

Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government
Group Number: 4044
Group Address: 3411 Highway 126 Ste 202
City, State, Zip Code: Blountville, TN 37617-4564
Contract Effective Date: January 1, 2022
Contract Renewal Date: January 1, 2024
Benefit Year: January 1 through December 31
Provider Network: Delta Dental PPO™ (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

New hires are eligible the first of the month following 60 days of hire.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Service Fee:

Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

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Benefits

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 14 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and implant related services are not Covered Services.
- Crowns over implants and their related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not payable.

Deductible: \$50 Deductible per person total per calendar year limited to a maximum Deductible of \$150 per family per calendar year. The Deductible does not apply to oral exams, prophylaxes (cleanings), fluoride, X-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

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**Delta Dental of Tennessee
List of Subclients
for**

Group Name: Sullivan County Government

Group Number: 4044

Subclient Name	Subclient Number
General - Base plan option	0001
Highway - Base plan option	0002
Sanitation - Base plan option	0003
Health - Base plan option	0004
EMS - Base plan option	0005
COBRA - Base plan option	0009

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Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

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Subclient Name	Subclient Number
General - Buy Up plan option	1001
Highway - Buy up plan option	1002
Sanitation - Buy up plan option	1003
Health - Buy up plan option	1004
EMS - Buy up plan option	1005
COBRA - Buy up plan option	1009

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between **Delta Dental of Tennessee** and **Sullivan County Government**.

It is agreed and understood that effective: **July 01, 2022**

New Hire Clause Change:

New hires are eligible the first of the month following 30 days of hire.

Please attach to your contract. No other action is necessary.

November 1, 2021

Michelle Turner
Sullivan County Government
3411 Highway 126 Ste 202
Blountville, TN 37617-4564

Dear Michelle Turner,

Thank you for the trust you place with us to keep your employees healthy. Our mission of ensuring healthy smiles doesn't stop with your teeth. Your overall health is an equally important factor. That's why we would like to remind you that Delta Dental now offers vision coverage for your employees—DeltaVision.

Did you know that four out of five adults need vision correction? Through a partnership with VSP, Delta Dental of Tennessee offers the same quality coverage, exceptional service, and unparalleled networks for vision coverage with DeltaVision. As with your dental plan, DeltaVision can be offered as a voluntary plan with little or no cost to you.

We know you care about your employees. That's why both Delta Dental and DeltaVision plans encourage preventive care. Those routine dental and eye exams may be the first line of defense in diagnosing more serious health problems like diabetes and heart conditions as dentists and eye doctors can detect those signs and symptoms. And with our networks of participating dentists and eye doctors, no matter where your employees live, work or play, Delta Dental and VSP providers are always nearby.

The renewal for your benefits plan is on the enclosed Declaration Page. No action is necessary on your part if you would like to continue your benefits plan. Payment of premium will suffice as your acceptance of the contract. If you would like to make changes to your benefits or add a DeltaVision plan to your benefit offering this open enrollment season, please contact your agent or Delta Dental account executive right away. Changes should be made at least thirty (30) days prior to your anniversary date.

Thank you for allowing us to provide value for you *and* your employees through access to care that puts you on the road to better overall health. We look forward to serving your company in the years to come.

Sincerely,



Jay Reavis
VP Business Development

cc: Jonathan Manfull



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Delta Dental of Tennessee
Renewal Rates for Sullivan County Government #4044
Effective January 1, 2022

Administrative Services Fees	
Rates per subscriber per month	Renewal Fee(s) January 1, 2022 through December 31, 2023
Composite	\$3.18
Overall Percent Change	
<p>In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for the Cost of Claims for the preceding week every Tuesday. Payment shall be due via Electronic Funds Transfer on or before Friday of that week.</p>	

Rating Requirements
Minimum client contributions: 100 percent for employee and 63 percent for dependent(s).
Tied to medical: No

Rating Assumptions
The fee is valid for the effective date noted above and is guaranteed through the period shown above.
Self-billing is not allowed and you agree to pay as invoiced each month.
Standard subscriber materials will be provided to you to distribute to your members. These include the Summary of Dental Plan Benefits and Certificates. ID cards are mailed to your members.
Printed dentist directories are not included. You can find participating dentists on our website at https://www.DeltaDentalTN.com .
<p>The plan specifications are subject to Delta Dental's standard exclusions and limitations, including:</p> <ul style="list-style-type: none"> ➤ Oral exams are payable twice per calendar year. ➤ Prophylaxes (cleanings) are payable twice per calendar year. ➤ Fluoride treatments are payable twice per calendar year for people age 18 and under. ➤ Space maintainers are payable once per area per lifetime for people age 14 and under. ➤ Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period. ➤ Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations. ➤ Composite resin (white) restorations are optional treatment on posterior teeth. ➤ Implants and implant related services are not Covered Services. ➤ Crowns over implants and their related services are not Covered Services. ➤ Crowns, dentures, and bridges over implants are not payable.



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Add Buy Up plan option:

Benefits will be same as current plan except the following:

Orthodontic Services: No Age Limit

Maximum Payment: The plan is designed to encourage yearly visits to your dentist for preventive care. The Maximum Payment for the first calendar year is \$2,500 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. If an Eligible Person obtains preventive services or periodontal maintenance services in a calendar year, the Maximum Payment will increase in the following calendar year by \$100 up to a Maximum Payment of \$3,000 per calendar year. If one of the required services is not received in a calendar year, the Maximum Payment in the following calendar year will be reduced to \$2,500. \$2,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Please attach to your contract. No other action is necessary.

November 2, 2020

Michelle Turner
Sullivan County Government
3411 Highway 126 Ste 202
Blountville, TN 37617-4564

Dear Michelle Turner,

At Delta Dental, we want to ensure healthy smiles for you and your employees. And, yes, that's "ensure" with an "e". We appreciate the trust you place with us to help keep your employees healthy. To better serve you, we would like to share information about two new services we can provide for you with your renewal: DeltaVision® and Quick Start.

Did you know that four out of five adults need vision correction? DeltaVision by Delta Dental of Tennessee is a new vision plan in partnership with VSP. For a very low rate, you can offer a vision plan backed by two of the most trusted brands in benefits—Delta Dental *and* VSP. As with your dental plan, DeltaVision can be offered as a voluntary plan with little or no cost to you.

Quick Start is a secure electronic eligibility tool that can help you capture and submit your eligibility files. Your Delta Dental representative can provide you with a secure link to set up an online account for you. From there, you will receive a link to send to your employees to complete their Delta Dental application. You will review the file at the end of your open enrollment and then submit it directly. No more paperwork to collect!

We know you care about your employees. Both Delta Dental and DeltaVision plans encourage preventive care. And those routine dental and eye exams may help reveal more serious conditions, like diabetes and heart conditions. No matter where your employees live, work or play, Delta Dental and VSP providers are always nearby.

The renewal for your dental benefits plan is on the enclosed Declaration Page. No action is necessary on your part if you would like to continue your benefits plan. Payment of premium will suffice as your acceptance of the contract. If you would like to make changes to your benefits, add DeltaVision, or use Quick Start this open enrollment season, please contact your agent or Delta Dental account manager right away. Changes should be made at least thirty (30) days prior to your anniversary date.

Thank you for allowing us to provide value for you *and* your employees through access to care that puts you on the road to better overall health. We look forward to serving your company in the years to come.

Sincerely,



Jay Reavis
VP Sales and Underwriting

Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government
Group Number: 4044
Group Address: 3411 Highway 126 Ste 202
City, State, Zip Code: Blountville, TN 37617-4564
Contract Effective Date: January 1, 2021
Contract Renewal Date: January 1, 2022
Benefit Year: January 1 through December 31
Provider Network: Delta Dental PPO (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

New hires are eligible the first of the month following 60 days of hire.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Service Fee:

Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

In addition to the administrative service fee, the GROUP agrees to reimburse Delta Dental for claims payments as described in section 2.02 of this contract.

This plan requires a minimum of 500 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

Premiums will be deemed delinquent if not paid as billed and received by the 5th of each month.

Benefits

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 14 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and implant related services are not Covered Services.
- Crowns over implants and their related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not payable.

Deductible: \$50 Deductible per person total per calendar year limited to a maximum Deductible of \$150 per family per calendar year. The Deductible does not apply to oral exams, prophylaxes (cleanings), fluoride, X-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

Maximum Payment: The plan is designed to encourage yearly visits to your dentist for preventive care. The Maximum Payment for the first calendar year is \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. If an Eligible Person obtains preventive services or periodontal maintenance services in a calendar year, the Maximum Payment will increase in the following calendar year by \$100 up to a Maximum Payment of \$2,200 per calendar year. If one of the required services is not received in a calendar year, the Maximum Payment in the following calendar year will be reduced to \$1,200. \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Delta Dental of Tennessee
Renewal Rates for Sullivan County Government #4044
Effective January 1, 2021

Administrative Services Fees		
Rates per subscriber per month	Current Fee(s) January 1, 2020 through December 31, 2020	Renewal Fee(s) January 1, 2021 through December 31, 2021
Composite	\$3.18	\$3.18
Overall Percent Change	0.00%	
<p>In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for the Cost of Claims for the preceding week every Tuesday. Payment shall be due via Electronic Funds Transfer on or before Friday of that week.</p>		

Rating Requirements
Minimum client contributions: 100 percent for employee and 63 percent for dependent(s).
Tied to medical: No

Rating Assumptions
The fee is valid for the effective date noted above and is guaranteed through the period shown above.
Self-billing is not allowed and you agree to pay as invoiced each month.
Subscriber materials are mailed directly to your members. These include the Summary of Dental Plan Benefits, Certificate, and ID card.
Printed dentist directories are not included. You can find participating dentists on our website at https://www.DeltaDentalTN.com .
The plan specifications are subject to Delta Dental's standard exclusions and limitations, including:
<ul style="list-style-type: none"> ➤ Oral exams are payable twice per calendar year. ➤ Prophylaxes (cleanings) are payable twice per calendar year. ➤ Fluoride treatments are payable twice per calendar year for people age 18 and under. ➤ Space maintainers are payable once per area per lifetime for people age 14 and under. ➤ Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period. ➤ Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations. ➤ Composite resin (white) restorations are optional treatment on posterior teeth. ➤ Implants and implant related services are not Covered Services. ➤ Crowns over implants and their related services are not Covered Services. ➤ Crowns, dentures, and bridges over implants are not payable.

Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government
Group Number: 4044
Group Address: 3411 Highway 126 Ste 202
City, State, Zip Code: Blountville, TN 37617-4564
Contract Effective Date: January 1, 2018
Contract Renewal Date: January 1, 2020
Benefit Year: January 1 through December 31
Provider Network: Delta Dental PPO (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

New hires are eligible the first of the month following 60 days of hire.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Service Fee:

Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

In addition to the administrative service fee, the GROUP agrees to reimburse Delta Dental for claims payments as described in section 2.02 of this contract.

This plan requires a minimum of 500 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

Premiums will be deemed delinquent if not paid as billed and received by the 5th of each month.

Benefits

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 15.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not a benefit.

Deductible: \$50 Deductible per person total per calendar year limited to a maximum Deductible of \$150 per family per calendar year. The Deductible does not apply to oral exams, prophylaxes (cleanings), fluoride, X-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

Maximum Payment: The plan is designed to encourage yearly visits to your dentist for preventive care. The Maximum Payment for the first calendar year is \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. If an Eligible Person obtains preventive services or periodontal maintenance services in a calendar year, the Maximum Payment will increase in the following calendar year by \$100 up to a Maximum Payment of \$2,200 per calendar year. If one of the required Covered Services is not received in a calendar year, the Maximum Payment in the following calendar year will be reduced to \$1,200. \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between **Delta Dental of Tennessee** and **Sullivan County Government**.

It is agreed and understood that effective **January 01, 2018**:

Add Preventive Incentive Maximum and Diagnostic & Preventive Limitations & Exclusions:

Maximum Payment: The plan is designed to encourage yearly visits to your dentist for preventive care. The Maximum Payment for the first calendar year is \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. If an Eligible Person obtains preventive services or periodontal maintenance services in a calendar year, the Maximum Payment will increase in the following calendar year by \$100 up to a Maximum Payment of \$2,200 per calendar year. If one of the required Covered Services is not received in a calendar year, the Maximum Payment in the following calendar year will be reduced to \$1,200. \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

A. Diagnostic & Preventive Benefits, Limitations & Exclusions

- 1) All oral examinations and cleanings (prophylaxis).
 - a) 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.
 - b) 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:
 - (1) Diabetics with periodontal disease
 - (2) Pregnant women with periodontal disease
 - (3) Individuals with renal failure/dialysis
 - (4) Individuals with suppressed immune systems (undergoing chemotherapy or radiation treatment, HIV positive, organ transplant patients, stem cell/bone marrow transplant patients)
 - (5) 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)
 - c) Adult prophylaxis for members under 14 years of age is not allowed.
 - d) Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
- 2) X-rays.
 - a) One set of bite-wing x-rays are covered in a calendar year.
 - b) Full mouth x-rays and/or panoramic x-rays are covered once within 3 years, unless special need is shown.
- 3) Fluoride. Topical application of fluoride is covered for members up to 19 years of age twice per calendar year.
- 4) Space maintainers.
 - a) Space maintainers are covered for missing posterior primary teeth for members 14 years of age or under.
 - b) 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.
 - c) Only one space maintainer is allowed per area per lifetime.

Please attach to your contract. No other action is necessary.

May 1, 2017

Michelle Turner
Sullivan County Government
3411 Highway 126 Ste 202
Blountville, TN 37617-4564

Dear Michelle Turner,

Thank you for continuing to put your trust in Delta Dental of Tennessee. By sponsoring a dental plan for your employees, we know you understand the important connection between good oral health and good overall health. Our goal at Delta Dental is to provide valuable health benefits for your employees with lower costs through our vast network of dentists, all at a competitive premium.

The renewal for your existing dental benefits plan is on the enclosed Declaration Page. No action is necessary on your part. Payment of premium will suffice as your acceptance of the contract. If you would like to make changes to your benefits, please contact your agent or Delta Dental account executive right away. Changes should be made at least thirty (30) days prior to your anniversary date. Please keep this letter and the enclosed Declaration Page with your Delta Dental contract.

We are continually monitoring the Affordable Care Act (ACA). At this time, it does not impact your group dental plan or your dental benefits. We will continue to monitor the legislation and will let you know if and when that should change for your group.

As the pioneer in dental benefits, we want to make it easy for you and your employees to know and understand the value of dental benefits and oral health care. This year, we have launched our new mobile app, available in both the App Store (for iPhone, iPad, iPod devices) and Google Play (for Android-compatible devices). The mobile apps provide mobile ID cards, access to coverage and claims information, dentist search, a brushing time, and more. We are happy to provide resources to you to help communicate this to your employees. More information is available on our Web site, www.DeltaDentalTN.com, or you can contact your account manager.

A Delta Dental plan is a great investment in health, benefitting both you and your employees. We appreciate having you as a customer and look forward to continuing to serve you and your employees over the years to come.

Sincerely,



Jay Reavis
VP Sales and Underwriting

Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government
Group Number: 4044
Group Address: 3411 Highway 126 Ste 202
City, State, Zip Code: Blountville, TN 37617-4564
Contract Effective Date: July 1, 2017
Contract Renewal Date: July 1, 2019
Benefit Year: January 1 through December 31
Provider Network: Delta Dental PPO (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

New hires are eligible the first of the month following 60 days of hire.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Service Fee:

Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

In addition to the administrative service fee, the GROUP agrees to reimburse Delta Dental for claims payments as described in section 2.02 of this contract.

This plan requires a minimum of 500 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

Premiums will be deemed delinquent if not paid as billed and received by the 5th of each month.

Benefits

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 15.
- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period, whether provided by a general dentist or specialist.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not a benefit.

Deductible: \$50 Deductible per person total per calendar year limited to a maximum Deductible of \$150 per family per calendar year. The Deductible does not apply to oral exams, prophylaxes (cleanings), fluoride, X-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

Maximum Payment: \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Delta Dental of Tennessee
Renewal Rates for Sullivan County Government #4044
Effective July 1, 2017

Administrative Services Fees		
Rates per subscriber per month	Current Fee(s) July 1, 2015 through June 30, 2017	Renewal Fee(s) July 1, 2017 through June 30, 2019
Composite	\$3.18	\$3.18
Overall Percent Change	0.00%	
In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for the Cost of Claims for the preceding week every Tuesday. Payment shall be due via Electronic Funds Transfer on or before Friday of that week.		

Rating Requirements
Minimum client contributions: 100 percent for employee and 63 percent for dependent(s).
Tied to medical: No

Rating Assumptions
The fee is valid for the effective date noted above and is guaranteed through the period shown above.
Self-billing is not allowed and you agree to pay as invoiced each month.
Subscriber materials are mailed directly to your members. These include the Summary of Dental Plan Benefits, Certificate, and ID card.
Printed dentist directories are not included. You can find participating dentists on our website at www.DeltaDentalTN.com .
The plan specifications are subject to Delta Dental's standard exclusions and limitations, including: <ul style="list-style-type: none"> ➤ Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months. ➤ Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months. ➤ Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19. ➤ Space maintainers are payable once per area per lifetime for people up to age 15. ➤ Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period, whether provided by a general dentist or specialist. ➤ Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations. ➤ Composite resin (white) restorations are optional treatment on posterior teeth. ➤ Implants and related services are not Covered Services. ➤ Crowns, dentures, and bridges over implants are not a benefit.



Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government
Group Number: 4044
Group Address: 3411 Highway 126 Ste 202
City, State, Zip Code: Blountville, TN 37617-4564
Contract Effective Date: July 1, 2015
Contract Renewal Date: July 1, 2017
Benefit Year: January 1 through December 31
Provider Network: Delta Dental PPO (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

New hires are eligible the first of the month following 60 days of hire.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Service Fee:

Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

In addition to the administrative service fee, the GROUP agrees to reimburse Delta Dental for claims payments as described in section 2.02 of this contract.

This plan requires a minimum of 500 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

Premiums will be deemed delinquent if not paid as billed and received by the 5th of each month.

Benefits

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 15.
- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period, whether provided by a general dentist or specialist.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not a benefit.

Deductible: \$50 Deductible per person total per calendar year limited to a maximum Deductible of \$150 per family per calendar year. The Deductible does not apply to oral exams, prophylaxes (cleanings), fluoride, X-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

Maximum Payment: \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between **Delta Dental of Tennessee and Sullivan County Government.**

It is agreed and understood that effective **January 1, 2017:**

New Hire Clause:

New hires are eligible the first of the month following 60 days of hire.

Please attach to your contract. No other action is necessary.

May 4, 2015

Gayvern Moore
Sullivan County Government
3411 Highway 126 Ste 202
Blountville, TN 37617-4564

Dear Gayvern Moore,

Thank you for continuing to put your trust in Delta Dental of Tennessee. By sponsoring a dental plan for your employees, we know you understand the important connection between good oral health and good overall health. Our goal at Delta Dental is to provide valuable health benefits for your employees with lower costs through our vast network of dentists, all at a competitive premium.

