## Summary of Benefits

<table>
<thead>
<tr>
<th>Deductible Calendar Year</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Benefit Maximums

- Unlimited

### Benefit Percentages apply to

- Any Dentist*

### Covered Services

<table>
<thead>
<tr>
<th>Coverage A</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams, X-rays</td>
<td>100%</td>
</tr>
<tr>
<td>Cleanings, Fluoride</td>
<td></td>
</tr>
<tr>
<td>Sealants, Space Maintainers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage B</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Restorative Services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Basic and Major Endodontics</td>
<td></td>
</tr>
<tr>
<td>Basic and Major Periodontics</td>
<td></td>
</tr>
<tr>
<td>Basic and Major Oral Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage C</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Restorative and Prosthodontics</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage D</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Choice Option

- Network Dentists paid at PPO fee schedule; non-network dentists paid at 90th percentile of UCR

### National Network

- Included

### Oral Health Program

- Included - Members with Diabetes, Rheumatoid Arthritis, High Risk Pregnancy, or certain forms of Head/Neck Cancer may qualify for one additional exam and cleaning per year. This program is proactive and does not require member or provider initiation.

### Blue365

- Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, 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 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 all charges that exceed our fee schedule.*
COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/ extensive and periodontal oral evaluations (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, detail/extensive 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 at least a yearly basis.

Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey x-ray films, cephalometrics and diagnostic photographs. Cephalometrics and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

Cleanings, Fluorides
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 12-month period. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics in Section VI, and may be subject to a different Coverage level at Attachment C: Schedule of Benefits. No more than one fluoride treatment in any 1-year period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.

Sealants
Covered: Space Maintained
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 re-sealing in any 24-month period.

Limitations: Numinal and tobacco counseling, oral hygiene instructions.

Basic Restorative Services
Covered: Basic restorative services, including amalgam restorations (silver fillings), resin composite restorations (both colored fillings), stainless steel crowns. Palliative (emergency) treatment for the relief of pain. Other restorative services, including repair of full and partial dentures.

Limitations: No more than one amalgam or resin restoration per tooth surface area 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 (metal, 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 under age 12, benefits may 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 dental prostheses, including pre-fabricated crowns, dentures, and permanent prosthodontic implants. Benefits are not provided for crown because of severe carious lesions or fracture or so extensive that retention of the existing restoration is not possible.

Limitations: 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 6 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, connective bars, partial crowns and coping metal.

Basic Endodontics
Covered: Pulpectomy, pulpectomy, pulpal 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, pulpotomy, pulpectomy and sedative fillings and temporary filling material provided in conjunction fillings and endodontic treatment.

Exclusions: Pulpal debridement.

Major Endodontics
Covered: Root canal treatment and re-treatment, specification, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.

Limitations: No more than one root canal treatment, re-treatment or specification per tooth 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 fillings and 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 12-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 major periodontal services 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 on the same day.

Exclusions: Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

Major Periodontics
Covered: Surgical periodontics including gingivectomy, gingivoplasty, 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 periodontic services are subject to a waiting period of 90 days of postoperative care.

Exclusions: Tissue regeneration 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 general anesthesia or inpatient sedation when performed in conjunction with basic surgical care.

Major Oral Surgery
Covered: Surgical extractions (including removal of impacted teeth and wisdom teeth), and any major 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 inpatient sedation (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

Exclusions: Implants and any related 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. Orthognathic surgery and treatment for congenital malformations.

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 malocclusion.

Limitations: The need for orthodontic services must be diagnosed, identifying a handpacing malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by us. The Plan must show that the Reviewer’s Member’s dental records, including x-rays, photographs, and models to determine whether orthodontic treatment is Covered. Orthodontics services may be Covered under a plan of limited scope, as defined in Attachment C: Schedule of Benefits. Orthodontic services may be Covered 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 implemented.

Exclusions: Replacement or repair of any lost, stolen and damaged orthodontic equipments or procedures.

Other Exclusions From Coverage
2) 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.
3) Charges for services performed by You or Your spouse, or You or Your spouse’s parent, sister, brother or child.
4) Services rendered by a Dentist beyond the scope of his or her license.
5) Dental services which are free, or for which You are not required or legally obligated to pay for or which no charge would be made if You had no dental Coverage.
6) Dental services to the extent that charges for such services exceed the charge that would have been made and collected if Coverage existed hereafter.
7) 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, or plan. For example, replacement of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
8) Any court-ordered treatment of a Member unless benefits are otherwise payable.
9) Courts of treatment undertaken before You Become Covered under this program.
10) Any services performed after You cease to be eligible for Coverage.
11) Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
12) Any treatment or service that the Plan determines is not Necessary within the meaning of the Act, that does not offer a favorable prognosis, does not meet generally accepted standards of professional dental care, or that is experimental in nature.
13) Changes for any hospital or other surgical treatment facility and any additional fees for, or transaction of treatment in 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) Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
18) Charges for the work of a person who is not a provider of professional services, or who is not maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
19) Charges for services performed by You or Your spouse, or You or Your spouse’s parent, sister, brother or child.
20) Services rendered by a Dentist beyond the scope of his or her license.
21) Dental services which are free, or for which You are not required or legally obligated to pay for or which no charge would be made if You had no dental Coverage.
22) Dental services to the extent that charges for such services exceed the charge that would have been made and collected if Coverage existed hereafter.
23) Charges for the treatment of dental injuries to the teeth, gums, or supporting structures, including fractures, lacerations, subluxation, avulsion, or avulsions of teeth, except as provided under major oral surgery.
24) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

J. Cameron Hill Circle
Chattanooga, TN 37402

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- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

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