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State of Tennessee Dental Preferred Provider Organization (DPPO) Program
Certificate of Coverage

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Introduction

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

I. Eligibility and Enrollment of Subscribers and Dependents

Eligibility Criteria ***Eligibility Status*** ***Employee and Retiree***	**STATE** • *Employee*: (A) Any person employed by the employer, who is regularly scheduled to work at least 30 hours per week; (B) Any person who has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204(a)(3); and (C) All other individuals cited in state statute or approved as an exception by the State Insurance Committee. • *Retiree* – An individual who: 1) has left active employment as a State Employee; and 2) receives a monthly benefit from the Tennessee Consolidated Retirement System (TCRS) or is a member of one of the Higher Education Optional Retirement Plan(s) (ORP). **LOCAL EDUCATION** • *Employee of participating agency* - 1) A teacher as defined in TCA 8- 34-101-(49); 2) An interim teacher whose salary is based on the local school system's schedule; 3) An Employee not defined in 1 or 2 in this section who is regularly scheduled to work at least 30 hours per week in a non- seasonal, non-temporary position; 4) A non-certified employee who has completed 12 months of employment with a local education agency that participates in the local education insurance plan and works a minimum of 25 hours per week [a resolution passed by the school system's

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	governing body authorizing the expanded 25 hour rule for the local education agency must be sent to Benefits Administration before enrollment]; or 5) Any other individual deemed eligible by applicable federal law, state law, or action of the Local Education Insurance Committee. • *Retiree* –An individual who: 1) has retired from the employer; and 2) receives a monthly benefit from the Tennessee Consolidated Retirement System (TCRS). **LOCAL GOVERNMENT** • *Employee of participating agency* - An individual who: 1) is scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position; 2) is a member of the chief legislative body of the county or municipal government (defined as only those elected officials who have the authority to pass local legislation); or 3) a utility board member appointed or elected pursuant to TCA 7-82-307, but only during their term of service. • *Employee who is a county official* - as defined in TCA 8-34-101(9)(A), regardless of whether the county participates in the local government plan, pursuant to TCA 8-27-704(a). • *Any other individual* - as deemed eligible by applicable federal law, state law, or action of the Local Government Insurance Committee. • *Retiree* – An individual who: 1) has retired from the employer; and 2) receives a monthly benefit from the Tennessee Consolidated Retirement System (TCRS).
Dependent	**STATE, LOCAL EDUCATION, LOCAL GOVERNMENT** Note: A person cannot enroll as an Employee and as a Dependent under the same group plan (State, Local Education, or Local Government. If both parents of a child qualify as eligible Employees, only one Employee (parent) can enroll dependent children. *Dependent*: An individual who meets the following eligibility criteria based upon an employee or retiree eligibility is eligible. A. A legally married spouse; or B. A child from birth to the last day of the month in which such child turns age 26 who meets at least one of the following criteria without consideration of factors such as financial dependency, marital status, enrollment in school, or residency: (1) Employee or retiree's natural (biological) child, or (2) Employee or retiree's adopted child (including a child placed for adoption in anticipation of adoption); or C. An employee/retiree or spouse's stepchild under the age of 26; or D. A person under age 26 who is placed with the Subscriber by a valid order of guardianship, custody, or conservatorship (or legally equivalent order) by a court of competent jurisdiction ("placement order"). (1) The Subscriber must provide certification upon enrollment and upon request that: (a) the placement order is in effect and has not expired by subsequent court order or by operation of law, and (b) the Subscriber shall immediately notify Benefits Administration when the placement order terminates or expires. (2) If a placement order terminates or expires due to the person attaining the legal age of majority, the person may remain an eligible dependent until age 26 if the Subscriber certifies that the following requirements in (a), (b) and (c) are met: a. The Subscriber and the person have a relationship as set forth in 26 U.S.C. §125(d)(2), which includes the following relationships: i. The person is a descendant of a son/daughter, stepson/stepdaughter of the Subscriber;