The renewal for your existing dental benefits plan is on the enclosed Declaration Page. No action is necessary on your part. Payment of premium will suffice as your acceptance of the contract. If you would like to make changes to your benefits, please contact your agent or Delta Dental account executive right away. Changes should be made at least thirty (30) days prior to your anniversary date. Please keep this letter and the enclosed Declaration Page with your Delta Dental contract.

We are continually monitoring the Affordable Care Act (ACA). At this time, it does not impact your group dental plan or your dental benefits. We will continue to monitor the legislation and will let you know if and when that should change for your group.

As the pioneer in dental benefits, we want to make it easy for you and your employees to know and understand the value of dental benefits and oral health care. This year, we have launched our new mobile app, available in both the App Store (for iPhone, iPad, iPod devices) and Google Play (for Android-compatible devices). The mobile apps provide mobile ID cards, access to coverage and claims information, dentist search, a brushing time, and more. We are happy to provide resources to you to help communicate this to your employees. More information is available on our Web site, www.DeltaDentalTN.com, or you can contact your account manager.

A Delta Dental plan is a great investment in health, benefitting both you and your employees. We appreciate having you as a customer and look forward to continuing to serve you and your employees over the years to come.

Sincerely,



Jay Reavis
VP Sales and Underwriting

Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government
Group Number: 4044
Group Address: 3411 Highway 126 Ste 202
City, State, Zip Code: Blountville, TN 37617-4564
Contract Effective Date: July 1, 2015
Contract Renewal Date: July 1, 2017
Benefit Year: January 1 through December 31
Provider Network: Delta Dental PPO (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

Employees are eligible on the first day of the month following 1 month of continuous employment.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Service Fee:

Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

In addition to the administrative service fee, the GROUP agrees to reimburse Delta Dental for claims payments as described in section 2.02 of this contract.

This plan requires a minimum of 500 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

Premiums will be deemed delinquent if not paid as billed and received by the 5th of each month.

Benefits

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipatin g Dentist Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 15.
- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period, whether provided by a general dentist or specialist.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not a benefit.

Deductible: \$50 Deductible per person total per calendar year limited to a maximum Deductible of \$150 per family per calendar year. The deductible does not apply to oral exams, prophylaxis, fluoride, x-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

Maximum Payment: \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. \$1,000 per person total per lifetime on cephalometric film, photos, diagnostic casts, and orthodontic services.

Delta Dental of Tennessee
Renewal Rates for Sullivan County Government #4044
Effective July 1, 2015

Administrative Services Fees		
Rates per subscriber per month	Current Fee(s) July 1, 2013 through June 30, 2015	Renewal Fee(s) July 1, 2015 through June 30, 2017
Composite	\$3.18	\$3.18
Overall Percent Change	0.00%	

In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for the Cost of Claims for the preceding week every Tuesday. Payment shall be due via Electronic Funds Transfer on or before Friday of that week.

Rating Requirements

Minimum client contributions: 100 percent for employee and 63 percent for dependent(s).

Tied to medical: No

Rating Assumptions

The fee is valid for the effective date noted above and is guaranteed through the period shown above.

Self-billing is not allowed and you agree to pay as invoiced each month.

Standard subscriber materials will be provided to you to distribute to your members. These include the Summary of Dental Plan Benefits and Certificates. ID cards are mailed to your members.

Printed dentist directories are not included. You can find participating dentists on our website at www.DeltaDentalTN.com.

The plan specifications are subject to Delta Dental's standard exclusions and limitations, including:

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 15.
- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period, whether provided by a general dentist or specialist.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not a benefit.

April 22, 2013

Gayvern Moore
Sullivan County Government
3411 Highway 126 Ste 202
Blountville, TN 37617-4564

Dear Gayvern Moore:

We're proud that you have selected Delta Dental of Tennessee once again to serve you for your dental benefit needs. The renewal for your existing dental benefits plan is on the enclosed Declaration Page. No action is necessary on your part. Payment of premium will suffice as your acceptance of the contract. If you would like to make changes to your benefits, please contact your agent right away. Changes should be made at least thirty (30) days prior to your anniversary date. Please keep this letter and enclosed Declaration Page with your Delta Dental contract.

As you are well aware, health care reform will be impacting your employee benefits in many ways. We are continually monitoring reform changes and will let you know if there will be any further impact on your dental benefits.

At Delta Dental, we take pride in the leadership role we have achieved in making dental care more accessible and affordable. Your employees have access to claims information and more, either online or by phone, anytime of day, any day of the week. We also have electronic materials available to help you educate your employees on the importance of oral health care and the benefits of preventive care. These can be used in newsletters, on your intranet and more. Visit our Web site, www.DeltaDentalTN.com, for more information or contact your account manager.

Having a Delta Dental plan is a great investment in health, benefitting both you, as the employer, and your employees. We appreciate having you as a customer and look forward to providing you and your employees superior service over the next year.

Best regards,



Jay Reavis
VP Sales and Underwriting

Enclosure

Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government Group Number: 4044

Group Address: 3411 Highway 126 Ste 202

City, State, Zip Code: Blountville, TN 37617-4564

Contract Effective Date: July 1, 2013 Contract Renewal Date: July 1, 2015

Benefit year: January 1 through December 31 Provider Network: Delta Dental PPO (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

Employees are eligible on the first day of the month following 1 month of continuous employment.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Service Fee:

Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

In addition to the administrative service fee, the GROUP agrees to reimburse Delta Dental for claims payments as described in section 2.02 of this contract.

This plan requires a minimum of 500 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

Premiums will be deemed delinquent if not paid as billed and received by the 5th of each month.

Benefits

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			

Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthetic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
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- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and related services are not Covered Services.
- Crowns, dentures, and bridges over implants are not a benefit.

Deductible: \$50 deductible per person total per calendar year limited to a maximum deductible of \$150 per family per calendar year. The deductible does not apply to oral exams, prophylaxis, fluoride, x-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

Maximum Payment: \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. \$1,000 per person total per lifetime on cephalometric film, photos, diagnostic casts, and orthodontic services.



Delta Dental of Tennessee Declaration Page

Group Name: Sullivan County Government Group Number: 4044
 Group Address: 3411 Highway 126 Ste 202
 City, State, Zip Code: Blountville, TN 37617-4564
 Contract Effective Date: July 1, 2011 Contract Renewal Date: July 1, 2013
 Benefit year: January 1 through December 31 Provider Network: Delta Dental PPO (Point-of-Service)

Eligibility Requirements

All permanent, full time EMPLOYEES who work a minimum of 35 hours per week who are hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the GROUP's eligibility requirements.

Employees are eligible on the first day of the month following 1 month of continuous employment.

The Dependent Age Limit under this Contract is to age: 26

Monthly Premiums

Administrative Services fee:
 Composite - \$3.18 per month per Subscriber

This rate is contingent upon the enrollment of a minimum of 100 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the GROUP for member coverage and 63 percent of cost paid by the GROUP for dependent coverage.

In addition to the administrative service fee, the GROUP agrees to reimburse Delta Dental for claims payments as described in section 2.02 of this contract.

This plan requires a minimum of 500 enrolled primary Subscribers. The GROUP will be billed for the greater of the actual number of Subscribers or the minimum number of Subscribers.

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Benefits

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays
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Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			

Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Implant Repair - implant maintenance, repair, and removal	50%	50%	50%
Prosthodontic Services - bridges and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19	from the age of 1 to the end of the month of age 19

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
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Deductible: \$50 deductible per person total per calendar year limited to a maximum deductible of \$150 per family per calendar year. The deductible does not apply to oral exams, prophylaxis, fluoride, x-rays, periodontal maintenance, full mouth debridement, diagnostic casts, photos, and orthodontics.

Maximum Payment: \$1,200 per person total per calendar year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. \$1,000 per person total per lifetime on cephalometric film, photos, diagnostic casts, and orthodontic services.

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between **Delta Dental of Tennessee** and **Sullivan County Government**.

It is agreed and understood that effective **7/1/2010 – 06/30/2013**

Monthly Premium:

Per EMPLOYEE Per Month: \$3.18

Please attach to your contract. No other action is necessary.

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between
Delta Dental Plan of Tennessee and Sullivan County Government

It is agreed and understood that effective: 7/1/2008 - 06/30/2010

Monthly Premium:

Per EMPLOYEE Per Month: \$3.18

Please attach to your contract. No other action is necessary.

Thursday, April 17, 2008

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between
Delta Dental Plan of Tennessee and Sullivan County Government

It is agreed and understood that effective: 7/1/2006 - 6/30/2008

Monthly Premium:

Per EMPLOYEE Per Month: \$3.18

Please attach to your contract. No other action is necessary.

Thursday, April 20, 2006

**Delta Dental Plan of Tennessee
Declaration Page**

Group Name: Sullivan County Government Group Number 4044
 Group Address: 3411 Hwy 126, Ste 202
 City: Blountville State: TN Zip: 37617
 Effective Date: July 01, 2000 Contract Term: July 01, 2004 - June 30, 2006
 Benefit Year: Calendar Year
 Type of Coverage: Delta Premier

Eligibility Requirements

All permanent, full time EMPLOYEES (i.e. those who work a minimum of 35 hours per week) hired on or prior to the EFFECTIVE DATE are eligible for enrollment on the EFFECTIVE DATE or when they have met the group's eligibility requirements.

EMPLOYEES hired after the EFFECTIVE DATE:

Employees are eligible on the first day of the month following 1 month of continuous employment.

Coverage for DEPENDENTS is allowed under this CONTRACT.

Minimum number/percentage of EMPLOYEES who must enroll in the dental plan is 100%

This plan requires a minimum of 500 enrolled primary SUBSCRIBERS. The GROUP will be billed for the greater of the actual number of SUBSCRIBERS or the minimum number of SUBSCRIBERS.

