<table>
<thead>
<tr>
<th>Summary of Benefits</th>
<th>DentalBlue</th>
<th>Standard Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group #: 115650</strong></td>
<td>Dental Option: PPO</td>
<td></td>
</tr>
<tr>
<td>Deductible Calendar Year</td>
<td>Individual</td>
<td>Family</td>
</tr>
<tr>
<td>Applies to Coverage B and C only</td>
<td>$50</td>
<td>$150</td>
</tr>
<tr>
<td>Benefit Maximums</td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>Applies to Coverage A, B, and C (per Calendar Year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Percentages apply to</td>
<td>Any Dentist*</td>
<td></td>
</tr>
<tr>
<td>Covered Services</td>
<td>Benefit Percentages</td>
<td></td>
</tr>
<tr>
<td><strong>Coverage A</strong></td>
<td>100%</td>
<td></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>80%</td>
<td></td>
</tr>
<tr>
<td>Basic Restorative Services</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>Basic and Major Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Coverage C *****</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Major Restorative and Prosthodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage D</strong></td>
<td>Not Available</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preferred Option</strong></td>
<td>Network Dentists paid at PPO fee schedule; non-network dentists paid 30% less than PPO fee schedule</td>
<td></td>
</tr>
<tr>
<td>National Network</td>
<td>Included</td>
<td></td>
</tr>
<tr>
<td>Blue365</td>
<td>Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more</td>
<td></td>
</tr>
</tbody>
</table>

***Coverage C Benefits will have a one year waiting period for those retirees and family members covered by the Dental Plan who have not had continuous coverage through Knox County Dental Plan or Knox County Schools Dental Plan prior to enrollment.***

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.*

**COVERED SERVICES, LIMITATIONS, & EXCLUSIONS**

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association
© Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans.
COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodontal/edentulous, and predischarge periodontal exams (waxing). Emergency exams, including limited and evaluations (waive).
Limitations: No more than one comprehensive exam in any 6-month period. No more than one emergency exam any 12-month period. No more than one comprehensive, detailed/diagnostic, or periodontal exam in any 26-month period.
Exclusions: Re-evaluations and consultations.

X-rays
Covered: Full mouth series, bitewing and bitewing radiography (x-ray).
Limitations: No more than one full mouth set of x-rays in any 26-month period. A full mouth set of x-rays is defined as either an intercuspal complete series or a panoramic x-ray. Benefit provided for other x-rays 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 of service.
Exclusions: Extorthoracic, skull and bone survey, mammography, TLM, and tomographic survey x-rays, cephalometric film and diagnostic photography. Cephalometric films and diagnostic photography may be covered as orthodontics benefits under Coverage D.

Cleanings, Fluoride Treatments
Covered: Other Preventive Services, including sealants, space maintainers. Limitations: No more than one sealant per first or second molar tooth per visit, for Dependent under age 18. Space maintainers for Dependents under age 18 must be placed in the permanent dentition in any 12-month period. Limitations: Mucosal and tobacco counseling, and hygiene instructions.

Basic Restorative Services
Covered: Basic restorative services, including amalgam restorations (silver fillings), composite restorations (both colored fillings), stainless steel crowns. Pulmonary (emergency) treatment for the relief of pain. Other restorative services, including repair of full and partial dentures. Limitations: No more than one molar restoration per visit. Limitations: Replace stainless steel crowns Coverage D only after 26 months from the date of initial placement. Exclusions: Gold full restorations.

Major Restorative Services
Covered: Teeth restoration, including crowns (rods, porcelain, 14 cast, and full cast), bridges and crowns (metallic, resilient, and porcelain), and veneers. Limitations: Only for the treatment of severe cavities or acute fracture on permanent teeth, and only when teeth cannot be restored with an amalgam restoration. Duration: Replacement of single tooth restorations Coverage D only after 26 months from the date of initial placement. Exclusions: Intraoral (mucous) dentures.