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	ii. The person is a brother/sister, half-brother/half-sister, stepbrother/stepsister, son/daughter-in-law, brother/sister-in-law, or niece/nephew of the Subscriber; or iii. The person has the same principal place of abode as the Subscriber and is a member of the Subscriber's household; and b. The Subscriber provides over one-half of the person's financial support for the calendar year in which the Subscriber's taxable year begins; and c. The person is a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada. (3) Additional documents and certifications may be requested to establish that the person is an eligible dependent. E. Dependents over the age of 26 years who meet at least one of the criteria in B or C in this section and who are incapacitated (mentally or physically incapable of earning a living regardless of age, provided the dependent is incapable of self-sustaining employment). This provision applies only when the incapacity existed before the dependent's 26th birthday and they were already insured by a state-sponsored plan. The child must meet the requirements for dependent eligibility listed in this section. A request to continue coverage due to incapacity must be provided to State of Tennessee, Department of Finance and Administration, Division of Benefits Administration prior to the dependent's 26th birthday. Annual proof may also be required. Approval is subject to review by the claims administrator. Coverage will not continue and will not be reinstated once the dependent is no longer incapacitated. F. Dependents not eligible for coverage: 1. Children in the care, custody or guardianship of the Tennessee Department of Children's Services or equivalent placement agency, who are placed with the Subscriber for temporary or long-term foster care, but not including a person who is placed with the Subscriber for the purpose of adoption; 2. Dependents not listed in the above definitions; 3. Parents of the employee/retiree or spouse; 4. Ex-spouse; and 5. Live in companions who are not legally married to the employee/retiree.
Annual Enrollment	Each year during a time period specified by the State, employees and retirees may: 1. elect enrollment in one of the dental insurance program options, 2. drop enrollment in the dental insurance program, and 3. add any eligible dependents to dental coverage, remove any dependents from dental coverage, or drop dependent dental coverage entirely.
Special Enrollment Provisions	Without regard to the dates or circumstances on which an individual would otherwise be able to enroll in one of the Programs, current Employees and Dependents as defined are permitted to enroll in coverage under one or more of these Programs if the Employee or Dependent meets the following conditions of a Special Qualifying Event (SQE), as stated in Section A or B below: <u>(A) Loss of Eligibility for Other Coverage.</u> (1) An individual, otherwise eligible to enroll in a specific benefit Program, may be enrolled through this Special Enrollment provision provided that they: (a) Declined coverage in a specific benefit Program when it was previously offered during their initial eligibility period, or during a subsequent annual enrollment period; (b) Had specific benefit coverage under any group dental insurance plan at the time a specific Program coverage was previously offered; and (c) Experience a loss of eligibility for other specific dental insurance

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	coverage for reasons including the following (but not for a failure to pay premiums or termination for cause): (i) Death; (ii) Divorce; (iii) Legal separation; (iv) Cessation of dependent status; (v) Termination of employment (voluntary and non-voluntary); (vi) Employer's discontinuation of contribution to insurance coverage (total contribution, not partial); (vii) Reduction in number of work hours of employment; (viii) Spouse maintaining coverage that has reached their lifetime maximum (if legally permitted); or (ix) Loss of TennCare or Children's Health Insurance Program (CHIP) coverage other than non-payment of premium, or expiration of COBRA coverage. (2) If an Employee/Retiree satisfies all three requirements of A (1) above, the Employee/Retiree and all Dependents of the Employee/Retiree are eligible for special enrollment to the specific benefit Program. (3) If a Dependent satisfies all three requirements of A (1) above, only that Dependent, the Employee/Retiree, and other Dependents satisfying the requirements of A (1) above are eligible for special enrollment to the specific benefit Program. (4) All Special Enrollments for Loss of Eligibility for Coverage must be submitted to and received by ABC/BA within sixty (60) days of the loss of eligibility for other coverage. (5) The effective date of coverage for a Special Enrollment for Loss of Coverage shall be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment. (6) Substantiation of Loss of Coverage. If requesting special enrollment based on loss of eligibility for other coverage, the Employee/Retiree must submit appropriate documentation to substantiate all of the following: (a) That the Employee/Retiree or Dependent was covered for any other group dental insurance plan at the time they declined the offer of specific coverage from This Program; and (b) That the Employee/Retiree experienced an event resulting in the Employee/Retiree or Dependent's loss of eligibility for the specific coverage under the other group dental insurance plan, and the date of the Employee/Retiree or Dependent's loss of eligibility. (B) Acquisition of New Dependents. (1) When an Employee/Retiree acquires a new Dependent by marriage, birth, adoption, placement for adoption or legal guardianship, the Employee/Retiree, Spouse, and any Dependent may be enrolled in the dental insurance program by Special Enrollment. (2) All Special Enrollment applications based upon the acquisition of a new Dependent must be submitted to and received by ABC/BA within thirty (30) days of the acquisition date. (3) The effective date of coverage for a Special Enrollment for acquiring a new Dependent Spouse, child pursuant to an order of guardianship, and new stepchild acquired by marriage shall be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment. (4) The effective date of coverage for a Special Enrollment for acquiring a new child by birth, adoption, placement for adoption, shall be the date of the birth, adoption, or placement for adoption. (5) Substantiation of Acquiring a New Dependent. If requesting enrollment based on acquiring a new Dependent, the Employee must submit

