COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/ extensive and periodontal oral exams (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.

Basic and Preventive Services
Covered: Full mouth series, intraoral and bitewing radiographs (x-rays). Exclusions:
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 a panoramic x-ray. Benefits provided in excess of the requirements may be considered, but may not be reimbursed unless medically necessary. Base x-rays include x-rays of 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.
Exclusions: Extraneous, skull and bone survey, angiography, TMJ, and tomographic survey x-rays. cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

Cleansings, 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 Periodic 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:
Exclusions: 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 remanentation in any 12-month period.
Exclusions: Any related consultation and smoking cessation counseling, or any hospital outpatient, and any other preventive dental services.

Basic Restorative Services
Covered: Basic restorative services, including amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), stainless steel crowns. Limitations:
Exclusions: 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. Conflicts: Gold foil restorations.

Major Restorative Services
Covered: Single tooth restorations, including crowns (resin, porcelain, 3/4, cast, and full cast), inlays and onlays (all-ceramic, metal, resin, and porcelain), and veneers.
Limitations: Only for the treatment of severe traumatic lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with a 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, and full cast).
Limitations: Only for treatment when 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 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, the benefits provided shall be limited to the cost for those which would otherwise be provided for the standard procedures or materials (as determined by the Plan). Benefits are not covered for Dependents under age 16. Replacement of removable dentures Covered only after 60 months from the date of initial placement.
Exclusions: Intrintr (temporairs) dentures.

Other Major Restorative & Prosthodontic Services
Covered: Crown and bridge services including care budish, rest and core, reparation, 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 a prebiotic or prosthodontist for 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 a second core build-up is necessary because of severe carious lesions or fracture so extensive that retention of the crown would not be possible. Post and core services are Covered only when performed in conjunction with a Crown or bridge. Crown and root repair and cementation are Covered separately only after 12 months from the date of initial placement. Denture adjustments are Covered separately from the denture only after the initial period. No more than one denture relin or rebases 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, pulp 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 sedation fillings provided in conjunction with basic endodontic treatment.
Exclusions: Pulpal debridement.

Major Endodontics
Covered: Root canal treatment and re-treatment, apicectomy services, root amputation, repositioning, filing, hemisection, pulp cap.
Limitations: No more than one root canal treatment, re-treatment or apicectomy service per 60-month period. No more than one apexification per root per lifetime. The benefits for major endodontic 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:
Exclusions:

Basic Oral Surgery
Covered: Surgical extractions (including removal of impacted teeth and other oral surgic.
Limitations:
Exclusions:

Orthodontics Services
Covered: Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malformation.
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. Refer to the Breakdown of Benefits in the 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 apparatus 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 Dental 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 for or as for which no charge would be made if You had no dental Coverage.
5) Refunds to the extent that charges for such services exceed the charge that would have been made and collected if Coverage hereunder was not a part of your health benefits package.
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, the officer filed an election not to accept Workers' Compensation with the appropriate governmental 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) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or to restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated musculoskeletal issues.
18) Diagnostic dental services such as diagnostic tests and oral pathology services.
19) Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under Basic Oral Surgery).
20) Charges for the treatment of desensitizing medications, drugs, occlusal guards and adjustment of nightguards, microabrasion, behavior management, and bleaching.
21) Charges for the treatment of professional outside the dental office or after regularly scheduled hours for or observation.

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