



**CITY OF CLEVELAND/CLEVELAND UTILITIES
PREFERRED DENTAL CARE**

Coverage A	100%
Coverage B	80%
Coverage C	50%
Coverage D	50%

Deductible/Calendar Year (applies to Coverage B & C only)

Individual	\$25.00
Family	\$75.00

Calendar Year Maximum (Coverage A, B, C)

\$1,000 per person

Lifetime Maximum (Coverage D)

\$2,000 per person

Out-of-network and Out-of-area benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. Member is responsible for paying any amount exceeding the maximum allowable charge in addition to deductible and coinsurance.

PREVENTIVE – Coverage A

- Routine and periodic examinations are covered twice in a 12-month period.
- A set of bitewing x-rays are covered once every 12-month period.
- Full mouth x-rays once in any 36-month interval.
- Topical fluoride application for dependent children once in any 12-month interval.
- Prophylaxis, including cleaning, scaling and polishing, (twice in a 12 month period)
- Sealants on first and second permanent molar on dependents up to age 16.
- Space maintainers (up to age 14)

BASIC – Coverage B

- Emergency treatment for relief of pain.
- Restorative services: fillings material such as amalgam, synthetic porcelain and plastic restorations. (once per tooth and surface within a 12 month period)
- Oral surgery: Provides for extractions and other oral surgery.
- Endodontics, including pulpotomy, pulp capping and root canal treatment.(Root Canal treatment is limited to once per tooth within a 5 year period)
- Periodontics (treatment for diseases of the gums and bones).(Surgery limited to once in 36 months for each area filed. Root planing once in a 24 month period for each area filed.)
- Repair of full and partial dentures.
- Stainless steel crowns(once per tooth within a 36 month period)

MAJOR – Coverage C (Crown & Prosthetic Care)

- Non-precious restorations.
- Crowns (plastic, plastic with non-precious metal, porcelain with non-precious metal)
- Bridges
- Full and partial dentures
- Relining of full and partial dentures (up to one in any three year period)
- Non-precious restorations, crowns and prosthetic appliances are a benefit only once in a (5) five year period.

ORTHODONTIA – Coverage D

- Straightening and alignment of teeth for dependent children.
- To age 24 or to age 26 if full time student



PREFERRED DENTAL CARE

WHAT IS NOT COVERED

The dental program will not provide benefits for the following services or supplies:

- dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group;
- services or supplies for the treatment of any work related illness or injury, regardless of the presence or absence of Workers Compensation coverage. This exclusion does not apply to illness or injury resulting from self-employment by a sole proprietor or partner of a group who has elected not to be covered by the Workers' Compensation Law.
- dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes (unless and to the extent orthodontic services are covered hereunder);
- 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.
- diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or restore occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles;
- replacement of tooth structure lost from wear or attrition;
- services rendered by a Dentist beyond the scope of his/her license;
- topical fluoride application for members age 19 and older
- charges for dental services which exceed the charge that would have been made and actually collected if no coverage hereunder existed;
- dental care or treatment not specifically listed in the Schedule of Benefits;
- dental services covered by any medical insurance coverage or by any non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other company, carrier or plan. For example; removal of impacted teeth, cysts and tumors of lip and gum, accidental injuries to the teeth, jaw, etc.
- dental services resulting from the loss or theft of a denture, crown or bridge;
- provisional splinting, or double (multiple) abutments for fixed bridges;
- courses of treatment, which were undertaken prior to the date the person became covered under this program;
- services of anesthetists or anesthesiologists or general anesthesia or intravenous sedation for restorative dentistry;
- any services performed after the last day of the month during which any person ceases to be eligible for coverage under this Contract;
- services rendered for oral hygiene or dietary instruction or for prescribed drugs or other medications;
- treatment for desensitizing teeth;
- a drug, device, medical or dental treatment or procedure which is Experimental or Investigational;
- charges by any hospital or other surgical or treatment facility and any additional fees charged by a dentist for treatment in any such facility;
- implants (or any synthetic material implanted into or on bone or gums), or their removal.
- a posterior bridge in conjunction with an allowance for a partial denture in the same arch;
- temporary partial dentures, excepting those immediately following extraction of anterior teeth; and/or
- gold foil restorations;
- Crowns and prosthetics including bridges, full and partial dentures, and relining and duplication of full and partial dentures (except as specified in the Schedule of Benefits); and/or orthodontics (except as specified in the Schedule of Benefits).

Note: This proposal is not a contract. Further details explaining the provisions and limitations of this coverage are in the Dental Coverage Contract.