Prenatal Services - Fixed Bridges
Covered: Partial dentures (partial plates), including pontics, retainers, and abutment crowns, lingual, and canines (rods, porcelain, and full cast). Limitations: Only for a missing tooth or teeth cannot be adequately restored with a removable partial denture. Duration: Replacement of single tooth restorations Coverage D only after 26 months from the date of initial placement. Exclusions: Intraoral (mucous) dentures.

Prenatal Services - Removable Dentures
Covered: Complete, immediate, and partial dentures. Limitations: X, if the construction of such dentures, the Member and the Dentist decide on a permanent restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided under the standard procedures or materials (as determined by the Plan). Benefits are not provided for Dependent under age 18. Replacement of complete dentures Coverage D only after 66 months from the date of initial placement. Exclusions: Intraoral (mucous) dentures.

Other Major Restorative & Prenatal Services
Covered: Dental bridge services including core buildups, pontic and core, recenteration, and repair; Denture services including adjustment, relining, extending and base conditioning, implants and supported prostheses, including lab milled metal.
Limitations: The benefit provided for crown and bridge restorations includes benefits for the removal of crown preparation, temporary or provisional crown, impression and composites. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where services are provided because of absence or destruction of certain teeth or defects; an extensive restoration of such coronal portion of the crown would not be feasible. Post endodontic care, including root canal performed in conjunction with a Crowned crown or bridge. Crown and bridge repair and recontouring are Covered separately only after 12 months from the date of initial placement. Posterior crowns are Covered separately only after 6 months from the date of initial placement. No more than one molar crown or bridge in any 26-month period.

Exclusions: Other major restorative services including endodontic fillings and crowns. Other prosthodontics services including crown, inlay, onlays, attachments, veneers, bar, braun, and coping metal.

Basic Endodontics
Covered: Pulmonary, spinal therapy.
Limitations: For primary teeth only. Not Covered when performed in conjunction with major endodontic treatment. The benefits for basic endodontic treatment include benefits for any, pulp vitality tests, and radiographs provided in conjunction with basic endodontic treatment. Exclusions: Pulped teeth.

Major Endodontics
Covered: Root canal treatment and re-treatment, specification, apicoplasty surgery, root amputation, reimplantation, filling, hemostasis, pulp cap.
Limitations: No more than one root canal treatment, re-treatment or specification per tooth in 6-month period. No more than one apicoplasty per visit. Benefits for major endodontics include benefits for any, pulp vitality tests, pulpotomy, pulpoplasty and endodontic Rings and temporary filling materials provided in conjunction with major endodontic treatment. Exclusions: Implantation, canal preparation, and endoextraction therapeutic.

Basic Periodontics
Covered: Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedures. Limitations: Not more than one periodontal scaling and root planing in any 26-month period. No more than two full mouth debridement per lifetime. No more than one of any periodontal (cleaning) or periodontal maintenance procedures in any 6-month period. Cleanings are subject to additional limitations listed below under Preventive Services, and may be subject to a different Coverage D copayment. Benefits for major periodontics are provided at a fee of the Group. Benefits for periodontal maintenance procedures are provided at a fee of the Group. Benefits for periodontal maintenance procedures are not provided at a fee of the Group. Benefits for periodontal maintenance procedures are not provided at a fee of the Group. Benefits for periodontal maintenance procedures are not provided at a fee of the Group. Benefits for periodontal maintenance procedures are not provided at a fee of the Group. Exclusions: Periodontal scaling.

Major Periodontics
Covered: Surgical periodontics including grafting, gingivoplasty, gingival flap procedures, crown lengthening, osseous surgery and bone and tissue grafting.
Limitations: No more than one major surgical periodontal procedure in any 26-month period. Benefits provided for major periodontics include benefits for services related to 10 days of postoperative care. Exclusions: Tissue regeneration and esthetically oriented flap procedures.

Basic Oral Surgery
Covered: Non-surgical or simple extractions.
Limitations: Benefits provided for basic oral surgery include benefits for extractions and periodontal procedures. Exclusions: Benefits for general anesthetics or intravenous sedation when performed in conjunction with oral surgical procedures.

Major Oral Surgery
Covered: Surgical extractions (including removal of impacted teeth and wisdom teeth), and other oral surgical procedures not Covered under a medical plan. Limitations: Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care. Benefits for general anesthetics or intravenous sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer anesthetics.