Monthly Premiums Basis of Payment: Administrative Service Contract

Per Employee Per Month: \$3.18

PREMIUMS will be deemed delinquent if not paid as billed and received by the 5th of each month.

Benefits

Co-pay percentage to be paid by Delta Dental Plan of Tennessee (subject to DEDUCTIBLES and maximums)

Diagnostic and Preventive	100 %	Periodontics	80 %
Radiographs	100 %	Complex Oral Surgery	80 %
Sealants	80 %	Major Restorative	50 %
Basic	80 %	Prosthodontics	50 %
Endodontics	80 %	Orthodontics	50 %
Special Benefits			

Deductibles for each calendar year shall be: Per Member \$ 50
 Maximum per family \$ 150

The DEDUCTIBLE does not apply to Diagnostic and Preventive benefits.

Maximum Amounts Payable

For all benefits except Orthodontic benefits, the Calendar Year annual maximum payment by DDPT shall not exceed \$ 1000

For Orthodontic benefits, the Lifetime Maximum payment by DDPT shall not exceed: \$ 1000

Orthodontic benefits are available to age 19

NAB: Not A Benefit
NA: Not Applicable

4/16/2004

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between
Delta Dental Plan of Tennessee and Sullivan County Government

It is agreed and understood that effective **7/1/2003**

Monthly Premium:

Per EMPLOYEE Per Month: \$3.09

Please attach to your contract. No other action is necessary.

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between
Delta Dental Plan of Tennessee and Sullivan County Government

It is agreed and understood that effective **1/1/2003**: 1.19 "Open Enrollment Period"
shall be the month of October each year to be effective January 1st the following year.

Need endorsement that says
Effective 1/1/03
1.19 "Open Enrollment Period" shall ~~now~~ be
the month of October each year to
be effective January 1st the following
year.

Please attach to your contract. No other action is necessary.

February 5, 2003

Policy Endorsement No. 4044

Attached to and forming a part of the agreement to provide Dental Care Benefits between
Delta Dental Plan of Tennessee and Sullivan County Government

It is agreed and understood that effective **7/1/2002**

Monthly Premium:

Per EMPLOYEE Per Month: \$3.09

Please attach to your contract. No other action is necessary.

GROUP PREPAID DENTAL CARE SERVICE CONTRACT

**ACCEPTANCE
AND
CONTRACT**

The issuance of this signed CONTRACT by DDPT acknowledges acceptance of the GROUP's application for coverage. The coverage detailed in this CONTRACT is extended to the GROUP at the rates stated in and upon the terms and conditions set out in this CONTRACT including all schedules, endorsements and amendments.

So long as GROUP pays the PREMIUM as agreed, DDPT agrees to provide the BENEFITS described in this CONTRACT. BENEFITS will start at 12:01 AM Standard Time on the EFFECTIVE DATE. This CONTRACT will continue for the period of time shown on the Declaration Page and after that will be extended as described in this CONTRACT, unless ended in accordance with ARTICLE 7.

Any changes to the rates, terms or conditions of this CONTRACT will only be effective when issued in writing by DDPT and signed by the appropriate officer of DDPT. No agent or broker or other employee of DDPT or GROUP has the authority to change or waive any provisions of this CONTRACT.

This CONTRACT is issued on this the 1st day of July, 2000, by,

Delta Dental Plan of Tennessee



President & Chief Executive Officer
Title

Delta Dental Plan of Tennessee
GROUP PREPAID DENTAL CARE SERVICE CONTRACT

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ARTICLE 1. DEFINITIONS

As used in this CONTRACT:

- 1.01 **"BENEFITS"** means the amounts that DDPT will pay for dental services under this CONTRACT.
- 1.02 **"BENEFIT YEAR"** is the period from January 1 to December 31 of the same calendar year, unless otherwise defined on the Declaration Page. No benefit period will begin before the EFFECTIVE DATE of the MEMBER'S coverage.
- 1.03 **"CLAIM FORM"** is the standard Attending Dentist Statement form used to file a claim or request predetermination of BENEFITS.
- 1.04 **"COBRA-MEMBER"** is a MEMBER who ceases to be eligible as a SUBSCRIBER or DEPENDENT, but chooses to continue coverage as allowed under 29 USC § 1161 et seq. or an applicable state continuation of coverage provision.
- 1.05 **"CONTRACT"** is this agreement between DDPT and GROUP, including the Application, Declaration Page, all Schedules and all Endorsements and Amendments as issued by DDPT.
- 1.06 **"CONTRACT TERM"** is the time starting with the EFFECTIVE DATE and ending 12 months later, plus any renewals or extensions. The CONTRACT TERM will end with the termination or cancellation of the CONTRACT.
- 1.07 **"CONTRACT YEAR"** is the 12 months starting on the EFFECTIVE DATE and each subsequent 12 months while the CONTRACT is in effect.
- 1.08 **"CUSTOMARY FEE"** is a fee that is in the range of USUAL FEE of DENTISTS of similar training and experience for the same service within the specific and limited geographical area (i.e., socio-economic area of the metropolitan area or other socio-economic area).
- 1.09 **"DDPT"** is Delta Dental Plan of Tennessee, a Tennessee Not-for Profit Corporation. As used in this contract, DDPT may refer to Delta Dental Plan of Tennessee acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association.
- 1.10 **"DEDUCTIBLE"** is the amount the MEMBER must pay for services in any calendar year before BENEFITS will be paid by DDPT, subject to limitations shown on the Declaration Page.
- 1.11 **"DENTIST"** is a person licensed to practice dentistry when and where services are performed. DENTIST may also apply to auxiliary personnel legally authorized to perform services under the supervision of a person licensed to practice dentistry.
- 1.12 **"DEPENDENT"** is a DEPENDENT of a SUBSCRIBER who is enrolled in this GROUP program.
- 1.13 **"EFFECTIVE DATE"** is 12:01 AM at the GROUP's address on the date the CONTRACT begins, as shown on the Declaration Page.

- 1.14 **"EMPLOYEE"** is an employee of the GROUP who is eligible for enrollment in the GROUP program.
- 1.15 **"GROUP"** is the employer, association or trust named in the Application.
- 1.16 **"MAXIMUM ALLOWABLE FEE"** is the maximum fee DDPT will pay for a single procedure.
- 1.17 **"MEMBER"** is a SUBSCRIBER or a DEPENDENT who is enrolled in this GROUP's dental program.
- 1.18 **"NON-PARTICIPATING DENTIST"** is any DENTIST who is not a member of DDPT or any other organization that is a member of Delta Dental Plans Association.
- 1.19 **"OPEN ENROLLMENT PERIOD"** is the last month of each CONTRACT YEAR. During this period, EMPLOYEES may change DEPENDENT coverage to be effective on the first day of the next CONTRACT YEAR
- 1.20 **"PARTICIPATING DENTIST"** is a licensed DENTIST who is a member of DDPT or any other organization that is a member of Delta Dental Plans Association, and who has agreed to abide by their rules and regulations.
- 1.21 **"PREMIUM"** is the monthly amount paid by GROUP to DDPT to provide coverage under this CONTRACT. PREMIUM will refer to the administrative fees as well as reimbursement for claims paid.
- 1.22 **"PREVAILING FEE"** is the fee for a single procedure which satisfies the USUAL FEE of most PARTICIPATING DENTISTS.
- 1.23 **"SUBSCRIBER"** is an EMPLOYEE who is enrolled in this GROUP's dental program.
- 1.24 **"USUAL FEE"** is that fee regularly charged and received for a given service by an individual DENTIST (i.e., his own usual fee). If more than one fee is charged for a given service, the fee determined to be the usual fee will not exceed the lowest fee which is regularly charged to or received from patients.

ARTICLE 2. MONTHLY PREMIUMS

- 2.01 GROUP will pay PREMIUMS to DDPT at the address shown in ARTICLE 6 or to any other address as directed by DDPT. GROUP will pay monthly PREMIUMS in the amount and manner shown on the Declaration Page or on a subsequently issued endorsement or amendment.

PREMIUMS for COBRA-MEMBERS will be the same as for MEMBERS with the same coverage. GROUP will pay monthly PREMIUMS for COBRA-MEMBERS to DDPT. GROUP may charge COBRA-MEMBERS for their coverage as permitted by 29 USC § 1162.
- 2.02 DDPT will administer the dental benefits for GROUP'S self insured dental benefit plan in accordance with this contract. Weekly, each Tuesday, DDPT will transmit via fax, an invoice showing the total of the claims payments processed the previous week. GROUP

will issue payment by electronic transfer payable to DDPT so that it arrives at the address designated by DDPT, before the end of that week. Monthly, DDPT will mail GROUP a report showing all claims payments. Should any of these days fall upon a holiday, the next business day will be substituted.

Before the first of each month, DDPT will invoice GROUP for the administrative fee for this dental program. Payment for this is due by the 10th of the month and may be made by check, wire, or ACH.

At least quarterly, DDPT will give GROUP credit for voided checks and refunds received by DDPT on behalf of GROUP.

If any payment by GROUP is made by wire or ACH, a fax confirming the date and amount of the transfer should be forwarded to DDPT at (615) 244-8108, ATTENTION: Accounts Receivable.

Since GROUP is self insured and will be funding the claim payments with a week's delay, DDPT will not require a deposit for the purpose of prepaying claims. This will allow DDPT to continue to use its normal claims payment process for issuing checks. If payment is not received on a timely basis, DDPT may require a deposit. If a deposit is required, it will act as an imprest fund from which claims will be paid and then replenished. If a deposit is required, it shall be based upon group size and experience. At the end of the contract, any unused portion of this deposit will be applied toward run out claims with any balance being returned to the GROUP. If a deposit is requested, it will be due within one week and should be sent to Delta Dental Plan of Tennessee, Finance Department, ATTN: Accounts Receivable, 240 Venture Circle, Nashville, Tennessee 37228.

