Covered Services, Limitations, & Exclusions

Exams
Covered: Standard exams including comprehensive, periodic, detailed, extended and periodontal oral exams (evaluations). Emergency exams, including limited oral evaluations (exams).
Limitations: No more than one standard exam in any 6-month period. No more than two emergency exams in any 6-month period. No more than one comprehensive, detailed, or periodontal exam in any 36-month period.
Exclusions: Re-evaluations and consultations.

X-rays
Covered: Full mouth series, introral and bite-wing 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 introral complete series or an extraoral series. Benefits provided under either benefit include benefits for all necessary introral and bite-wing films taken on the same day. No more than four bite-wing films in any 12-month period. Bite-wing films must be taken on the same date of month.
Exclusions: Extraoral, skull and bone survey, sialography, 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.

Cleaneings, 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 prophylaxis or periodontal maintenance procedure in any 8-month period. Periodontal maintenance procedures are subject to additional limitations listed below in 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 reapplication in any 12-month period.
Exclusions: Bite-wing films, 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 treatments are the relief of pain. No more than one fluoride treatment in any 12-month period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.

Major Restorative Services
Covered: Major restorative services, including crowns (resin, porcelain, ¼ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.
Limitations: 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.
Exclusions: Gold foil restorations.

Prosthodontic Services - Fixed Bridges
Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¼ cast, and full cast), indwelling and bridge veneers. Replacement of single tooth restorations covered only after 60 months from the date of initial placement.
Exclusions: Fixed partial dentures.

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, then such treatment will 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 care boul dings, post and core, recementation, and repair. Denture services including adjustment, relining, rebasing and tissue conditioning. Implants and supported prosthetics, including local aesthetic.

Limitations: The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, core build-ups separate from those provided for crown construction, except in those circumstances where the core build-up is performed because of severe caries 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 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 12 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, 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 sedative fillings provided in conjunction with basic endodontic treatment. Exclusions: Pulpal debridement.

Major Endodontics
Covered: Root canal treatment and re-treatment, apicectomy services, root amputation, retromolar filling, hemisection, pulp cap.
Limitations: No more than one root canal treatment, re-treatment or apicectomy per tooth in any 60-month period. No more than one apicectomy 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 than 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 in any 24-month period.
Exclusions: Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

Major Periodontics
Covered: Surgical periodontics including gingivectomy, gingioplasty, 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 regenration 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 periodontal 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 anesthesia.
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. Orthodontic surgery and treatment for congenital malformations.

Orthodontics Services
Covered: Exams, photographs, images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malposition.
Limitations: The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and recognizable, 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 pre-approved age limit by prior approval and to a Schedule of Benefits. Orthodontic services may be limited by a Maximum Allowable Charge, Calendar Year Deductible and lifetime maximum as approved under 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.

Exclusions From Coverage
Benefits are not provided for the following services or supplies: 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 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 became 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) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfuction (TMJ) or associated muscles. 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 major or basic surgery). 20) Charges for the treatment of desensitizing medications, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching. 21) Charges for the treatment of professional offices outside the dental office or after regularly scheduled hours or for observation.

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