### Summary of Benefits

**Dental Option: Base Plan**  
**Effective Date:** 1/1/2021

<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>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Maximums</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to Coverage A, B, and C (per Calendar Year)</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Percentages apply to</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Dentist*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Covered Services

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Benefit Percentages</th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams, X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanings, Fluoride</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants, Space Maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage B</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Basic Restorative Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic and Major Endodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic and Major Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic and Major Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage C</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Major Restorative and Prosthodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage D</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Choice Option</th>
<th>Network Dentists paid at PPO fee schedule; non-network dentists paid at 90th percentile of UCR</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>National Network</th>
<th>Included</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Oral Health Program</th>
<th>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</th>
</tr>
</thead>
</table>

| Blue365 | Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more |

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%), deductibles, 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 any billed charges that exceed our Maximum Allowable Charge.
COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/ intensive, and periodontal 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, detailed/intensive, or periodontal exam in any 36-month period.

Exclusions: Re-evaluations and consultations.

X-rays
Covered: Full mouth series, intraoral 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 intraoral complete series or panoramic x-rays. Benefits provided for either include benefits for all necessary intraoral and bite-wing films taken on the same day. No more than four bitewing films in any 12-month period. Bite-wing films being taken on the same day are excluded.

Exclusions: External, skull and bone survey, tomography, and panoramic x-rays. Cephalometric x-ray series and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage.

Cleanings, 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 procedures in any 6-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 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.

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 21, for at least one molar tooth in any 12-month period.

Exclusions: Nutritional and 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 (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 in any 12-month period. Limitation for replacing amalgam and composite restorations Covered only after 12 months from the date of initial restoration. Replacement of a tooth restoration Covered only after 36 months from the date of initial restoration. No more than one repair per denture per 24 months.

Exclusions: Gold for restorations.

Major Restorative Services
Covered: Single tooth restorations, including crowns (veneal, porcelain, 1/2 cast, and full cast), inlays and onlays (metallic, resin and porcelains), and veneers.

Limitations: No more than one tooth per year that requires a crown or filling restoration. Replacement of single tooth restorations Covered only after 50 months from the date of initial placement.

Exclusions: Temporary and provisional crowns.

Prosthodontic Services - Fixed Bridges
Covered: Fixed bridges, including pontics, retainers, and attachment crowns, inlays and onlays (veneal, porcelain, 1/2 cast, and full cast).

Limitations: Only for the treatment of severe caries 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 only. For Dependents under age 12, benefits will not be provided for cast crowns or veneerCrowns. Replacement of single tooth restorations Covered only after 50 months from the date of initial placement.

Exclusions: Temporary and provisional crowns.

Other Major Restorative & Prosthodontic Services
Covered: Crown and bridge services including core buildups, post and core, received during Your Coverage (if applicable) including adjustments, relining and tissue conditioning. Implants and supported prosthodontics, including local anesthetics.

Limitations: The benefits provided for crown and bridge restorations include benefits provided for the crown preparation, temporary or prefabricated crowns, impressions and cementsation. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown 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- cmentation 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 relin or rebase in any 36 month period.

Exclusions: Other major restorative services including sedative fillings and coping. Other prosthodontic services including overdentures, precision attachments, connector bars, stress reliever and coping metal.

Basic Endodontics
Covered: Pulpotomy, 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, and sedative fillings provided in conjunction with basic endodontic treatment.

Exclusions: Pulpal depletion.

Major Endodontics
Covered: Root canal treatment and re-treatment, apicectomy, apicoectomy, root amputation, root regeneration, hemisection, pulp cap.

Limitations: No more than one root canal treatment, re-treatment, or apicectomy per tooth in 60-month period. No more than one apicoectomy per root per lifetime.

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 procedures.

Limitations: No more than one periodontal scaling and root planing per quadrant in any 24-month period. Periodontal maintenance treatment per lifetime. No more than one of any prophylaxis (cleanings) or periodontal maintenance procedures in any 24-month period. Limitation 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 for patients with severe 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 scaling, splitting 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 periodontics include benefits for services related to 90-days of postoperative care.

Exclusions: Tooth transplantation and apically positioned flap procedure.

Basic Oral Surgery
Covered: Non-surgical or simple extractions.

Exclusions: Benefits provided for basic oral surgery include benefits and suturing and postoperative care.

Exclusions: Benefits for general 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 dental plan.

Exclusions: Benefits for major oral surgery include benefits for local anesthesia, suturing and postoperative care. Benefits for general anesthesia or intravenous sedation are provided only in conjunction with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

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. Orthognathic surgery and treatment for congenital malformations.

Orthodontics Services
Covered: Exams, photographic images, diagnostic casts, cephalometric tracings, 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 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, as defined on Attachment C: Schedule of Benefits. Orthodontic services may be limited by a Maximum Allowable Charge. Calendar Year “Deductible and Lifetime maximum as defined on Schedule of Benefits. Maximum occurrences of orthodontic treatment may be allowed subject to the lifetime maximum. All orthodontic services shall be deemed to have been completed on the last date treatment performed during Member’s Coverage, even if a prior approved Treatment Plan has not been completed.

Exclusions: Services for replacement or repair of any lost, stolen and damaged appliance 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) Dental services for services performed by You or Your spouse, or Your spouse’s parent, sister, brother or child.
3) Services rendered by a Dentist beyond the scope of his or her license.
4) Dental services which are false, 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 Covered as existed hereafter.

Exclusions of treatment undertaken before You become Covered under this program.
6) Any services performed after You cease to be eligible for Coverage.
7) Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.

Any treatment or service that the Plan determines is not Necessary Dental Care, that does not offer a favorable diagnosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
8) Services or supplies for the treatment of work related illness or injury, compensation claims.
9) Treatment for burns, tissue damage, or allergy.
10) Exclusion does not apply to injuries or illnesses of an employee who is (1) a member of the Group; (2) a partner of the Group; or (3) a corporate offee of the Group, provided the officer filed an election not to accept Workers’ Compensation with the appropriate government department.
11) Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dental for treatment in any such facility.
12) Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under orthodontic benefits for any individual in that category.
13) Replacement of tooth structure lost from wear or attrition.
14) Dental services resulting from or due to a thief of a denture, crown, bridge or removable orthodontic appliance.
15) Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage became effective under the Plan unless it also replaces one or more natural teeth extracted or before Coverage became effective.
16) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
17) Prosthetic dental services such as diagnostic tests and oral pathology services.
18) Corrective dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
19) Charges for the treatment of developing malignancies, drugs, esophageal guards and adjustments, mouthguards, microabrasion, behavior management and bleaching.
20) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

This document has been classified as public information.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

Notice: if you speak Spanish, language assistance services are available free of charge. Call 1-800-565-9140 (TTY: 1-800-848-0298).

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ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).


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注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY: 1-800-848-0298)。

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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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