Exclusions: Oral surgery Typically Covered under a medical plan, including but not limited to, extraction of teeth and bone trauma, treatment of fractures, abcesses, swelling and other oral procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations.

Orthodontics Services
Covered: Orthodontics services including fixed braces, retainers, lingual braces, and aligners. Limitation and exclusion of orthodontic and appliance treatment to reduce or eliminate an existing malocclusion.
Limitations: The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both anesthetic and correctable, and a Treatment Plan must be submitted and approved by the Plan. The Plan reserves the right to review from Member’s dental records, including necessary X-rays, photographs, and models to determine whether orthodontic treatment is Covered. Orthodontic services may be limited to Dependent under age 18, as defined on Attachment D: Schedule of Benefits. Orthodontics services may be limited by a Maximum Allowable Charge, Calendar Year Deductible and lifetime maximums as defined or Attachment D: Schedule of Benefits. Multiple occurrences of orthodontic treatment may be allowed subject to the lifetime maximum. All orthodontic services shall be deemed to have been considered on the last date treated during Member’s Covered time, even if a new approved Treatment Plan has not been completed.
Exclusions: Replacement or repair of any lost, stolen or damaged or used under the Treatment Plan. Surgical procedures to aid in orthodontic treatment.

Other Exclusions From Coverage
Benefit not provided for any covered services or supplies or charges:
1) Dental services rendered from a dental or medical facility maintained by or on behalf of an Employee, including benefit association, stool, treatment, or similar person.
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 Dentist beyond the scope of his or her licensure.
4) Dental services which are free or for which You are not required to or diligently paid for or for which no charge would be made if You had no Coverage.
5) Dental services to the extent that changes for such services exceed change that would have been made and collected if no Coverage existed elsewhere.
6) Dental services covered by any residual insurance coverage, or a non-dental contract or credit life plan issued by Blue Cross Blue Shield of Tennessee or any other insurance company, earlier, or prior, or insurance, treatment that is treated by the Plan.
7) Any court order or judgment of a Member unless benefits are otherwise payable.
8) Courses of treatment undertaken before You become Covered under one program.
9) Any services performed after You cease to be eligible for Coverage.
10) Dental care or treatment not specifically listed in Attachment D: Schedule of Benefits.
11) Any treatment or service that the Plan determines is not Necessary, that does not offer a favorable prognosis that does not meet given accepted standards of professional dental care, or that is experimental nature.
12) Services or supplies for the treatment of any related illness or injury. Regardless of the presence or absence of workers’ compensation cover. This exclusion does not apply to injuries or illnesses of an employee of a sole proprietorship of the Group, or a partner of the Group, or insole of the Group, provided the other plan is not an employee’s compensation under the appropriate government department.
13) Charges for any hospital or other surgical or treatment facility and a additional fees charged by a Dentist for any such facility.
14) Any services rendered with respect to congenital malformations or spinal surgeries or surgical procedures.
15) Exclusions of basic services under Coverage B (if applicable).
16) Replacement of teeth lost as a result of general and accidental sedation, and anesthesia (except as provided under major oral surgery).
17) Dental services rendered after one or more kits, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural tooth extracted or lost after Your Coverage became effective.
18) Exclusions for, or fabrication of, appliances or restorations necessary for correction of serious or/minor temporomandibular joint dysfunction (TMJD) or associated musculoskeletal disorder.
19) Dental diagnostic services such as diagnostic tests and oral pathology.
20) Dental services including all local and general anesthesia induction, and analgesia (except as provided under major oral surgery).
21) Charges for the treatment of cancrum oris, xerostomia, or other oral malignancies.
22) Charges for the treatment of cancrum oris, xerostomia, or other oral malignancies.
23) Charges for the treatment of professional visits outside that dental or regular scheduled homor or for observation.

BlueCross BlueShield of Tennessee
1 Camelot Hill Circle
Chattanooga, TN. 37402
www.bct.com

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association
Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans.

This document has been classified as public information.