**City of Knoxville**

### Summary of Benefits (SL#)

**Dental Option: High Option**

**Effective Date: 1/1/2021**

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

**Benefit Percentages apply to Any Dentist**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Benefit Percentages</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage A</strong></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Exams, X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanings, Fluoride</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants, Space Maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage B</strong></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Basic Restorative Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage C</strong></td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Major Restorative and Prosthodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic and Major Endodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic and Major Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage D</strong></td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontics-Child to age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Choice Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Dentists paid at PPO fee schedule; non-network dentists paid at 90th percentile of UCR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Network</th>
<th>Included</th>
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<table>
<thead>
<tr>
<th>Oral Health Program</th>
<th>Included- Members with Diabetes, Rheumatoid Arthritis, High Risk Pregnancy, or certain forms of Head/Neck cancer may qualify for one additional exam and cleaning per year. This program is proactive and does not require member or provider initiation.</th>
</tr>
</thead>
</table>

| Blue365 | Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more |

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.*

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COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/ extensive, or periodic intraoral evaluations (exams). Emergency exams, including limited oral evaluations (exams).

Limitations: No more than one standard exam in any 6-month period. No more than one emergency exam in any 12-month period. No more than one comprehensive, detailed/extensive, or periodontal exam in any 18-month period.

Exclusions: Re-evaluations and consultations.

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

Limitations: No more than one full mouth set of x-rays in any 36-month period. All 4 full mouth set of x-rays is defined as either an intraoral complete or panoramic x-ray. Benefits provided for either include 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 taken on the same day are not covered.

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

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

Limitations: No more than one of any prophylaxis or periodontal maintenance procedures in any 6-month period. Periodontal maintenance procedures are subject to additional limitations listed below under 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.

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

Limitations: No more than one sealant per first or second molar teeth per lifetime, for Dependents under age 16. Space maintainers for Dependents under age 16, may be covered a maximum of 3 months in any 12 month period.

Exclusions: Nutritional and 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. Palliative (emergency) treatment for the relief of pain. Other restorative services, including repair of full and partial dentures.

Limitations: No more than one amalgam or resin restoration per tooth surface in any one treatment visit. No more than one amalgam and composite restorations Covered only after 12 months from the date of initial restoration. Restorations may be Covered only after 36 months from date of initial restoration. No more than one repair per denture per 24 months.

Exclusions: Gold for restorations.

Major Restorative Services
Covered: Single tooth restorations, including crowns (enamel, porcelain, 1/3 cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.

Limitations: Covered for 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 similar restorations. Replacement of single tooth restorations Covered only after 60 months from the date of initial placement.

Exclusions: Temporary and provisional crowns.

Prosthodontic Services - Fixed Bridges
Covered: Fixed partial dentures, Full mouth series, inlays and onlays, including pontics, retainers, and abutment crowns, inlays and onlays (enamel, porcelain, 1/3 cast and full cast).

Limitations: Covered 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 similar restorations. 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 provisional restoration to be emergency rather than standard technique, the Member will be responsible for any supplies or charges provided shall be limited to 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: Inferior (temporary) dentures.

Other Major Restorative & Prophylactic Services
Covered: Crown and bridge services including core buildups, post and core, veneers and full mouth series, inlays and onlays (metallic, resin and porcelain), and no sooner than 90 days after completion of such treatment. The benefits for major restorative treatment include benefits for x-rays, pulp vitality tests, pulpotomy, and sedation benefits provided in conjunction with basic endodontic treatment. Exclusions: Pulpal débridement.

Major Endodontics
Covered: Root canal treatment and re-treatment, apicectomy, root surface debridement, retrograde filling, hemisection, pulp cap.

Limitations: No more than two root canal treatment, re-treatment, re-apexitization per tooth in 60-month period. No more than one apicectomy per root per lifetime. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, and sedation benefits and temporary filling material provided in conjunction with major endodontic treatment.

Exclusions: Implantation, canal preparation, and incomplete endodontic therapy.

Basic Periodontics
Covered: Non-surgical periodontics, including periodontal scaling and root planing, full-mouth debridement and periodontal maintenance procedures.

Limitations: No more than one periodontal scaling and root planing per quadrant in any 24-month period. Portion of the periodontal maintenance (peripheral, or non-surgical), and no sooner than 90 days after completion of such treatment. Benefits for periodontal scaling and root planing, full-mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.

Exclusions: Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

Major Periodontics
Covered: Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.

Limitations: No more than one major periodontal surgical procedure in any 36-month period. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.

Exclusions: Tissue regeneration and apically positioned flap procedure.

Basic Oral Surgery
Covered: Non-surgical or simple extractions.

Limitations: Benefits provided for basic oral surgery include benefits and sedation and postoperative care.

Exclusions: Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.

Major Oral Surgery
Covered: Surgical extractions (including removal of impacted teeth and wisdom teeth), and other oral surgical procedures typically not Covered under a medical plan.

Limitations: Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative benefits. Benefits for general anesthesia or intravenous IV sedation are provided only in connection with major oral surgical procedures, and only when provided by a Dentist licensed to administer such agents.

Exclusions: Oral surgery typically Covered under a medical plan, including but not limited to, exclusion of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations.

Orthodontics Services
Covered: Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

Limitations: The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan. The Plan reserves the right to review the Member’s dental records including necessary x-rays, photographs, and models to determine whether orthodontic treatment is Covered. Orthodontic services may be limited to Dependents under a specified age limit, as defined on Attachment C: Schedule of Benefits. Orthodontic services may be limited by a Maximum Allowable Charge. Calendar Year Deductible and Lifetime maximum as defined in Schedule of Benefits. Maximum occurrences of orthodontic treatment may be allowed subject to the lifetime maximum. All orthodontic services shall be deemed to have been concluded on the last date treatment performed during Member’s Coverage, even if a prior approved Treatment Plan has not been completed.

Exclusions: Re-treatment or repair of any lost, stolen and damaged appliances furnished under the Treatment Plan. Surgical procedures to aid in orthodontic treatment. Excessive or inappropriate treatment, cost, or location.

Other Exclusions From Coverage
Benefits are not provided for the following services supplied or charged:
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) Dental services for services performed by You or Your spouse, or Your spouse’s parent, sister, brother or child.
3) Services rendered by a Dentist 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 or for which no charge would be made if You had no dental Coverage.

Dental services for the extent that charges for such services exceed the charge that would have been made and collected if covered and existed hereunder.

Denture services covered by any medical insurance coverage, or by any oral 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.

Any course of treatment undertaken before You become Covered under this program.

Any services performed after You cease to be eligible for Coverage.

Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.

1) 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.
2) Services or supplies for the treatment of work related illness or injury, compensation, or veterans benefits.
3) Any exclusion does not apply to injuries or illnesses of an employee who is (1) a member of a 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.
4) Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dental for treatment in any such facility.
5) Dental services with respect to congenital malformations or primary for cosmetic or aesthetic purposes. This does not exclude those services provided under orthodontic procedures.
6) Replacement of tooth structure lost from wear or attrition.
7) Any fees related to the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management and bleaching.
8) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

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Chattanooga, TN 37402
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- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

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