Should DDPT not receive reimbursement for the claims paid or any administrative fee within five (5) calendar days of their due date, DDPT may suspend any further payment of claims. Should DDPT not receive payment within 10 calendar days of its due date, DDPT may cancel its contract with GROUP immediately and pursue collections of all monies owed to DDPT by GROUP plus reasonable collection fees, attorney fees and/or court costs.

2.03 DDPT may change the rate of monthly PREMIUMS whenever the CONTRACT is amended or renewed.

2.04 Term and conditions governing membership enrollment will be found in Schedule E.

ARTICLE 3. LIMITATIONS AND EXCLUSIONS FOR ALL BENEFITS

3.01 DDPT will only pay the BENEFITS stated for each type of dental service described in the schedule or schedules of benefits. Not all dental services are BENEFITS under this contract. BENEFITS will only be provided for MEMBERS who are enrolled on the date of treatment. BENEFITS will be determined based on the date services were completed. Services must be provided by a DENTIST or properly licensed employee of DENTIST. Services must be necessary and customary. Services must be provided by generally accepted dental practice standards, as determined by the dental profession, to be a paid BENEFIT. DDPT will pay allowable BENEFITS based upon the percentages shown on the Declaration Page. Such percentages will be applied to the lesser of the MAXIMUM ALLOWABLE FEE or the fees the DENTIST charges for the service. The MAXIMUM ALLOWABLE FEE for in state NON PARTICIPATING DENTISTS is limited to the PREVAILING FEE.

3.02 OPTIONAL SERVICES

- a) Services that are more expensive than the treatment usually 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: an inlay or crown where an amalgam filling would restore the tooth). BENEFITS for Optional Services will be based on the cost of the usual service. The MEMBER will be responsible for the remainder of the DENTIST'S fee.
- b) Payment made by DDPT for any surgical service will include charges for routine post-operative evaluations or visits.
- c) In the event a MEMBER transfers from one DENTIST to another during the course of treatment, BENEFITS will be limited to the amount that would have been paid had only one DENTIST rendered the service.

3.03 EXCLUSIONS

DDPT does not pay BENEFITS for:

- a) Treatment of injuries or illnesses 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, 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 license.
- k) Dental services for which the MEMBER 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) General Anesthesia or I.V. Sedation is a BENEFIT only when administered by a properly licensed DENTIST in a dental office in conjunction with covered surgical procedures or when necessary due to concurrent medical conditions.

3.04 No change in BENEFITS will become effective during a CONTRACT TERM unless GROUP and DDPT agree in writing.

ARTICLE 4. DEDUCTIBLE, MAXIMUM AND COORDINATION OF BENEFITS

4.01 DDPT will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied. The annual DEDUCTIBLE per MEMBER and per family is shown on the Declaration Page. The DEDUCTIBLE will apply for the calendar year unless noted otherwise on the Declaration Page.

4.02 The DEDUCTIBLE applies to the benefit categories as shown on Declaration Page. Only fees a MEMBER pays for services covered under the benefit schedules included in this CONTRACT will count toward satisfying the DEDUCTIBLE.

4.03 Unless otherwise indicated on the Declaration Page, the DEDUCTIBLE and MAXIMUMS apply each CALENDER YEAR.

4.04 **MAXIMUM**
DDPT will pay up to the Maximum Amount shown on Declaration Page.

4.05 **COORDINATION OF BENEFITS**
If a MEMBER is entitled to coverage under more than one insurance policy or benefit program, the BENEFITS of this CONTRACT will be subject to the following conditions:

- a) If the other program is not primarily a dental program, this program is primary.
- b) If the other program is for dental coverage, the following rules are applied:

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 health care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.
- c) When primary coverage cannot be determined according to a) and b), the program which has covered the patient for the longer period will be primary.

If this coverage is primary, BENEFITS will be provided without regard to any other coverage. If this coverage is not primary, BENEFITS are limited to services which are BENEFITS of this CONTRACT that are not fully paid by any other coverage.

ARTICLE 5. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 CHOICE OF DENTIST. DDPT does not furnish covered services directly. DDPT pays for licensed DENTISTS to provide these services. A MEMBER may choose any DENTIST. MEMBERS should determine for themselves the professional qualification of the DENTIST they select. Participation in DDPT is open to all DENTISTS who are licensed in Tennessee unless they have previously had their participation in DDPT terminated for cause. Whether a DENTIST is a PARTICIPATING or NON-PARTICIPATING DENTIST should not be viewed as a statement about that DENTIST'S ability.

DDPT shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, DDPT cannot ensure your DENTIST'S use of precautions against the spread of such diseases, nor can DDPT compel your DENTIST to be tested for HIV or to disclose test results to DDPT or to you. DDPT informs its PARTICIPATING DENTISTS about the need for clinical precautions as recommended by recognized health authorities on this issue. But if you have questions about your DENTIST'S health status or use of recommended clinical precautions, you should discuss them with your DENTIST.

DDPT is not responsible for any injuries or damages suffered due to the actions of any provider. DDPT is also not liable for a DENTIST's refusal or failure to provide services.

5.02 CLINICAL EXAMINATION. Before approving a claim, DDPT may obtain from any DENTIST or hospital such information and records DDPT may require to administer the claim. DDPT may require a MEMBER be examined by a dental consultant, retained by DDPT, in or near his community or residence. Such information and records will be kept confidential.

- 5.03 CLAIM FORMS.** DDPT will furnish to any DENTIST or MEMBER a standard CLAIM FORM to make a claim for payment of BENEFITS. To make a claim, the form must be properly completed and submitted to DDPT. Electronic claims may be accepted but require supporting documentation be maintained by the DENTIST.
- 5.04 PREDETERMINATION.** A DENTIST may file a CLAIM FORM showing the services he or she recommends. DDPT then will predetermine the BENEFITS payable under this CONTRACT. Payment will only be made for predetermined services if the MEMBER remains eligible and has not exceeded his or her annual maximum BENEFITS. A CLAIM FORM requesting a predetermination may be submitted electronically.
- 5.05 PROOF OF LOSS.** Proof of loss must be furnished to DDPT within 12 months after completion of treatment for which BENEFITS are payable. Any claim filed after this period will be denied.
- 5.06 REVIEW OF CLAIMS DENIAL.** DDPT will give the SUBSCRIBER reasons why any payment for services are denied. A SUBSCRIBER has 60 days after receiving a notice of denial to appeal it. All appeals to DDPT must be in writing, giving reasons the denial was wrong. The SUBSCRIBER may also ask to examine any records to aid his or her appeal.
- DDPT 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 DDPT receives the appeal request.
- If the SUBSCRIBER does not agree with the review decision, he or she may refer the appeal to the Peer Review Committee of DDPT.
- GROUP, in its roll as the fiduciary for this program, will have the responsibility for final decisions relating to the payment of all benefits.
- 5.07 TERMINATION OF BENEFITS ON LOSS OF ELIGIBILITY.** DDPT will not pay BENEFITS for any services received by a patient who is not eligible at the time of treatment. GROUP will repay DDPT for any payments made because of errors in reporting required of the GROUP.
- 5.08 TO WHOM BENEFITS ARE PAID.** BENEFITS provided under this CONTRACT will be paid as follows:
- a) For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.
 - b) For services provided by a NON-PARTICIPATING DENTIST, payment will be made to SUBSCRIBER unless assigned to the DENTIST.

ARTICLE 6. GENERAL PROVISIONS

- 6.01 ENTIRE CONTRACT: CHANGES.** This CONTRACT, including Schedules, the Application, Declaration Page and any Endorsements or Amendments issued by DDPT make up the entire agreement between the parties. No agent has authority to change this CONTRACT or waive any of its provisions. No change in this CONTRACT will be valid unless made by written amendment signed by an Officer of DDPT.

- 6.02 SEVERABILITY.** If any part of this CONTRACT or any amendment is found to be illegal, void or not enforceable, all other portions will remain in full force and effect.
- 6.03 CONFORMITY WITH STATE LAWS.** The laws of the State of Tennessee will govern this CONTRACT. Any part of this CONTRACT which, on its EFFECTIVE DATE, conflicts with the laws of Tennessee is hereby amended to conform to the minimum requirements of such laws.
- 6.04 LEGAL ACTIONS.** No action at law or in equity will be brought before 60 days after proof of loss has been filed as required by this CONTRACT. Any action must be brought within 3 years from the time proof of loss is required by this CONTRACT. In any case, action may only be brought after a MEMBER has exercised all the review and appeal rights available under this CONTRACT.
- 6.05 CHOICE OF JURISDICTION.** All litigation related to the terms or conditions of this CONTRACT will be in a court of competent jurisdiction in Davidson County, Tennessee.
- 6.06 DOES NOT REPLACE WORKERS' COMPENSATION.** This CONTRACT does not affect any requirements for coverage by Workers' Compensation Insurance.
- 6.07 CERTIFICATE OF INSURANCE.** DDPT will furnish summary plan description booklets for distribution by the Employer to EMPLOYEES. Such booklets will describe available BENEFITS and, where applicable, rights under ERISA and claims review and appeals procedures. The terms of the CONTRACT, will in all cases, be controlling. Should the wording of this CONTRACT and the summary plan description conflict, the CONTRACT will govern.
- 6.08 APPLICATION CONFLICTS.** The terms of the CONTRACT, Schedules of Benefits and Declaration Page, along with any Amendments or Endorsements issued by DDPT, will, in all cases, be controlling. Should the wording of this CONTRACT, Schedule of Benefits or Declaration Page, along with any Amendments or Endorsements issued by DDPT, conflict with the Group Application or proposal, the CONTRACT, Schedules of Benefits and Declaration Pages along with any Amendments or Endorsements issued by DDPT will govern.
- 6.09 PROFESSIONAL RELATIONSHIP.** GROUP and DDPT agree to permit and encourage the professional relationship between DENTIST and patient to be maintained without interference.
- 6.10 NOTICE: WHERE DIRECTED.** All notices under this CONTRACT must be in writing. Notices for DDPT will be addressed to:
Delta Dental Plan of Tennessee
240 Venture Circle
Nashville, Tennessee 37228-1699
Notices to the GROUP will be sent to the address shown on the Declaration Page. All notices will be effective 48 hours after deposit in the United States mail with fully prepaid postage.