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	appropriate documentation as listed on the enrollment application to substantiate the following: (a) The date of birth of a child; or (b) The date of the adoption or the order placing the child in custody for adoption; or (c) The date of guardianship specified by the order granting guardianship and requiring financial support and insurance coverage; or (d) The date of marriage.
Survivor	*Survivor in Current Plan* - Upon the employee or retiree's death, surviving dependents covered under this dental plan on the date of an employee or retiree's death may continue their enrollment in this dental plan with one of the two options listed below. • Deceased employee or retiree was eligible for continuation of coverage as a retiree at time of death - dependents may elect COBRA or RETIREE continuation of dental elections in effect for them on the date of employee or retiree's death; or • Deceased employee or retiree was not eligible for continuation of coverage as a retiree at time of death - dependents may elect COBRA continuation for dental elections in effect for them on the date of employee or retiree's death. *Survivor with New Agency Joining Plan* – Upon a new agency joining the State Group Insurance Plan (SGIP), surviving dependents of deceased employees or retirees may enroll in this dental plan if the following criteria is satisfied. • The new agency opts to offer the SGIP dental plan to its employees, and • Surviving dependents were enrolled in COBRA or the new agency's regular dental plan in the month prior to the new agency joining the SGIP, and • The deceased employee or retiree was eligible to receive a pension from the Tennessee Consolidated Retirement System (TCRS) (note: this does not apply to COBRA participants)
Participation Requirements	**An agency must be participating in the State of Tennessee Sponsored Group Health Plan in order to qualify for participation in the State of Tennessee Voluntary Dental Insurance Program.** • Employees and Dependents of Employees ARE NOT required to participate in a state-sponsored group health plan as a condition of participating in the State Group Dental Insurance Program. • Retirees and Dependents of Retirees ARE NOT required to participate in a state-sponsored group health plan as a condition of participating in the State Group Dental Insurance Program. • An Employee or Retiree's participation in the State Group Dental Insurance Program is required for participation of eligible Dependents. Participation by those enrolled in the State Group Dental Insurance Program is on a calendar year basis, and enrollment may only be dropped by the participants during the Annual Enrollment Period for the beginning of the next calendar year or due to a Special Enrollment Provision.
Cancellation	*Cancellation Provisions* Members may only cancel coverage during the annual enrollment period for the beginning of the next calendar year unless there is a loss of eligibility under the State Group Dental Insurance Program or due to a qualifying event. Only persons who lose eligibility under this plan or become newly eligible for other coverage may cancel. An

