### Dental Option: DPPO

**Effective Date:** January 1, 2012

<table>
<thead>
<tr>
<th>Deductible Calendar Year</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to Coverage B, C and D</td>
<td>$50</td>
<td>$150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Maximums</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to Coverage B and C (per Calendar Year)</td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>Coverage D (per Lifetime)</td>
<td>$1,000</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Percentages apply to</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Dentist*</td>
<td></td>
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</tbody>
</table>

### Covered Services

**Benefit Percentages**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage A</td>
<td>Exams, X-rays</td>
</tr>
<tr>
<td></td>
<td>Cleanings, Fluoride</td>
</tr>
<tr>
<td></td>
<td>Sealants, Space Maintainers</td>
</tr>
<tr>
<td>Coverage B</td>
<td>Basic Restorative Services</td>
</tr>
<tr>
<td></td>
<td>Basic Oral Surgery</td>
</tr>
<tr>
<td>Coverage C</td>
<td>Major Restorative and Prosthodontics</td>
</tr>
<tr>
<td></td>
<td>Endodentics</td>
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<tr>
<td></td>
<td>Periodontics</td>
</tr>
<tr>
<td></td>
<td>Major Oral Surgery</td>
</tr>
<tr>
<td>Coverage D (12-mo waiting period applies for new enrollees)</td>
<td>Orthodontics-Child to age 19</td>
</tr>
</tbody>
</table>

### Choice Option

- Network Dentists paid at PPO fee schedule; non-network dentists paid at 90th percentile of UCR

### DenteMax National Network

- Included**

### BluePerks

- Discounts on routine vision care, Lasik surgery, weight loss and fitness centers, complementary/alternative medicine and more

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This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions From Coverage, and Schedule of Benefits sections of the Evidence of Coverage.

When applicable, benefits will be paid based on the Benefit Percentages listed above. Members will be responsible for co-insurance (when benefit percentages are less than 100%), deductible(s), and all other charges when benefit maximums have been met.

*Members may see any dentist. We have contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because we have no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

**DenteMax National Network: We have partnered with DenteMax to provide access to their nationwide network of more than 100,000 dental access points. Members may access the DenteMax network via www.bcbst.com.
COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/ extended and periodontal oral exams (evaluations). Emergency exams, including limited oral exams (evaluations).

Limitations: No more than one standard exam in any 6-month period. No more than 2 exams at any 12-month interval. No more than one comprehensive, detailed/extended, or periodontal exam in any 36-month period.

Exclusions: Re-evaluations and consultations.

X-rays
Covered: Full mouth series, intraoral and bitewing radiographs (x-rays).

Limitations: No more than one full mouth set of x-rays in any 36-month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided are in addition to other benefits for all necessary intraoral and bitewing films taken on the same day. No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date.

Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic surgery x-rays, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

Cleaneings, Fluoride Treatment
Covered: Adult and child prophylaxis (cleaning). Child and adult (subject to age limitations) fluoride treatments, performed with or without a prophylaxis.

Limitations: No more than one of any prophylaxis or periodontal maintenance procedure in any 6-month period. Periodontal maintenance procedures are subject to additional limitations listed below. Basic Periodontics in Section VI, and may be subject to a different Coverage level under Attachment C. Schedule of Benefits. No more than one fluoride treatment in any 12-month period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.

Sealants, Space Maintainers
Covered: Other Preventive Services, including sealants, space maintainers.

Limitations: No more than one sealant per first or second molar tooth per lifetime, for Dependents under age 16. Space maintainers for Dependents under age 14. No more than one resealerment in any 12-month period.

Exclusions: No sealant for tobacco counseling, oral hygiene instructions.

Basic Restorative Services
Covered: Basic restorative services, including amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), stainless steel crowns. Radiographs for the relief of pain from other restorative services, including repair of full and partial restorations.

Limitations: No more than one amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration. Replacement of stainless steel crowns Covered only after 36 months from the date of initial restoration. No more than one repair per denture 24 months.

Exclusions: Gold foil restorations.

Major Restorative Services
Covered: Single tooth restorations, including crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.

Limitations: Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). For permanent teeth only. For Dependents under age 12, benefits will not be provided for cast crowns or laminate veneers. Replacement of single tooth restorations Covered only after 60 months from the date of initial placement.

Exclusions: Temporaries and provisional crowns.

Prosthodontic Services - Fixed Bridges
Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, and full cast).

Limitations: Only for treatment when a missing tooth or teeth cannot be adequately restored with a removable partial denture. For permanent teeth only, no benefits for Dependents under age 16. Replacement of fixed partial dentures covered only after 60 months from the date of initial placement.

Prosthodontic Services - Removable Dentures
Covered: Complete, immediate and partial dentures.

Limitations: If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques, no benefits shall be provided for those which would otherwise be provided for the standard procedures or materials (as determined by the Plan). Benefits are not provided for Dependents under age 16. Replacement of removable dentures Covered only after 60 months from the date of initial placement.

Exclusions: Interim (temporary) dentures.

Other Major Restorative & Prosthodontic Services
Covered: Crown and bridge services including care bays, post and core, retoration, and repair. Denture services including adjustment, relining, rebasing and tissue conditioning. Implants and supported prosthodontics, including local aesthetic.

Limitations: The benefits provided for crown and bridge restorations include benefits for the services provided by a practitioner or prosthodontist for crowns, impressions and cementation. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where placement of core material is necessary because of severe carious lesions or fracture so extensive that retention of the crown would not be possible. Post and core services are Covered only when performed in conjunction with a Crown or bridge. Crown and root repair and cementation are Covered separately only after 12 months from the date of initial placement. Denture adjustments are Covered separately from the denture and shall not be provided for the same date treatment performed during Member’s Coverage, even if a prior approved Treatment Plan has not been completed.

Exclusions: Replacement or repair of lost, stolen and damaged appliance furnished under the Treatment Plan. Surgical procedures to aid in orthodontic treatment.

Other Exclusions From Coverage
Benefits are not provided for the following services supplies or changes:

1) Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
2) Charges for services performed by You or Your spouse, or Your or Your spouse’s parent, sister, brother or child.
3) Services rendered by a Dental beyond the scope of his or her license.
4) Dental services which are free, or for which You are not required or legally obligated to pay for or for which no charge would be made if You had no dental Coverage.
5) Services to the extent that charges for such services exceeded the change that would have been made and collected if Coverage existed hereunder.
6) Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
7) Any court-ordered treatment of a Member unless benefits are otherwise payable.
8) Courses of treatment undertaken before You became Covered under this program.
9) Any services performed after You cease to be eligible for Coverage.
10) Dental care or treatment not specifically listed in Attachment C. Schedule of Benefits.
11) Any treatment or service that the Plan determines is not Necessary Dental Care, that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
12) Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers’ compensation coverage.
This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole owner or a general partner of the Group, (2) a partner of the Group, or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers’ Compensation with the appropriate government department.
13) Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
14) Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)
15) Replacement of tooth structure lost from wear or attrition.
16) Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
17) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or to reposition or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
18) Adjunctive dental services such as diagnostic tests and oral pathology services.
19) Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
20) Charges for the treatment of desensitizing medications, drugs, occlusal guards and adjustment, splints, microabrasion, behavior management, and bleaching.
21) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

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