ADDENDUM NO. 2

DATE: August 7, 2018

TO: All Potential Proposers

FROM: Penny Owens, Assistant Purchasing Agent, City of Knoxville

SUBJECT: Addendum No. 2 to the RFP for Fully-Insured Dental Benefits Program

RFPS TO BE OPENED: August 9, 2018 at 11:00:00 a.m. (Eastern Time)

This addendum is being published to respond to the following questions asked by potential proposers regarding the above referenced RFP. This addendum becomes a part of the contract documents and modifies the original specifications as follows:

Question #1: Can you provide full dental certificates?

Response: Please find the certificates attached.

Question #2: What is the average in-network discount and in-network utilization measured by 3 digit zip with the current carrier? Can you confirm bidding carriers should also provide this information?

Response: The average or Net Effective Discount is 24% for a combined savings in the PPO and Premier networks. 26.83% of claims savings were from the PPO network and 19.50% savings were from the Premier network. The network utilization totals 95.42%, with 65.14% of the procedures submitted by PPO providers and 30.08% by Premier providers.

Question #3: Are the in-network discounts with the current carrier based on the average charge? Confirm bidding carriers should distinguish what their discounts reflect

Response: Discounts are calculated and referred to as the maximum plan allowance. This is a proprietary fee schedule based on claims from participating and non-participating providers. The MPA is reviewed annually and may or may not be revised.

Question #4: Can you confirm bidding carriers should identify and review dentists with unusual billing patterns as a normal practice included in their claims management operations?

Response: Yes

Question #5: Confirm bidding carriers should provide information on how they review and monitor dentists' practice patterns? What are the provider rejection and turnover rates for the network?

Response: Yes, bidding carriers should provide information on how they review and monitor dentists' practice patterns. Currently, the City's provider has less than 2% attrition in both proprietary networks.

Question #6: Please provide a full DPPO utilized provider file for disruption analysis including provider first & last name, address, city, state, zip and tax id.

Response: See Exhibit H posted with the RFP.

END OF ADDENDUM 2

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Certificate of Coverage

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Introduction

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I. Eligibility and Enrollment of Subscribers and Dependents

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

Dependents in military service are not eligible.

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

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

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

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

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

in this dental plan and be covered immediately.

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

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

II. Choosing a Dentist

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

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

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

III. General Provisions

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

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

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

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

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

spouse (i.e. stepparent) will be primary.

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

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

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

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

IV. Benefits

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

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

General Limitations and Exclusions

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

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

V. Optional Services

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

VI. Schedule of Benefits

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

A. Diagnostic & Preventive Benefits, Limitations & Exclusions

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

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E. Treatment to restore tooth structure lost from wear.
F. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
G. Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
H. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
I. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.
J. Services by a dentist beyond the scope of his or her license.
K. Dental services for which the patient incurs no charge.
L. Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
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- Adult prophylaxis for members under 14 years of age are not allowed.
- Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
- X-rays. One set of bite-wing x-rays is covered in a calendar year. Full mouth x-rays are covered once within 3 years, unless special need is shown.
- Fluoride. Topical application of fluoride is covered for members up to 19 years of age.
- Space maintainers. Space maintainers are covered for members up to 15 years of age.

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.

C. Basic Benefits, Limitations & Exclusions

- Simple extractions.
- General Anesthesia & I.V. 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.
- 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 of a stainless steel crown by the same dentist or dental office within a 24 month period of the initial placement is not allowed.
- Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.
- Denture Repairs – services to repair complete or partial dentures.

D. Endodontic Benefits, Limitations & Exclusions

- Endodontia – treatment of the dental pulp

(root canal procedures). Payment for root canal treatment includes charges for x-rays and temporary restorations. Root canal treatment is limited to once in a 24 month period by the same dentist or dental office.

E. Periodontic Benefits, Limitations & Exclusions

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

F. Major Restorative Benefits, Limitations & Exclusions

- Cast Restorations**.** Crowns and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.
- Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same dentist within a 12 month period.
- A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
- Procedures for purely cosmetic reasons are not benefits.
- Porcelain, gold or veneer crowns for children under 12 years of age are not a benefit.

G. Oral Surgery Benefits, Limitations & Exclusions.

- Oral Surgery – complex extractions and other surgical procedures (including pre- and post operative care).

H. Prosthodontic Benefits, Limitations & Exclusions

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

I. Implant Benefits, Limitations & Exclusions

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

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

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

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

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

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

in this dental plan and be covered immediately.

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

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

II. Choosing a Dentist

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

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

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

III. General Provisions

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

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

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

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

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

spouse (i.e. stepparent) will be primary.

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

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

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

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

IV. Benefits

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

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

General Limitations and Exclusions

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

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

V. Optional Services

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

VI. Schedule of Benefits

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

A. Diagnostic & Preventive Benefits, Limitations & Exclusions

- Oral examinations and cleanings (prophylaxis). Oral exams and cleanings, to include periodontal maintenance procedures, are limited to two times in any calendar year.
- Members with high risk health conditions may receive a total of four cleanings, to include periodontal maintenance procedures, in any calendar year. Eligible members include diabetics 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.
- Adult prophylaxis for members under 14 years of age are not allowed.
- Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
- X-rays. One set of bite-wing x-rays is covered in a calendar year. Full mouth x-rays are covered once within 3 years, unless special need is shown.
- Fluoride. Topical application of fluoride is covered for members up to 19 years of age.
- Space maintainers. Space maintainers are covered for members up to 15 years of age.

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.

C. Basic Benefits, Limitations & Exclusions

- Simple extractions.
- General Anesthesia & I.V. 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.
- 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 of a stainless steel crown by the same dentist or dental office within a 24 month period of the initial placement is not allowed.
- Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.
- Denture Repairs – services to repair complete or partial dentures.

D. Major Restorative Benefits, Limitations & Exclusions

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

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

- Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same dentist within a 12 month period.
- A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
- Procedures for purely cosmetic reasons are not benefits.
- Porcelain, gold or veneer crowns for children under 12 years of age are not a benefit.

E. Oral Surgery Benefits, Limitations & Exclusions.

- Oral Surgery – complex extractions and other surgical procedures (including pre- and post operative care).

F. Endodontic Benefits, Limitations & Exclusions

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

G. Periodontic Benefits, Limitations & Exclusions

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

H. Prosthodontic Benefits, Limitations & Exclusions

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

I. Implant Benefits, Limitations & Exclusions

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

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. DDTN shall make regular payments for orthodontic benefits.
- 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.