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	Employee or Retiree requesting to cancel dental coverage for themselves or their Dependents must complete an Insurance Cancel Request Application and submit The application and the required documentation noted on the application within 60 days of a qualifying event. Purchase of a private policy, voluntary cancellation of other coverage, and financial hardship do not qualify as reasons to cancel coverage. *Qualifying events For Cancellation Requests* • *Marriage, divorce, legal separation, annulment* • *Birth, adoption, placement for adoption* • *Death of spouse, dependent* • *New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependent)* • *Entitlement to Medicare, Medicaid, TRICARE* • *Court decree or order* • *Open enrollment* • *A change in place of residence or workplace out of the national service area (i.e., move out of the U.S.)*
Transfer from Prior Contract	Members enrolled under the prior DPPO contract with the State as of December 31, 2021 shall be automatically enrolled under the new DPPO contract with the State with no break in coverage if premium payments are current and the Member did not make a change effective January 1, 2022. Waiting periods, benefit frequencies and other limitations under this DPPO contract shall incorporate Member's experience under the prior DPPO contract.

Your or your dependent's coverage terminates when you are no longer eligible for benefits as a member of the group. Specific state and federal laws or group policies may allow an extension of membership for a limited time. You should speak to the administrator of your group to see if an extension is available and for how long the benefits could be extended.

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

II. Choosing a Dentist

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

Although you are free to choose any dentist, your out-of-pocket expenses may be less if you choose a participating Delta Dental PPO dentist. To receive the maximum (In Network) benefits, you must visit a Delta Dental PPO provider. If you visit a Non-Participating Provider, you will receive the Out of Network benefits described on the Benefit Summary Page of this COC. Therefore, you should always ask your dentist if he is a participating Delta Dental PPO dentist or verify with DDTN that your dentist is a participating dentist before receiving any dental services. For a list of participating Delta Dental PPO providers visit www.DeltaDentalTN.com.

Delta Dental "Safety Net"—If you visit a dentist who is not a Delta Dental PPO provider but is a *Delta Dental Premier* provider, the amount you may be balance billed is limited. Delta Dental Premier providers are allowed to charge more than a Delta Dental PPO provider, but cannot bill you for any charges over the Delta Dental Premier maximum plan allowance. This may be an additional savings to you or your family

members. To find out if your dentist is a Delta Dental Premier provider visit www.DeltaDentalTN.com.

DDTN is not responsible for any injuries or damages suffered due to the actions of any dentist.

III. General Provisions

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

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

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

D. If you or your covered dependent receive an injury requiring dental treatment because of the action or fault of another person, and if DDTN is unaware of other coverage, DDTN may pay benefits but would assume you or your covered dependent's rights to recover from the other person. You and your covered dependent would be required to help DDTN in making such a recovery.

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

F. If you or your covered dependent has two dental coverages, DDTN will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
   1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.
   2. Where the patient is a dependent child, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e. stepparent) will be primary.
   3. If there is a court decree stating that one parent has financial responsibility for a child's dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.

G. After a claim is processed, an Explanation of Benefits (EOB) will be made available to you. If any payment for services was denied, the EOB will give the reason why. If you disagree with the denial you must submit a request in writing asking that the claim be reviewed. Such request should include the reason why you believe the claim was wrongly denied. The request for your first level review must be received by DDTN within 180 days of your receipt of the EOB. DDTN will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to you within 30 days after DDTN receives the request for review.

   If you do not agree with the first level review decision, you may request a second level review. The manner in which to seek a second level review will be included with the letter informing you of our first level review decision.

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

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IV. Benefits

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

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

General Limitations and Exclusions

A. Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
B. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
C. Cosmetic surgery or procedures for purely cosmetic reasons unless specifically listed as a benefit.
D. Services for congenital (hereditary) malformations such as but not limited to cleft palate or upper and lower jaw malformations, or congenitally missing third molars.
E. Treatment to restore tooth structure lost from wear or attrition.
F. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
G. Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
H. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
I. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction unless specifically listed as a benefit.
J. Services by a dentist beyond the scope of his or her license.
K. Dental services for which the patient incurs no charge.
L. Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
M. Missed appointments.
N. Services covered under other coverage provided by the Policyholder.
O. Temporary or provisional restorations.
P. Temporary or provisional appliances.
Q. Prescription drugs.
R. The following when charged on a separate basis: claim form completion, infection control such as gloves, masks and sterilization of supplies or local anesthesia such as nitrous oxide.
S. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting food.
T. Caries susceptibility tests;
U. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
V. Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
W. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
X. Duplicate prosthetic devices or appliances;
Y. Replacement of a lost or stolen appliance, Cast Restoration or Denture;
Z. Replacement of an orthodontic device;
AA. During the first twelve months when the Member is insured for Dental Insurance, dentures and

implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance;

BB. Services or supplies received by the Member before the coverage starts for that person.
CC. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
DD. Intra and extraoral photographic images.

