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**Certificate of Coverage  
Delta Dental PPO Plan**

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**Introduction**

This Certificate of Coverage (COC) is a guide to your dental plan. It is not the contract between Delta Dental of Tennessee (DDTN) and your group nor any member of the plan. Should there be any conflict between the COC and the contract, the contract will prevail.

**I. Eligibility and Enrollment of Subscribers and Dependents**

Subscribers who have enrolled in this dental plan through their employer or other group sponsoring this plan may also enroll their dependents.

Dependents are defined as a lawful husband or wife or child(ren) from birth to their 24<sup>th</sup> birthday. Child includes a natural or adopted child, regardless of where they live; stepchildren, if the subscriber or his/her spouse has legal or joint custody or shared parenting; children living in the home for 12 months a year for whom you are the legal guardian; any dependent child living in your home for 12 months a year who is dependent upon you for support and maintenance as evidenced by being claimed as a dependent on your federal income taxes; incapacitated children (mentally or physically disabled and incapable of earning a living) may continue coverage beyond age 24 as long as the incapacity existed before their 24<sup>th</sup> birthday and they were already insured under the state’s insurance program.

Dependents in military service are not eligible.

Dependents must enroll along with the subscriber or as

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

A subscriber or dependent who drops their coverage but who still meets all requirements of the plan, may re-enroll during the next annual transfer period after having been out of the plan for 12 consecutive months except in the event of a life status change.

Coverage for any subscriber or dependent terminates when they are no longer eligible for benefits as a member of the group. Specific state and federal laws or group policies may allow an extension of membership for a limited time. You should speak to an insurance preparer 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 subscribers and dependents is only effective after DDTN receives the premium for the period to be covered. If DDTN does not receive the premium when it is due, we may stop paying claims until payment is received. If premiums have not been received within 30 days after the due date, DDTN may cancel the contract with the group. DDTN does not bill individuals for premiums.

**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 Group Variables page of this Certificate of Coverage. Therefore, you should always ask your dentist if he or she is a participating Delta Dental PPO dentist or verify with DDTN that your dentist is a participating Delta Dental PPO dentist before receiving any dental services. For

a list of participating Delta Dental PPO Providers in your area call DDTN or visit [www.deltadentaltn.com](http://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 *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 our website at [www.deltadentaltn.com](http://www.deltadentaltn.com) or call your dentist’s office.

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

### **III. General Provisions**

- A. Participating dentists will file your claim with DDTN. If you need a claim form for services provided by a non-participating dentist you may contact DDTN which will provide you with a claim form, or you can print a claim form from our website at [www.deltadentaltn.com](http://www.deltadentaltn.com). 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 predetermination. You may have your dentist send DDTN a claim form detailing the projected treatment and DDTN will give an estimate of the benefits to be paid. A predetermination is not a guarantee of payment. Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums.
- D. If you or your covered dependent receive an injury requiring dental treatment because of the action or fault of another person, and if DDTN is unaware of other coverage, DDTN may pay benefits but would assume the subscriber’s or covered dependent’s

rights to recover from the other person. The subscriber and covered dependent would be required to help DDTN in making such a recovery. This dental plan does not replace any workers’ compensation coverage.

- E. If a subscriber or covered dependent has two dental coverages, DDTN will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
  - 1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.
  - 2. Where the patient is a dependent child, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent’s spouse (i.e. stepparent) will be primary.
  - 3. If there is a court decree stating that one parent has financial responsibility for a child’s dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.
- F. After a claim is processed, an Explanation of Benefits (EOB) will be sent to the subscriber. If any payment for services was denied, the EOB will give the reason why. If the subscriber disagrees with the denial he or she must submit a request in writing asking that the claim be reviewed. Such request should include the reason why the subscriber believes the claim was wrongly denied. The request must be received by DDTN within 180 days of the subscriber’s receipt of the EOB. DDTN will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after DDTN receives the request for review.

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

If the subscriber does not agree with the second

level review decision, he or she may file civil action in court.