6.11 **RIGHT TO RECOVERY.** Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, DDPT will have the right to recover any excess. DDPT will recover the excess from any persons to whom the payment was made, insurance companies or other organizations involved. Any MEMBER covered under this CONTRACT will execute and deliver any necessary documents and do whatever is necessary to secure such rights to DDPT.

6.12 **SUBROGATION.** DDPT assumes the MEMBER'S legal rights to recovery for payment for dental services the patient required because of the action or fault of another. DDPT has the right to recover from the MEMBER any payments made by or for the other party. In such cases, DDPT has the right to recover amounts equal to the BENEFITS paid by DDPT plus all collection cost.

DDPT has the right to make the recovery by suit, settlement or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source such as third party motorist coverage.

The MEMBER must help DDPT make a recovery. They must give requested information and sign necessary papers. If the MEMBER fails to help DDPT, or settles any claim without DDPT's written consent, DDPT may recover from the MEMBER. DDPT will be entitled to any recovery received by the MEMBER and reasonable and necessary attorney's fees and court costs.

6.13 **AMENDMENTS.** This CONTRACT may be amended or canceled by agreement between DDPT and GROUP without the approval of MEMBER.

6.14 **COLLECTIONS.** Should any payment owed DDPT by GROUP be due for more than 30 days, DDPT may pursue any and all collection efforts it deems necessary to collect such payment. GROUP will be responsible for all cost of such collection efforts including but not limited to collection fees, court cost and reasonable legal fees.

6.15 **SUBCONTRACTOR(S) AND AGENT(S).** DDPT may subcontract certain functions or appoint an agent or agents to act on DDPT's behalf and fulfill expressed, limited duties under this contract. Such agent(s) have no authority to change or modify this agreement.

6.16 **PARTICIPATING DENTISTS WITHHOLD.** DDPT and other members of the Delta Dental Plans Association have agreements with PARTICIPATING DENTISTS that allow payments to be based on the MAXIMUM ALLOWABLE FEES. These agreements provide that DDPT or other members of the Delta Dental Plans Association may deduct and retain a Withhold from payments to PARTICIPATING DENTISTS. Amounts deducted as Withhold are considered to have been paid in the discharge of the claims of the PARTICIPATING DENTIST. PARTICIPATING DENTISTS agree that the Withhold will not increase the charges to program beneficiaries.

ARTICLE 7. RENEWAL AND CANCELLATION

7.01 At the end of CONTRACT TERM, DDPT must give the GROUP 30 days notice of any change of PREMIUM or BENEFITS. Such notice will renew the CONTRACT unless GROUP provides written notice of cancellation

7.02

This CONTRACT may be canceled only as follows:

- a) By GROUP with 15 days written notice at the end of a CONTRACT TERM.
- 2) By DDPT with 30 days written notice at the end of a CONTRACT TERM.
- c) By DDPT, if GROUP:
 - 1) does not furnish DDPT a listing of all EMPLOYEES as required under Schedule E; or,
 - 2) does not permit DDPT to inspect GROUP'S records as called for under Schedule E; or,
 - 3) does not pay PREMIUM, as required by ARTICLE 2; or
 - 4) misrepresents any information required in the CONTRACT; or
 - 5) does not meet the underwriting guidelines established for the program described on the Declaration Page.

7.03

DDPT must give GROUP 10 days written notice to cancel the CONTRACT because GROUP did not pay PREMIUM. Cancellation for any other reason requires 30 days written notice.

If the CONTRACT is canceled, GROUP will owe DDPT all unpaid PREMIUMS due prior to cancellation. Should GROUP fail to pay DDPT PREMIUMS through the cancellation date within 10 days of cancellation, DDPT may collect the greater of any unpaid premium or the reimbursement for any claim payments made plus an administrative fee equal to 12% of the claim payments.

7.04

DDPT will not continue to pay BENEFITS for services performed after the cancellation date of this CONTRACT.

ARTICLE 8. ATTACHMENTS

These documents are attached to this CONTRACT and made a part of it:

SCHEDULE A - DIAGNOSTIC AND PREVENTIVE BENEFITS AND LIMITATIONS AND EXCLUSIONS.

SCHEDULE B - BASIC BENEFITS AND LIMITATIONS AND EXCLUSIONS

SCHEDULE C - CROWNS AND CAST RESTORATIONS, PROSTHODONTIC BENEFITS AND LIMITATIONS AND EXCLUSIONS

SCHEDULE D – ORTHODONTIC BENEFITS, LIMITATIONS AND EXCLUSIONS

SCHEDULE E - ELIGIBILITY AND ENROLLMENT

Group Application

Declaration Page

Delta USA Endorsement

**DELTA DENTAL PLAN OF TENNESSEE
SCHEDULE A
DIAGNOSTIC AND PREVENTIVE BENEFITS
AND
LIMITATIONS AND EXCLUSIONS**

A1.00 DIAGNOSTIC AND PREVENTIVE BENEFITS

- a) Diagnostic - oral examination to aid the DENTIST in planning required dental treatment
- b) Preventive - prophylaxis (cleaning)
 - topical application of fluoride
 - space maintainers

A2.00 LIMITATIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

- a) DDPT will pay for two oral exams and cleanings, to include periodontal maintenance procedures, in any 12-month period.
- b) DDPT will pay for full mouth x-rays once within 3 years unless special need is shown.
- c) DDPT will pay for one set of bite-wing x-rays in a 12 month period.
- d) DDPT will not pay for topical application of fluoride for a MEMBER 19 years or older.
- e) DDPT will not pay for adult prophylaxis for MEMBERS under 14 years of age.
- f) DDPT will not pay for a space maintainer for a MEMBER more than 14 years of age.
- g) General Limitations and Exclusions found in Article 3 of this CONTRACT also apply to Diagnostic and Preventive Benefits.

**DELTA DENTAL PLAN OF TENNESSEE
SCHEDULE B
BASIC BENEFITS
AND
LIMITATIONS AND EXCLUSIONS**

B1.00 BASIC BENEFITS

- a) Oral Surgery extractions and other surgical procedures (including pre- and post-operative care)

- b) General Anesthesia & I.V. Sedation 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.

- c) Endodontia treatment of the dental pulp (root canal procedures)

- d) Periodontia treatment of the gums and bones that surround the tooth

- e) Sealants resin filling used to seal grooves and pits on the chewing surface of permanent molar teeth

- f) Denture Repairs services to repair complete or partial dentures.

- g) Basic Restorations amalgam (silver fillings), composites (white fillings), and prefabricated stainless steel crown restorations for the treatment of decay.

B2.00 LIMITATIONS ON BASIC BENEFITS

- a) Restorative BENEFITS are allowed once per surface in a 24 month period, irrespective of the number or combinations of procedures requested or performed.

- b) 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.

- c) 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.

- d) 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 16 years of age. Only one BENEFIT will be allowed for each tooth within a lifetime.

- e) The replacement, by the same DENTIST or dental office, of amalgam or composite restorations within 24 months is not a BENEFIT.

- f) DDPT will pay for the use of composite fillings on the facial (outside) surfaces of the bicuspid teeth. DDPT will consider any composite fillings used in molars or on the chewing surfaces of bicuspid teeth an Optional Service.
- g) DDPT will not pay for the replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within a 24 month period of the initial placement.
- h) DDPT will not pay for the replacement of a stainless steel crown on a permanent tooth by the same dentist or dental office within a 60 month period off the initial placement.
- i) DDPT will consider any gold foil restoration as an Optional Service.
- j) Any graft using synthetic materials.
- k) General Limitations and Exclusions found in Article 3 of this CONTRACT also apply to Basic Benefits.

**DELTA DENTAL PLAN OF TENNESSEE
SCHEDULE C
CROWNS AND CAST RESTORATIONS
PROSTHODONTIC BENEFITS
AND
LIMITATIONS AND EXCLUSIONS**

C1.00 CROWNS AND CAST RESTORATIONS

Crowns and cast restorations 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.

C2.00 LIMITATIONS ON CROWNS AND CAST RESTORATIONS

- a) DDPT will not pay to replace any crowns or cast restorations received in the previous five years. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same DENTIST within a 12 month period.
- b) DDPT will not pay for a crown or cast restoration on a tooth that can be restored with an amalgam or composite restoration.
- c) Procedures for purely cosmetic reasons are not a BENEFIT.
- d) Porcelain, gold or veneer crowns for children under 12 years of age are not a BENEFIT.
- e) General Limitations and Exclusions found in Article 3 of this CONTRACT also apply to crowns and cast restorations

C3.00 PROSTHODONTIC BENEFITS

- a) Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
- b) Complete or Partial Denture Reline chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums)
- c) Complete or Partial Denture Rebase laboratory replacement of the acrylic base of the appliance

C4.00 LIMITATIONS ON PROSTHODONTIC BENEFITS

- a) DDPT will not pay to replace any fixed bridges or partial or complete dentures that the MEMBER received in the previous five years. DDPT will not pay to replace a bridge or denture unless it cannot be made satisfactory.
- b) Payment for a complete or partial denture shall include charges for any necessary adjustment within a six month period. 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.
- c) DDPT limits payment for standard dentures 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.