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

V. Optional Services

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

VI. Schedule of Benefits

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

A. Diagnostic & Preventive Benefits, Limitations & Exclusions

- All oral examinations and cleanings (prophylaxis).
  - Oral exams (including problem focused exams and teledentistry) 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. Periodontal maintenance procedures are a benefit under "**Basic Benefits**" and Full mouth debridement is a benefit under "***Major Services***"
  - Members with high-risk health conditions may receive a total of four cleanings and exams, to include periodontal maintenance procedures, in any calendar year. Eligible members include:
    - Diabetics with periodontal disease
    - Pregnant women with periodontal disease
    - Individuals with renal failure/dialysis
    - Individuals with suppressed immune systems (undergoing chemotherapy or radiation treatment, HIV positive, organ transplant patients, stem cell/bone marrow transplant patients)
    - Individuals at high risk for infective endocarditis (such as those with a history of infective endocarditis, certain congenital heart defects, artificial heart valves, heart valve defects, hypertropic cardiomyopathy, or mitral valve prolapse)
  - Adult prophylaxis for members under 14 years of age is not allowed.
  - Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
  - Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than two times in a calendar year.
  - Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than two times in a calendar year.

- X-rays.

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- One set of bite-wing x-rays are covered every 12 months.
- Full mouth x-rays and/or panoramic x-rays are covered once every 60 months unless special need is shown.
- Intraoral-periapical x-rays.

- Fluoride.
  - Topical application of fluoride is covered for members up to 19 years of age twice every 12 months.
  - Topical fluoride treatment for members 55 years of age and older with a history of periodontal surgery, once every 12 months.
- Space maintainers.
  - Space maintainers are covered for members 14 years of age or under.
  - Only one space maintainer is allowed per area per lifetime.
- Biopsies of hard or soft oral tissue.

B. Sealant Benefits, Limitations & Exclusions

- Sealants – resin filling used to seal grooves and pits on the chewing surface of permanent molar teeth.
  - A sealant is a benefit only on the unrestored, decay free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars.
  - Sealants are only a benefit on members under 16 years of age.
  - Only one benefit will be allowed for each tooth within a lifetime.
  - Benefits include repair or replacement within 24 months by the same dentist or dental office.
- Preventive resin restorations -- applied to non-restored first and second permanent molars, once per tooth
  - Not allowed in conjunction with a sealant on the same tooth.

C. Basic Benefits, Limitations & Exclusions

- Simple extractions.
- Minor Restorations – amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.
  - Restorative benefits are allowed once per surface in a 24-month period, regardless of the number or combinations of procedures requested or performed.
  - The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not allowed.
  - The replacement, by the same dentist or dental office, of a stainless steel crown within 24 months of the initial placement is not allowed.
- Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.
- Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
- Genetic test for susceptibility to oral diseases.
- Diagnostic casts.
- Emergency palliative treatment to relieve tooth pain.
- Protective (sedative) fillings.
- Pulp capping (excluding final restoration).
- Therapeutic pulpotomy (excluding final restoration).
- Pulp therapy.
- Apexification/recalcification.
- Pulpal regeneration, but not more than once per lifetime.
- Injections of therapeutic drugs.
- Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

- **Oral Surgery Benefits, Limitations & Exclusions.**
  - Oral Surgery – complex extractions and other surgical procedures (including pre- and

post-operative care). Some procedures are limited to once per lifetime. Excludes procedures that are considered medical procedures.