#### **IV. Benefits**

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

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

##### **General Limitations and Exclusions**

- A. Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
- B. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
- C. Cosmetic surgery or procedures for purely cosmetic reasons.
- D. Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate, or upper and lower jaw malformations. This does not exclude those services provided under Orthodontic benefits, if covered.
- E. Treatment to restore tooth structure lost from wear.
- F. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
- G. Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- H. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- I. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofascial pain dysfunction.

- J. Services by a dentist beyond the scope of his or her license.
- K. Dental services for which the patient incurs no charge.
- L. Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
- M. DDTN will apply the limitations and exclusions of this benefit plan based upon the member's complete and prior history as reflected in DDTN's records.
- N. Athletic mouthguards or the replacement of lost or stolen appliances.
- O. DDTN will not pay benefits for the replacement of natural teeth missing on the date the member's coverage begins.

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

##### **V. Optional Services**

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

##### **VI. Schedule of Benefits**

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

##### **A. Diagnostic and Preventive Benefits**

- a) Diagnostic: Oral examination and bitewing x-rays to aid the dentist in planning required dental treatment.
- b) Preventive: Prophylaxis (cleaning), topical application of fluoride, harmful habit devices, sealants and space maintainers.

##### **Limitations and Exclusions On Diagnostic**

### **And Preventive Benefits**

- a) Two oral exams and cleanings in any calendar year. This frequency limitation is combined with periodontal maintenance procedures.
- b) Members with high risk health conditions may receive a total of four cleanings, to include periodontal maintenance procedures, in any 12 month period. Eligible members include diabetics and pregnant women with periodontal disease, those with renal failure, those with suppressed immune systems such as those undergoing chemotherapy/radiation treatment, HIV positive or organ or stem cell transplant patients or those at high risk for infective endocarditis.
- c) One set of bite-wing x-rays in a calendar year.
- d) Topical application of fluoride for members up to 14 years of age.
- e) Adult prophylaxis for members under 14 years of age are not allowed.
- f) Space maintainers are allowed for children under age 16.
- g) 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 17 years of age. Only one benefit will be allowed for each tooth within a lifetime.
- h) Harmful habit devices are allowed once per lifetime for children under age 16.

### **B. Basic Benefits**

- a) Basic Restorations: Amalgams (silver fillings) and composite (white fillings) restorations for the treatment of decay.
- b) Oral Surgery: Simple extractions, surgical incision, and removal of exposed roots.
- c) Diagnostic Radiographs
- d) Other Basic Services including Bacteriologic Studies, Palliative Treatment, Therapeutic Drug Injection, Histopathic Examinations.

### **Limitations and Exclusions On Basic Benefits**

- a) Restorative benefits are allowed once per surface in a 24 month period, regardless of the number or combinations of procedures requested or performed.
- b) Gold foil restorations are an Optional Service.
- c) Although composites (white fillings) on the facial (outside) surfaces of the bicuspid teeth are an allowable benefit, composites used in molars or on the chewing surfaces of bicuspid teeth are considered Optional Services.
- d) Complete Series or Panoramic x-rays are limited to once in any 5 year period. Panoramic x-rays may also be payable in

connection with the removal of impacted teeth.

- e) No more than 4 Periapical x-rays are allowed in any calendar year; no more than 2 Occlusal Films are allowed in any calendar year; no more than 2 Extraoral Films are allowed in any calendar year.

### **C. Major Benefits**

- a) Complex Oral Surgery: Extractions and other surgical procedures (including pre- and post operative care).
- b) Endodontia: Treatment of the dental pulp (root canal procedures).
- c) Periodontia: Treatment of the gums and bones that surround the tooth including Periodontal Maintenance procedures.
- d) Cast Restorations: Crowns and metal inlays 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.
- e) Stainless steel or resin crowns.
- f) Prosthodontics: Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
- g) Complete or Partial Denture Reline: Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
- h) Complete or Partial Denture Rebase: Laboratory replacement of the acrylic base of the appliance.
- i) Denture Repairs: Services to repair complete or partial dentures.
- j) 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.
- k) Implants: The surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered benefits.

### **Limitations and Exclusions On Major Benefits**

- a) 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.
- b) 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.
- c) Periodontal Splinting is not a covered benefit.