- d) DDPT will not pay for implants (artificial materials implanted into or on bone or gums) or their removal. DDPT will make an allowance for a standard complete or partial denture toward the cost of replacing multiple missing teeth. For single tooth implants, DDPT will make an allowance for a pontic but not for the placement of the implant.
- e) DDPT does not pay for fixed bridges or cast partials for children under 16 years of age.
- f) A posterior bridge where a partial denture is constructed in the same arch is not a covered BENEFIT.
- g) Temporary partial dentures are a BENEFIT only when upper anterior teeth are missing.
- h) General Limitations and Exclusions found in Article 3 of this CONTRACT also apply to Prosthodontic Benefits and Crowns and Cast Restorations.

**DELTA DENTAL PLAN OF TENNESSEE
SCHEDULE D
ORTHODONTIC BENEFITS
AND
LIMITATIONS AND EXCLUSIONS**

D1.00 ORTHODONTIC BENEFITS

As shown on the Group Variables page, DDPT will pay BENEFITS for procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a BENEFIT.

D2.00 LIMITATIONS ON ORTHODONTIC BENEFITS

- a) Orthodontic benefits are limited to MEMBERS shown on the Declaration Page.
- b) DDPT shall make regular payments for orthodontic benefits.
- c) If treatment has begun, DDPT will begin BENEFITS with the first payment due after the MEMBER becomes eligible.
- d) BENEFITS end with the next payment due after loss of eligibility. BENEFITS end immediately if treatment stops or at the end of this CONTRACT.
- e) BENEFITS are not paid to repair or replace any orthodontic appliance received.
- f) Orthodontic BENEFITS are not paid for extractions or other surgical procedures. Other services may be covered under Diagnostic, Preventive or Basic BENEFITS.

D3.00 ORTHODONTIC PAYMENT METHODOLOGY

- a) The initial payment (initial banding fee) made by DDPT for comprehensive treatment is 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.
- b) 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.

**DELTA DENTAL PLAN OF TENNESSEE
SCHEDULE E
ELIGIBILITY AND ENROLLMENT**

E1.01 All permanent full time EMPLOYEES of GROUP on the EFFECTIVE DATE will be eligible to enroll in this GROUP dental program. Other permanent EMPLOYEES will be eligible on the first of the month after they have worked full time for the number of months shown on the Declaration Page.

E1.02 DEPENDENTS will become eligible along with the EMPLOYEE or as soon after that as they become DEPENDENTS. The following family members of the EMPLOYEE may be considered DEPENDENTS:

- a) Lawful husband or wife;
- b) Children from birth to their 24th birthday. "Child" includes a natural child, step child, adopted child or foster child. The child must be dependent on the employee for at least 50% of support and maintenance. The child must not be married.

A child 24 years or older may continue to be eligible. Such DEPENDENT child must meet the support, maintenance and marriage tests above. In addition the child must not be able to support themselves because of mental incapacity or physical handicap. Such disabling condition shall have begun before age 24. Proof of these facts must be given to DDPT or GROUP within 31 days if requested. Proof will not be required more than once a year.

E1.03 DEPENDENTS in military service are not eligible.

E1.04 Any EMPLOYEE who does not elect coverage, before entering the group, must satisfy all eligibility requirements to entering the GROUP. The application for coverage is subject to DDPT'S approval. Such EMPLOYEE may only enter the GROUP during an OPEN ENROLLMENT PERIOD.

E1.05 Any MEMBER who drops coverage may only re-enter the GROUP during the first OPEN ENROLLMENT PERIOD after having been out of the plan for 24 consecutive months.

E1.06 For coverage to be in effect, DDPT must have received the enrollment information and the payment of that month's PREMIUM. The monthly PREMIUM for a MEMBER must have been paid for coverage to be in effect for that month.

E1.07 GROUP will be responsible for enrolling all MEMBERS. Enrollment information must be furnished to DDPT in a timely manner. Enrollment must be reported using one of DDPT's standard formats. If special programming is need to accommodate GROUP's eligibility format, the cost will be billed to the GROUP.

E1.08 By the EFFECTIVE DATE of the program, GROUP will furnish eligibility information for all EMPLOYEES. This information shall include the EMPLOYEE'S name, social security number, date of birth, date of hire, DEPENDENT coverage information and location code. GROUP may submit this information by electronic media or by completing dental enrollment cards provided by DDPT. GROUP will report EMPLOYEES hired after the EFFECTIVE DATE and COBRA-MEMBERS as described above.

- E1.09** Unless eligibility is reported by electronic media or DDPT has agreed to allow the GROUP to self bill, DDPT will provide to GROUP each month a listing of EMPLOYEES as reported to DDPT. GROUP will confirm continued eligibility of EMPLOYEES and return the listing to DDPT by the 10th day of the month. DDPT will not pay BENEFITS for an EMPLOYEE or his or her DEPENDENTS if the EMPLOYEE is not on the listing.
- E1.10** DEPENDENTS may be enrolled under the following rules:
- a) DEPENDENTS must enroll at the time the SUBSCRIBER becomes eligible, or as soon after that as they become DEPENDENTS. Otherwise DEPENDENTS may only enroll during an OPEN ENROLLMENT PERIOD.
 - b) After enrollment, DEPENDENT coverage shall continue while the SUBSCRIBER has coverage. DEPENDENT coverage shall cease if they no longer meet the definition of DEPENDENT or the SUBSCRIBER chooses to drop DEPENDENT coverage. If DEPENDENT coverage is dropped, DEPENDENTS may re-enter the GROUP during the first OPEN ENROLLMENT PERIOD after having been out of the plan for 24 consecutive months..
 - c) A minimum percentage of EMPLOYEES with DEPENDENTS must enroll all their DEPENDENTS. DEPENDENTS covered by another group plan are not counted in this requirement. The minimum percentage is shown on the Declaration Page.
- E1.11** The GROUP will be allowed to continue BENEFITS during a MEMBER'S unpaid leave of absence as determined by the policy of the GROUP. If it is the policy of the GROUP not to continue BENEFITS for an unpaid leave of absence, the MEMBER will not have coverage during this leave. Coverage will resume on the first day of the month after the EMPLOYEE returns to work. MEMBERS may continue coverage under 29 USC § 1161 et seq. or an applicable state continuation of coverage provision when the EMPLOYEE is on strike or layoff.
- E1.12** If it is the policy or legal responsibility of the GROUP to continue coverage during a leave of absence, the GROUP will be responsible for the timely payment of all PREMIUMS due to DDPT for the EMPLOYEE on leave of absence. The employer must continue to consider the person a permanent EMPLOYEE and all other GROUP benefits, including dental, must be continued.
- E1.13** An EMPLOYEE loses coverage when employment benefits are terminated by the GROUP at the end of employment or at the end of the CONTRACT. DEPENDENTS lose coverage along with the EMPLOYEE, or earlier if they lose their DEPENDENT status. Subscribers lose coverage at the end of the month.
- E1.14** Possession of an I.D. card does not guarantee a MEMBER is eligible for BENEFITS. Eligibility is based upon information reported to DDPT by the GROUP. Eligibility may be confirmed by calling DDPT's Customer Service representatives.
- E1.15** DDPT will not continue to pay BENEFITS for any MEMBERS when they lose eligibility. As provided by 29 USC § 1161 et seq. or an applicable state continuation of coverage provision, coverage may continue for up to 18 months where the EMPLOYEE'S coverage ends as a result of a reduction in work hours or termination of employment. Coverage may not continue if the termination is as a result of gross misconduct.

Under 29 USC § 1161 et seq. or an applicable state continuation of coverage provision, DEPENDENTS may continue coverage under this CONTRACT for up to 36 months. To continue coverage, the DEPENDENT must be a:

- (1) surviving spouse or child of a deceased EMPLOYEE,
- (2) separated or divorced spouse,
- (3) DEPENDENT ineligible for Medicare who reaches the limiting age or otherwise ceases to meet the definition of DEPENDENT.

In any case, coverage shall end if the MEMBER fails to pay the required PREMIUM, becomes eligible for Medicare, obtains other group coverage or the GROUP cancels group dental coverage.

MEMBERS must choose whether or not to continue their coverage. MEMBERS have 60 days to make such an election. The 60-day period shall start at the earlier of the date the MEMBER'S coverage would otherwise end or the date the MEMBER receives notice of his rights.

EMPLOYEE is responsible for notifying the GROUP within 60 days of any change(s) in eligibility. EMPLOYEE should tell GROUP of changes in DEPENDENT status, divorce, or eligibility for Medicare.

E1.16 As plan administrator, it will be the GROUP'S responsibility to tell EMPLOYEES and DEPENDENTS of their rights under this CONTRACT.

E1.17 GROUP will let DDPT inspect GROUP'S records to verify that the listing of EMPLOYEES is correct and to confirm compliance with ARTICLE 2. DDPT will give GROUP reasonable written notice before the date of the inspection.

DELTA DENTAL PLAN OF TENNESSEE

DECLARATION PAGES

GROUP NAME Sullivan County Government GROUP NUMBER 4044
GROUP ADDRESS P.O. Box 529
CITY Blountville STATE TN ZIP 37617
EFFECTIVE DATE July 1, 2000 CONTRACT TERM 2 years
BENEFIT YEAR July 1, 2000 – June 30, 2002
DDPT Coverage: Delta Premier Delta Preferred (DPO)
 Other: ASC Group
 Tennessee USA

ELIGIBILITY REQUIREMENTS

All permanent, full-time **EMPLOYEES** (i.e. those **EMPLOYEES** who work a minimum of 35 hours (per week) hired on or prior to the **EFFECTIVE DATE** are eligible for enrollment on the **EFFECTIVE DATE** or when they have met the group's eligibility requirements.