- **Endodontic Benefits, Limitations & Exclusions**
  - Endodontic - treatment of the dental pulp (root canal procedures) including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery.
    - Payment for root canal treatment includes charges for x-rays and temporary restorations.
    - Root canal treatment is limited to once in a 24 month period by the same dentist or dental office.
    - Post-operative procedures are considered part of the total fee.

- **Periodontic Benefits, Limitations & Exclusions**
  - Periodontic - treatment of the gums and bones that surround the natural tooth.
    - Payment for periodontal surgery shall include charges for three months post-operative care and any surgical re-entry for a 36 month period.
    - Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.
    - Scaling and root planing procedures are allowed once within 24 months.
    - Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any Year less the number of teeth cleanings received during such 1 Year period

- **Major Services**
  - General Anesthesia & IV. Sedation is covered only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions. General anesthesia and IV sedation are limited to one hour. Any additional minutes are disallowed unless clinical documentation supports additional minutes.
  - Local chemotherapeutic agents.
  - Consultations for interpretation of diagnostic image by a dentist not associated with the capture of the image is a benefit once in a 12 month period.
  - Other consultations are a benefit once in a 12 month period.
  - Full mouth debridement, but not more than once per lifetime.
  - Occlusal adjustments, but not more than once is a 12 month period.
  - Cleaning and inspection of a removable appliance, but not more than twice per year.
  - Crown and denture repairs - services to repair crowns and complete or partial dentures are benefits once in a 12 month period

- **Major Restorative Benefits, Limitations & Exclusions**
  - Cast Restorations. Crowns and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations. A benefit waiting period applies.
    - Replacement of crowns, prefabricated crowns or cast restorations received in the previous seven years is not a benefit. However, if a prefabricated crown or cast restoration is damaged beyond repair and is replaced prior to 7 years, then the cast restoration will be covered but at a lower covered percentage in accordance with the Replacement Table below.
    - Payment for cast restorations shall include charges for preparations of tooth and gingiva, impression, temporary restoration and any re-cementation by the same dentist within a 12 month period.
    - A cast restoration on a tooth that can be restored with an amalgam or composite

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restoration is not a benefit.

- Procedures for purely cosmetic reasons are not benefits. Some procedures (ex. Veneers) may be made optional.
- Porcelain, gold or veneer crowns for children under 12 years of age are not a benefit.
- Labial veneers for a covered person age 12 or older are a benefit once per tooth is a seven year period.
- A prefabricated post and core in addition to crown is payable only on an endodontically treated tooth.
- Posts, cores and core buildup are covered once per tooth in a period of seven years. However, if a post, core or core build up is damaged beyond repair and is replaced prior to seven years, then they will be covered but at a lower covered percentage in accordance with the Replacement Table below.

- **Prosthodontic Benefits, Limitations & Exclusions**
  - Prosthodontics. Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges when needed to replace natural teeth that were lost while the person receiving such benefits was insured for Dental. Once the Member has been insured for 12 months, the Member will be covered for initial installation of full or partial dentures regardless of when the Member's natural tooth was lost.
    - Replacement of any fixed or removable bridges or partial or complete dentures that the member received in the previous seven years is not a benefit. However, if a fixed denture is damaged beyond repair and, as a result, is replaced prior to seven years then the denture will be covered, but at a lower covered percentage in accordance with the Replacement Table below.
    - Payment for a complete or partial denture shall include charges for any necessary adjustment within a six month period. Adjustments made after the initial 6 month period are covered once in a 12 month period.
    - Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
  - Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit. A temporary partial-stayplate denture is a benefit in children 16 years of age or under for missing anterior permanent teeth.
  - A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
  - Temporary partial dentures are a benefit during the healing period for missing upper anterior teeth.
  - Temporary or provisional fixed prosthodontics are not separate benefits and should be included in the fee for the permanent prosthesis.
  - Complete or Partial Denture Reline and Rebase procedures. Payment for a reline or rebase of a partial or complete denture is limited to once in a three year period and includes all adjustments required for 12 months after delivery.
  - Addition of teeth to a partial removable denture is a benefit after the waiting periods have been met.
  - Replacement of an immediate, temporary, full denture with a permanent, full denture, if the immediate, temporary full denture cannot be made permanent and such replacement is done within 12 months of the installation is a benefit.
  - Other removable prosthetic services not described elsewhere are benefits.
  - Other fixed denture prosthetic services not described elsewhere are benefits.

