# Murfreesboro City Schools

## Summary of Benefits

<table>
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<th>DentalBlue</th>
<th>Standard Plan</th>
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<tr>
<td><strong>Dental Option:</strong></td>
<td>1</td>
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<tr>
<td><strong>Effective Date:</strong></td>
<td>January 1, 2018</td>
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### Deductible Calendar Year
- Applies to Coverage B only
- **Individual** $50
- **Family** $150

### Benefit Maximums
- Applies to Coverage A, B, and C (per Calendar Year)
- **$750**

### Benefit Percentages apply to
- Any Dentist*

## Covered Services

### Coverage A
- Exams, X-rays
- Cleanings, Fluoride
- Sealants, Space Maintainers
- **100%**

### Coverage B
- Basic Restorative Services
- Basic Endodontics
- Basic Periodontics
- Basic Oral Surgery
- **80%**

### Coverage C
- Major Restorative and Prosthodontics
- Not Covered
- Major Endodontics
- Major Periodontics
- Major Oral Surgery

### Coverage D
- Orthodontics
- Not Available

### 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

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

Exams
Covered: Standard exams including comprehensive, periodic, detailed and periodontal oral examinations (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/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 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: Exodontal, skull and bone survey, tomography, TMJ, and tomographic survey x-rays, cephalometric and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

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

Limitations: Not more than one cleaning and one fluoride treatment per 24 months. Not more than one oral prophylaxis and one fluoride treatment in any 12-month period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.

Sealsants, 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 Members under age 16. Space maintainers for Dependents under age 14. No more than one reapplication 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, and root canal therapy for the replacement of non-carious 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, 1/4 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 bridges (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, 1/4 cast, 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 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 have been provided under standard procedures (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, retreatment, and replacement. 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 preparation, temporary or otherwise defined on Attachment C: Schedule of Benefits. Orthodontic services may be limited to a limited number of teeth and/or to a limited type of treatment, as defined on Attachment C: Schedule of Benefits. Multiple occurrences of orthodontic treatment may be allowed subject to the lifetime maximum of orthodontic services shall be deemed to have been concluded on the 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 are orthodontic treatment.

Other Exclusions From Coverage
Benefits are not provided for the following services or supplies or charge:
1) Dental services rendered at a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, union, trustee or similar person or group.
2) Charges for services performed by You or Your spouse, or Your or 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 to pay or for which no charge would be made if You had no Coverage.
5) Dental services to the extent that charges for such services exceed 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 Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries 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 under the coverage hereunder.
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 Necessity Dental Care, that does not offer a favorable prognosis that does not result generally accepted standards of professional dental care, or that is experimental in nature.
12) Services for the supply of the treatment of work-related illnesses or in regards to the absence or presence of workers’ compensation coverage.
This exclusion does not apply to injuries or illnesses of an employee: (1) a sole employee of the Group, (2) a partner in 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 any additional fees charged by a Dentist for treatment in any such facility. Please refer to the schedule of benefits for more information.
14) Benefits under a limited or any other cohort limitations or prints 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 crown, bridge, removable orthodontic appliance.
17) Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage became effective. Benefits for replacement are not provided for the extraction or loss of an extracted tooth before Your Coverage became effective.
18) Diagnosis for, or fabrication of, appliances or restorations necessary 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 path processes.
20) Adjunctive dental services including all local and general anesthesia sedation, and analgesia of the Group or any other covered under major oral surgery.
21) Charges for the treatment of desensitizing medications, drugs, g guards and adjustments, mouthgaurds, microabrasion, behavior management, and bleaching.
22) Charges for the treatment of professional visits outside the dental or after regularly scheduled hours or for observation.

Orthodontic Services
Covered: Excluded are orthodontic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an abnormal condition.

Limitations: The need for orthodontic services must be diagnosed, and 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 under a specified age limit, as defined on Attachment C: Schedule of Benefits. Orthodontic services may be limited by a Major 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 orthodontic services shall be deemed to have been concluded on the 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 are orthodontic treatment.

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