EMPLOYEES hired after the **EFFECTIVE DATE** are eligible on the first day of the month following 1 month of continuous employment.

Coverage for dependents is allowed under this CONTRACT.

MINIMUM NUMBER/PERCENTAGE OF EMPLOYEES WHO MUST ENROLL IN THE DENTAL PLAN 100 %

MINIMUM PERCENTAGE OF EMPLOYEES WITH ELIGIBLE DEPENDENTS WHO MUST ENROLL IN THIS DENTAL PLAN 50 %

MONTHLY PREMIUMS

Basis of Payment: Prepaid Dental Plan \$ 3.03* Administrative Services Contract (ASC)

Day of the month when premiums will be deemed delinquent 5th of each month

* Group will be billed weekly

BENEFITS COVERAGE AND PERCENTAGE TO BE PAID BY DELTA DENTAL (SUBJECT TO DEDUCTIBLES AND MAXIMUM AMOUNTS PAYABLE)

Diagnostic and Preventive Benefits	<u>100</u> %	Prosthodontic Benefits	<u>50</u> %
Basic Benefits	<u>80</u> %	Orthodontic Benefits	<u>50</u> %
Crowns and Cast Restorative Benefits	<u>50</u> %		

DEDUCTIBLES - For each CALENDAR YEAR the DEDUCTIBLES shall be as follows:

For Each MEMBER \$ 50.00 Maximum for Each Family \$ 150.00

The DEDUCTIBLE does not apply to Diagnostic and Preventive Services

MAXIMUM AMOUNTS PAYABLE

For all BENEFITS except Orthodontic Benefits, the CALENDAR YEAR annual maximum payment by DDPT shall not exceed:

\$ 1000.00

Orthodontic Benefits (Lifetime Maximum Amount)

\$ 1000.00

ORTHODONTIC BENEFITS are limited to:

Dependent Children to Age 19

NA NOT APPLICABLE
NAB NOT A BENEFIT

THIS PLAN REQUIRES A MINIMUM OF 500 ENROLLEES TO ELECT COVERAGE. THE GROUP WILL BE BILLED FOR THE ACTUAL NUMBER OF ENROLLEES OR THE MINIMUM NUMBER OF EMPLOYEES, WHICHEVER IS GREATER.

DELTA DENTAL PLAN OF TENNESSEE
240 VENTURE CIRCLE
NASHVILLE, TENNESSEE 37228

NEW GROUP APPLICATION

- 1. Name of Group Sullivan County Gort Phone No. 423-323-6413
Address P.O. Box 529 Fax No. 423-283-2699
City Blountville State TN Zip 37617 Tax ID No. 62-6000-858
- 2. Group Executive Gil Hodges Title Co. Executive Phone No. 423-323-6417
- 3. Administrative Contact Gayvern Moore Title Payroll Emp. Bene Manager Phone No. 423-323-6413
- 4. Nature of Business or Industry County Gort
- 5. Business/Industry is presently organized as a:
Proprietorship Partnership Corporation Other (Specify) _____
- 6. Effective Date 7-1-2000 7. Contract Date 6-30-2002
- 8. Group Contribution. The Group will contribute the following amount(s) toward the monthly premium:
100 % or \$ _____ For SUBSCRIBER 63 % or \$ _____ For Dependent

ELIGIBILITY REQUIREMENTS

- 9. All permanent, Full-time Employees (i.e. those Employees who work a minimum of 35 hours per week) hired on or prior to the Effective Date of the Contract are eligible for enrollment on the Effective Date or when they have met the group's eligibility requirements. (Indicate under special eligibility conditions, group's eligibility requirements.)

Employees hired after the Effective Date are eligible on the first day of the month following completion of 1 months of continuous employment of 35 hours per week.

Children to age 24 unless an ASC contract then to age N/A

Other classes of Eligible/Ineligible Employees N/A

Other special eligibility conditions N/A

PLAN DESCRIPTION

11. Program Type: Delta Premier Delta Preferred Option _____ Delta Care _____

12. Administered as: Tennessee Plan DeltaUSA Plan _____

13. Covered Services and the Percentages Payable (Check one for each type of service selected):

For Diagnostic and Preventive Care	<u>100%</u>	60%	<u>100</u> %
For Basic Care	100%	<u>80%</u>	<u>80</u> %
For Crown and Cast Restorations and Prosthodontia (if included)	80%	<u>50%</u>	<u>50</u> %
For Orthodontia Care for dependents to age 19(if selected)		<u>50%</u>	<u>50</u> %
For Orthodontia Care for all members (If selected)		50%	_____ %
Other (Specify) _____			

14. Annual Deductibles (applied on a Calendar Year basis):
 Per Individual: \$ 50.00 Family: \$ 150.00
 Deductible applies to A Coverage B Coverage C Coverage Check all that apply)
15. Annual Maximum for services other than Orthodontia (applied on a Calendar Year basis):
 \$500 \$1000 \$1500 \$ 1,000.00
16. Lifetime Maximum for Orthodontia (if selected):
 \$500 \$1000 \$1500 \$ 1,000.00
17. Total Number of Eligible Employees Census Data 712
18. Number of Employees enrolled in current Dental Plan (if applicable):
 SUBSCRIBER Only _____ → 345
 SUBSCRIBER plus Spouse _____
 SUBSCRIBER plus Child(ren) _____
 Family _____ → 367
 TOTAL _____ → 712

PREMIUMS

19. Fully insured (per month) N/A
- | | Two Tiered | Three Tiered | Four Tiered |
|------------------------------|------------|--------------|-------------|
| SUBSCRIBER only | \$ _____ | \$ _____ | \$ _____ |
| SUBSCRIBER and Spouse | \$ _____ | \$ _____ | \$ _____ |
| SUBSCRIBER and Child(ren) | \$ _____ | \$ _____ | \$ _____ |
| SUBSCRIBER and One Dependent | \$ _____ | \$ _____ | \$ _____ |
| Family | \$ _____ | \$ _____ | \$ _____ |
20. Administrative Services Contract
 Per SUBSCRIBER per month \$ 303 or _____ % of paid claims
 Prefund Required \$ 0

OTHER INFORMATION

21. Will this plan replace a present dental plan through another carrier? Yes No
 If Yes, present Insurer's name: BLUE CROSS / BLUE SHIELD TN
 Termination date of current plan: 6/30/2000
22. The Group agrees that it will provide to DDPT a current list of eligibles by the tenth (10th) of each month.
23. The Group agrees to:
 a) pay the initial month's premium and thereafter the monthly premiums billed by DDPT; or
 b) any Prefund, if applicable, as determined by DDPT.
24. For coverage to be effective, a minimum of 1 or 100 % of eligible Employees must be enrolled. For Orthodontia coverage to be effective, a minimum of 1 or 100 % of eligible employees with dependents must enroll their dependents. Thereafter, the Group agrees to maintain the above stated enrollment minimums and give all eligible employees an opportunity to enroll in the plan.

ERISA INFORMATION

(THIS INFORMATION, IF APPLICABLE TO YOUR AGREEMENT, IS REQUIRED FOR EMPLOYEE RETIREMENT INCOME SECURITY ACT COMPLIANCE.)

Plan Sponsor Sullivan County Govt Plan Administrator Group Insurance Services

Plan Identification Number _____ Sponsor's Employee ID Number _____

Agent for Service of Legal Process Group Insurance Services

Address for Service of Legal Process: Street 801 Pine St

City Chattanooga State Tn Zip 37401 Telephone: () _____

Ending Date of Plan's Fiscal Year: Month Jan 1 - Dec 31 Day _____

Form 5500 (Schedule A) Required? Yes No If YES, send to

Sullivan County Payroll, PO Box 529, Blountville TN 37617

Indicate the Plan Category (check one): Single Employer Plan Multi-Employer Plan _____

Trade or Association Plan maintained by a group of employees who are financially related

Other (Specify) _____

Indicate sources of contribution to the Plan (Check all applicable):

Employer Employee Organization (Union, etc.) Employee Other (Specify) _____

CERTIFICATION

This is to certify that the information contained in this Application is true, complete and accurate. It is understood that the rates, terms and conditions of any related contract issued by DDPT shall be based upon the representations in this Application and other information previously provided to DDPT. It is further understood that if any information or representation is not true, complete or accurate, that DDPT may adjust the rates, terms or conditions and/or cancel any CONTRACT. This Application shall become a part of the CONTRACT issued by DDPT.

Certified by: SULLIVAN COUNTY

Group

Nelda P. Huise
Signature

5/18/2000
Date

NELDA P. HUISE
Printed Name

PURCHASING AGENT
Title

AGREEMENT

GROUP hereby agrees that if DDPT accepts this Application and issues a signed CONTRACT, the GROUP shall be bound by the terms and conditions of said CONTRACT. GROUP further agrees to pay the PREMIUMS defined in said CONTRACT in accordance with the terms of said CONTRACT. GROUP also recognizes that this CONTRACT may only be modified by written document issued by DDPT as defined in the CONTRACT.

Executed this 18TH day of

MAY 2000

Nelda P. Huise
Group's Authorized Signature

PURCHASING AGENT
Title

In addition to the above, I certify that I have explained the terms and conditions of this coverage to the representatives of the GROUP.

David L. Hamilton
Agent/Broker

5/18/2000
Date