Appendix 7.6

- Tissue conditioning is a benefit once in a 36 month period.

- **Implant Benefits, Limitation and Exclusions**
  - Implants. The surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered benefits when needed to replace natural teeth that were lost while the person receiving such benefits was insured for Dental. Once the Member has been insured for 12 months, the Member will be covered regardless of when the Member's natural tooth was lost. Includes sinus augmentation and bone replacement and graft for ridge preservation.
    - Replacement of implants or abutments received in the previous 60 months is not a benefit.
    - Implant supported cast restorations are a benefit once per tooth in a seven year period.
    - Implant supported removable dentures are a benefit once per tooth in a seven year period.
    - Implant supported fixed dentures are a benefit once per tooth in a seven year period.
    - The removal of an implant is allowed once per lifetime.
    - Implants are not a benefit for patient's under 19 years of age.
    - Implant maintenance procedures are allowed once in a 12 month period.

- **Replacement Table with Covered Percentages**
  - For Cast Restorations, Fixed Dentures, Removable Dentures, Prefabricated Crown, Core Buildup and Posts and Cores replaced within:

    1 year but less than 2 years: 10%
    2 years but less than 3 years: 15%
    3 years but less than 4 years: 20%
    4 years but less than 5 years: 25%
    5 years but less than 6 years: 30%
    6 years but less than 7 years: 35%

J. Orthodontic Benefits, Limitations & Exclusions

- Orthodontics. Procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a benefit.
  - Orthodontic benefits are limited to members shown on the Benefit Summary Page and after satisfying the waiting periods.
  - If orthodontic treatment began prior to enrolling in this plan, DDTN will begin benefits with the first payment due the dentist after the subscriber or covered dependent becomes eligible.
  - Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
  - Benefits are not paid to repair or replace any orthodontic appliance received.
  - Orthodontic benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under other benefits of this plan.
  - The initial payment (initial banding fee) made by DDTN for comprehensive treatment will be 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.
  - Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment percentage and lifetime maximum.
  - Fixed and removable appliances for correction of harmful habits for children under age 19 are a benefit once per lifetime.

Transition of Orthodontic Claims

A transition orthodontic claim is when treatment began prior to your Dental Preferred Provider Option coverage with Delta Dental of Tennessee.

Appendix 7.6

First, let your dentist know you have a change in coverage. The dental office can send a claim to Delta Dental with all case details, including total months of treatment. The dentist should note on the claim that it is a transition claim.

Delta Dental will calculate the remaining treatment fee for the case and the months remaining. Delta Dental will subtract the initial banding fee and the total monthly fees for each month the patient was not eligible from the total fee for treatment. Payment is not made for months prior to eligibility or during the waiting period.* Here's an example where treatment began on May 1, 2022, and eligibility with Delta Dental began on January 1, 2023, with 24 months of treatment:

Total Fee for Treatment	$4,200	
Initial Banding Fee (33% of total fee)	-$1,386	
Remaining Fee Balance to be Paid Monthly	$2,814	
Remaining Fee per Month	$117.25	($2,814 / 24 months)
Total monthly fee prior to 1/1/23 [$117.25 x 7 months (Jun.-Dec.)]	$820.75	
Total Treatment Fee Remaining ($2814 - $820.75)	$1,993.25	
Monthly Treatment Fee not Payable During Waiting Period (12 x $117.25)	-$1,407	
Total Treatment Fee Remaining to be Paid Monthly	$586.25	

Delta Dental will pay 50% of the $586.25 over the 5 remaining months of treatment or the remainder of the patient's orthodontic maximum.

Delta Dental DPPO Monthly Benefit ($117.25 x 50%)	$58.63
Delta Dental Monthly Benefit for Remaining 5 Months beginning January 1, 2024 ($58.63 X 5)	$293.15

*Waiting period: 12-month waiting period for orthodontic coverage