- d) Scaling and Root Planing is allowed once per quadrant in any 24 month period.
  - e) Occlusal adjustment is allowed once in any 12 month period only when performed with periodontal surgery.
  - f) Periodontal Maintenance is allowed twice per calendar year. This frequency limitation is combined with cleanings.
  - g) Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same dentist within a 12 month period.
  - h) A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
  - i) Procedures for purely cosmetic reasons are not benefits.
  - j) Porcelain, gold or veneer crowns for children under 16 years of age are not a benefit. Benefits are limited to prefabricated stainless or resin crowns.
  - k) The replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within a 3 year period of the initial placement is not a benefit. The replacement of a stainless steel crown on a permanent tooth by the same dentist or dental office within a 60 month period of the initial placement is not a benefit.
  - l) Replacement of any fixed bridges or partial or complete dentures that the member received in the previous five years is not a benefit.
  - m) Payment for a complete or partial denture shall include charges for any necessary adjustment within a 12 month period. Payment for a 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. Payment for a reline procedure is only a benefit if more than 12 months have passed since the initial insertion.
  - n) 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.
  - o) Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit.
  - p) A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
  - q) Temporary partial dentures are a benefit only when upper anterior teeth are missing.
  - r) Implants are a benefit for members 16 years of age and older.
  - s) Replacement of implants or abutments received in the previous five years is not a benefit.
  - t) The removal of an implant is allowed once per lifetime.
  - u) Specialized techniques are not benefits (ie. bone grafts, guided tissue regeneration, precision attachments, etc.).
  - v) Implant maintenance procedures are allowed once in a 12 month period.
- D. Orthodontic Benefits**
- As shown on the Group Variables page, DDTN 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.
- Limitations and Exclusions On Orthodontic Benefits**
- a) Orthodontic benefits are limited to members shown on the Group Variables Page.
  - b) DDTN shall make regular payments for orthodontic benefits.
  - c) 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.
  - d) Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
  - 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. However, these additional services may be covered under Diagnostic and Preventive or Basic Benefits.
- Orthodontic Payment Method**
- a) 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.
  - 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 OF TENNESSEE  
CERTIFICATE OF COVERAGE  
GROUP VARIABLES**

<b>GROUP NAME</b>	<u>State of Tennessee</u>	<b>GROUP NUMBER</b>	<u>1800</u>
<b>ORIGINAL ISSUE</b>	<u>January 01, 2005</u>	<b>EFFECTIVE DATE</b>	<u>January 01, 2010</u>

	Delta Dental PPO (In Network) <u>Benefits</u>	Out of Network <u>Benefits</u>
<b>ANNUAL DEDUCTIBLE – APPLIES TO SCHEDULE B &amp; C</b>		
Amount per Person per calendar year	None	\$100
Maximum per Family per calendar year	None	\$300
<b>BENEFIT PERCENTAGES</b>		
Schedule A – Diagnostic and Preventive Benefits	100%	80%
Schedule B – Basic Benefits	80% of	60% of
Schedule C – Major Benefits (waiting periods apply)	50% MPA*	50% MPA*
Schedule D – Orthodontic Benefits (waiting periods apply)	50%	50%
<b>ANNUAL MAXIMUM FOR SCHEDULE A, B AND C DENTAL SERVICES</b>		
Amount per Person per calendar year		\$1,000
<b>LIFETIME MAXIMUM FOR SCHEDULE D DENTAL SERVICES</b>		
Lifetime amount per dependent child to age 19		\$1,250
<b>BENEFIT WAITING PERIODS</b>		
<ul style="list-style-type: none"> <li>• Inlay/Onlay Restorations, Crowns, Complete or Partial Dentures, the addition of teeth to existing Partial Dentures, Fixed Partial Dentures, Implants and Orthodontics</li> </ul>		12 Months

**SPECIAL ENROLLMENT NOTATIONS:** Eligibility requirements are established by the State of Tennessee. Dependent coverage is available under this plan.

**\*MAXIMUM PLAN ALLOWANCE (MPA)**—You are not responsible for charges exceeding the MPA if you go to a participating Delta Dental PPO dentist. You are responsible for charges exceeding the MPA if you go to a non-participating dentist. The MPA charges are based on fees charged in your geographic area.