summary Page.

- If orthodontic treatment began prior to enrolling in this plan, DDTN will begin benefits with the first payment due the dentist after the subscriber or covered dependent becomes eligible.
- Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
- Benefits are not paid to repair or replace any orthodontic appliance received.
- Orthodontic benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under other benefits of this plan.
- The initial payment (initial banding fee) made by DDTN for comprehensive treatment will be 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.
- Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment percentage and lifetime maximum.