City of Gallatin
BlueCross BlueShield of Tennessee Voluntary Dental Plans
Effective 10-1-2012

Summary of Benefits	Dental Option 1	Dental Option 2	Dental Option 3
Deductible Calendar Year Applies to Coverage B and C Only	**Individual** $50 **Family** $150	**Individual** $50 **Family** $150	**Individual** $50 **Family** $150
Benefit Maximums Applies to Coverage A,B, and C Coverage D	$1,000 per Calendar Year	$1,000 per Calendar Year	$1,000 per Calendar Year $1,000 per Lifetime
Benefits Percentages Apply to	Any Dentist*	Any Dentist*	Any Dentist*
Covered Services	**Benefit Percentages**	**Benefit Percentages**	**Benefit Percentages**
Coverage A (Preventive) Exams, X-Rays, Cleanings, Fluoride, Sealants, Space Maintainers	100%	100%	100%
Coverage B (Basic) Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	50%	50%	80%
Coverage C (Major) Major Restorative and Prosthodontics	30%	50%	50%
Coverage C Waiting Period	12 Month Waiting Period Applies	12 Month Waiting Period Applies	12 Month Waiting Period Applies
Coverage D (Orthodontics) Orthodontics - Child to Age 19	Not Applicable	Not Applicable	50%
Coverage D Waiting Period	Not Applicable	Not Applicable	12 Month Waiting Period Applies
Network Option	Network Dentists paid at PPO fee schedule; Non-Network dentists paid at 70th percent of PPO fee schedule.	Network Dentists paid at PPO fee schedule; Non-Network dentists paid at 70th percent of PPO fee schedule.	Network Dentists paid at PPO fee schedule; Non-Network dentists paid at 70th percentile of Usual, Customary & Reasonable
DenteMax National Network	Included **	Included **	Included **
BluePerks	Discounts on routine vision care, Lasik surgery, weight loss and fitness centers complementary / alternative medicine and more		

Voluntary Dental Rates 12 Month Rate Guarantee	**Dental Option 1**			**Dental Option 2**			**Dental Option 3**		
		Monthly	**Biweekly**		**Monthly**	**Biweekly**		**Monthly**	**Biweekly**
	Individual	**$16.01**	**$8.01**	**Individual**	**$27.42**	**$13.71**	**Individual**	**$31.54**	**$15.77**
	2-Person	**$32.04**	**$16.02**	**2-Person**	**$44.28**	**$22.14**	**2-Person**	**$64.17**	**$32.09**
	Family	**$55.23**	**$27.62**	**Family**	**$67.97**	**$33.99**	**Family**	**$118.62**	**$59.31**

This document serves as a summary of 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. BCBST has contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because BCBST has no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

****BCBST also has a nationwide network**

>If a member changes to Option 3 from Option 1 or Option 2 at open enrollment, there will be a 12 month waiting period for orthodontics.

>Dependent children can stay on the dental plan until age 26. However, the orthodontics coverage is only to age 19.

Members are encouraged to use In-Network dentists for all services.

This summary was created by Premier Benefits Group/Coley Lyles Insurance. Please refer to your Evidence of Coverage for more details.

BlueCross BlueShield of Tennessee

City of Gallatin

Summary of Benefits	DentalBlue	Standard Plan
	Dental Option: 1 **Effective Date: October 1, 2013**	
Deductible Calendar Year Applies to Coverage B and C only	**Individual** $50	**Family** $150
Benefit Maximums Applies to Coverage A, B, and C (per Calendar Year)	$1,000	
Benefit Percentages apply to	Any Dentist*	

Covered Services	Benefit Percentages
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	50%
Coverage C Major Restorative and Prosthodontics Implants	30%
Coverage D Orthodontics	Not Available
Preferred Option	Network Dentists paid at PPO fee schedule; non-network dentists paid 30% less than PPO fee schedule
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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BlueCross BlueShield of Tennessee

City of Gallatin

Summary of Benefits	DentalBlue	Standard Plan
	Dental Option: 2	
	Effective Date: October 1, 2013	
Deductible Calendar Year Applies to Coverage B and C only	**Individual** $50	**Family** $150
Benefit Maximums Applies to Coverage A, B, and C (per Calendar Year)	$1,000	
Benefit Percentages apply to	Any Dentist*	

Covered Services	Benefit Percentages
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	50%
Coverage C Major Restorative and Prosthodontics Implants	50%
Coverage D Orthodontics	Not Available
Preferred Option	Network Dentists paid at PPO fee schedule; non-network dentists paid 30% less than PPO fee schedule
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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City of Gallatin

Summary of Benefits	DentalBlue	Standard Plan
	Dental Option: 3 **Effective Date: October 1, 2013**	
Deductible Calendar Year Applies to Coverage B and C only	**Individual** $50	**Family** $150
Benefit Maximums Applies to Coverage A, B, and C (per Calendar Year) Coverage D (per Lifetime)	$1,000 $1,000	
Benefit Percentages apply to	Any Dentist*	

Covered Services	Benefit Percentages
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	80%
Coverage C Major Restorative and Prosthodontics Implants	50%
Coverage D Orthodontics-Child to age 18	50%
Choice Option	Network Dentists paid at PPO fee schedule; non-network dentists paid at 70th percentile of UCR
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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COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/ extensive and periodontal oral 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 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 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 must be taken on the same date of service.
Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey x-ray films, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

Cleanings, 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 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 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 recementation 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 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 per 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: Temporary and provisional crowns.

Prosthodontic Services - Fixed Bridges
Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast).
Limitations: Only for treatment where 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 or materials, benefits 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: Interim (temporary) dentures.

Other Major Restorative & Prosthodontic Services
Covered: Crown and bridge services including core buildups, post and core, recementation, and repair. Denture services including adjustment, relining, rebasing and tissue conditioning. Implants and supported prosthetics, including local anesthetic.
Limitations: The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated 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 benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge. Crown and bridge repair and re-cementation are Covered separately only after 12 months from the date of initial placement. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement. No more than one denture reline or rebase in any 36 month period.
Exclusions: Other major restorative services including sedative fillings and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.

Basic Endodontics
Covered: Pulpotomy, pulpal 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 x-rays, pulp vitality tests, and sedative fillings provided in conjunction with basic endodontic treatment.
Exclusions: Pulpal debridement.

Major Endodontics
Covered: Root canal treatment and re-treatment, apexification, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.
Limitations: No more than one root canal treatment, re-treatment or apexification per tooth in 60-month period. No more than one apicoectomy per root per lifetime. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative fillings 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 procedure.
Limitations: No more that one periodontal scaling and root planing per quadrant in any 24-month period. No more than one full mouth debridement per lifetime. No more than one of any prophylaxis (cleanings) or periodontal maintenance procedure in any 6-month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical 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 or suturing 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 care. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery 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, excision 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 xrays, 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 on Attachment C: 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 concluded on the last date treatment performed during Member's Coverage, even if a prior approved Treatment Plan has not been completed.
Exclusions: Replacement or repair of any 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 charges:
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 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.
5) Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no 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 become 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-proprietor 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) Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
18) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
19) Diagnostic dental services such as diagnostic tests and oral pathology services.
20) Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
21) Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
22) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

BlueCross BlueShield of Tennessee

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This document has been classified as public information