DentalBlue plans from BlueCross BlueShield of Tennessee offer you flexibility, convenience and exceptional customer service – all from one of the most trusted names in the business. Additionally, DentalBlue offers administrative ease with combined ID cards and billing for your dental and medical plans from BlueCross BlueShield of Tennessee.

Whether added as a complement to your existing health plan with BlueCross BlueShield of Tennessee or as a stand-alone, DentalBlue offers network, benefit plan and service advantages from a name you can trust.

**Network:**
- Largest dental PPO network in Tennessee that delivers average claim savings in excess of 20 percent
- With over 2,600 dental locations in Tennessee, 80 percent of our members use network dentists
- Offers a national network solution of over 100,000 dental locations so members have access to discounted services outside of Tennessee

**Benefit Plan:**
- A wide selection of comprehensive and preventive plans to meet your needs
- Low participation voluntary dental options with DentalBlue Select
- Plan options with reduced coinsurance out-of-network and choices for out-of-network reimbursement
- New plans and enhancements such as a high deductible dental plan and the healthy maintenance option

**Service:**
- Best in class service with real-time claims adjudication
- Best discount programs with BluePerks including routine vision, lasik and health club discounts

With DentalBlue you also get extra services when you bundle both medical and dental with BlueCross BlueShield of Tennessee including secondary medical coverage for third molar extraction (wisdom teeth) and an Oral Health Program that offers extra cleanings to members with certain chronic conditions. With an award winning Web site that has dental tools and oral health information we can help employees stay in tune with their dental care needs. Best of all, our plans promote routine dental care which helps prevent small dental issues from becoming major oral and total health care problems.
### SUMMARY OF BENEFITS

**DentalBlue Traditional Standard Plan**  
**Group Name:** Arnold Fab & Machine Shop  
**Group Number:** 87868  
**Benefits Effective:** August 1, 2015

<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>3x</td>
</tr>
</tbody>
</table>

**Benefit Maximums**  
• Applies to Coverage A, B, and C  
$1,500 per Calendar Year

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Covered Services</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage A</strong></td>
<td>Exams, X-rays, Cleanings, Fluoride, Sealants, Space Maintainers</td>
<td>Copay - None, Network - 100%, Non-Network - 100%</td>
</tr>
<tr>
<td><strong>Coverage B</strong></td>
<td>Basic Restorative Services, Basic and Major Endodontics, Basic and Major Periodontics, Basic and Major Oral Surgery</td>
<td>Network - 80%, Non-Network - 80%</td>
</tr>
<tr>
<td><strong>Coverage C</strong></td>
<td>Major Restorative, Implants and Prosthodontics</td>
<td>Network - 50%, Non-Network - 50%</td>
</tr>
<tr>
<td><strong>Coverage D</strong></td>
<td>Orthodontics</td>
<td>Your Plan does not Cover these services</td>
</tr>
</tbody>
</table>

**Network Option**  
Preferred

**BluePerks**  
Discounts on routine vision care, Lasik surgery, weight loss and fitness centers, complimentary/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 on 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.  
Implants have been added effective 1/1/08. Anesthesia in conjunction with an implant service is also now covered.*

*Quote: 181*
Uncovered:

- Standard exams including comprehensive, periodic, detailed, emergency and periodontal oral evaluations (exams), emergency exams, including limited and evaluations (extra fees).
- Examinations: 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/exam, or periodic exam in any 12-month period.
- Exclusions: Re-evaluations and consultations.

Covered:

- Full mouth series, and in-plane and panoramic x-rays.
- Cleanings: no more than one prophylactic cleaning during any 12-month period.
- Basic Oral Surgery: Covered.
- Selected functional procedures: basic (cleaning) and child and adult (or age limitations) (limited to two per lifetime, for Dependent under age 18). Space maintainers for Dependents under age 14. No more than one recommendation in any 12-month period.
- Prophylaxis: no more than one per year. No more than one per year on partial dentures.
- Exclusions: Gold fill procedures.

Major Restorative:

- Restorative procedures, including crowns (root, porcelain, cast, and full cast), inlays and onlays (metal, resin, and porcelain), and core buildups.
- Limitations: Only for the treatment of severe caries, lesions or severe fractures on permanent teeth, and only when teeth cannot be adequately restored with an onlay or resin composite similar (if available). For permanent teeth only. For Dependents under age 12, benefits will not be provided for cast crowns or inlays. Replacement of tooth structure lost from wear or attrition.
- Exclusions: Temporary or provisional crowns.

Prophylactic Services - Fixed Bridges

- Procedures that involve crowns, partials, retainers, and partial dentures, inlays and onlays (resin, porcelain, and full cast).
- Limitations: Only for treatment due to missing teeth or teeth cannot be adequately restored with a removable partial denture. For permanent teeth only, no benefits for Dependents under age 12. Replacement of fixed partial dentures covered only after 90 months from the date of initial placement.

Prophylactic Services - Removable Dentures

- Replacement or repair of any lost, damaged, or broken dentures.
- Limitations: If, in the construction of a denture, the incisors and the canines are replaced on a personalized arrangement or any special, other than standard techniques or materials, benefits provided shall be limited to those provided for the standard procedure or materials (as determined by the Plan). Benefits are not provided for Dependents under age 12. Replacement of removable dentures covered only after 6 months from the date of initial placement.

Other Major Restorative and Prophylactic Services

- Crown and bridge services including cast crowns, post and core, restoration, and bridge. Benefits include all necessary procedures including adjustment, relining, relining and tissue conditioning. Implants and supported prosthetics, including local anesthetics.

Limitations: The benefits provided for crowns and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation. Benefits will not be provided for crown build-up services from those provided for crown construction, except in those circumstances when benefits are provided for a crown because of severe caries lesion or fracture is existent, it is necessary to reinstate the crown would not be possible. Post and core services are Covered only when performed in conjunction with a Crown or bridge. Crowns 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 relining or relining in any 18 month period.

Exclusions: Other major restorative services including sedative fillings and replacement or repair of any lost, damaged, or broken dentures.

Basic Endodontics

- Cephalometric photographs.
- Exclusions: Limited to one examination per year. No more than one cephalometric examination is allowed per year for Dependent under age 12.

Major Endodontics

- Endodontic treatment and treatment, extraction, apicectomies, root amputation, sequestration filling, hemostasis, pulp capping, apexification per tooth in 60-month period. No more than one apicoectomy per tooth in 60-month period. No more than one one procedure is performed on any one tooth in any 24-month period. No more than one root amputation per tooth in any 24-month period.

- Prophylaxis: no more than one per year for permanent teeth. Benefits for periodontal maintenance are provided only after active treatment in any 12-month period.

Basic Periodontics

- Non-surgical periodontal procedures.
- Limitations: No more than one per year. Benefits for periodontal scaling and root planing are provided only for permanent teeth in any 24-month period. No more than one root amputation per tooth in any 24-month period.

Basic Oral Surgery

- Non-experimental in nature.
- Limitations: Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care.

Major Oral Surgery

- Surgical situations (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) solution are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

Oral Surgery: Typically Covered under a medical plan, include but not limited to, extraction of lesions and bone tissue, treatment of fractures, resection, removal, and other repair procedures. TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations.

Orthodontic Services

- Covered; graphic images, diagnostic casts, cephalometric, study models, and installation of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

Limitations: The need for orthodontic treatment 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-ray, 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 Change, 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. Additional orthodontic services shall be deemed to have been completed on the last date the treatment performed was documented by Member’s Coverage, even if prior approved Treatment Plan has not been completed.

Exclusions: Replacement or repair of any lost, damaged, or broken dentures provided on or after the date of initial placement.

Other Exclusions:

- Dental services covered by the patient’s medical insurance policy 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, tonsil and adenoid, allergic reactions to teeth, etc.

- Any over-the-counter treatment of a Member others unless benefits are otherwise payable.

- Coverage of treatment undertaken before you became Covered under this plan.

- Dental services performed after the period of time for which coverage would not be made.

- Dental services provided under the coverage created or amended or modified by or as a result of any legislation.

- Benefits for general anesthesia or intravenous sedation when not reasonably necessary to correct a problem or to resume the correct temporomandibular joint dysfunction (TMJ) or associated muscle.

- Diagnostic dental services such as diagnostic tools and endopathology services.

- Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).

- Charges for the treatment of dentists for the diagnosis of complications, drugs, esophageal reflux and adjustments, mouthguard, microabrasion, behavior management, and aerosol.

- This document has been classified as public information.