BlueCross BlueShield of Tennessee

Mastercorp Inc

Summary of Benefits	BCBST Dental	Standard Plan
	Dental Option: 1	
	Effective Date: January 1, 2025	
Deductible Calendar Year	**Individual**	**Family**
Applies to Coverage B, C and D	$50	$150
Benefit Maximums		
Applies to Coverage A, B, and C (per Calendar Year)	$1,000	
Coverage D (per Lifetime)	$1,000	
Benefit Percentages apply to	Any Dentist*	

Covered Services	Benefit Percentages
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	80%
Coverage C Major Restorative and Prosthodontics Implants	50%
Coverage D Orthodontics-Child to age 19	50%
Choice Option	Network Dentists paid at PPO fee schedule; non-network dentists paid at 80th percentile of UCR
National Network	Included
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%), 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 any billed charges that exceed our Maximum Allowable Charge.

COVERED SERVICES AND EXCLUSIONS

EXAMS

Covered: One periodic exam in any 6-month period. One limited oral evaluation in any 12-month period. One comprehensive, detailed/extensive, or periodontal exam in any 36- month period.

X-RAYS

Covered: 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. Up to four bitewing films in any 12-month period. All bitewing films must be taken on the same date of service.

Exclusions: Extraoral, skull and bone survey, sialography, temporomandibular joint dysfunction (TMJ), and tomographic survey x-ray films, cephalometric films and diagnostic photographs, unless otherwise stated in this Dental EOC.

CLEANINGS, FLUORIDE TREATMENT

Covered: One prophylaxis in any 6-month period, except when replaced as described below in Basic Periodontics. One fluoride treatment in any 12-month period for Members age 18 and under.

SEALANTS, SPACE MAINTAINERS

Covered: One sealant or preventive resin restoration per lifetime on first and second permanent molars for Members age 15 and under. Space maintainers for Members age 13 and under. One recementation per space maintainer in any 12-month period.

BASIC RESTORATIVE SERVICES

Covered: 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. Stainless steel crowns. Replacement of stainless steel crowns Covered after 36-months from the date of initial restoration. One sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per lifetime, for Members age 15 and under. Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits. Palliative (emergency) treatment for the relief of pain. One repair per denture in any 24-month period. General anesthesia or intravenous (IV) sedation in connection with major oral surgery procedures and implants when provided by a Dentist licensed to administer such agents.

Exclusions: Gold foil restorations.

MAJOR RESTORATIVE SERVICES – SINGLE TOOTH RESTORATIONS

Covered: Crowns, inlays and onlays 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).Replacement of single tooth restorations or fixed partial dentures (bridges) after 60-months from the date of initial placement. Veneers for anterior permanent teeth.

Exclusions: Provisional restorations and crowns. Cast crowns or laminate veneers for Members age 11 and under.

PROSTHODONTIC SERVICES – FIXED BRIDGES

Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast) for permanent teeth only. Replacement of fixed partial dentures or single tooth restorations after 60-months from the date of initial placement.

Exclusions: Provisional or interim restorations. Bridges for Members age 15 and under.

PROSTHODONTIC SERVICES – REMOVABLE DENTURES

Covered: Complete, immediate and partial dentures utilizing standard techniques and materials as determined by the Plan. Personalized restorations, special techniques or materials shall be covered up to the amount allowed for standard techniques and materials. Replacement of removable dentures after 60-months from the date of initial placement.

Exclusions: Interim (temporary) dentures. Dentures for members age 15 and under.

OTHER MAJOR RESTORATIVE & PROSTHODONTIC SERVICES

Covered Services: Core build-up covered separately from restoration only in those circumstances where benefits are provided because severe carious lesions or fractures are so extensive that retention of the restoration would not be possible. Crown inlay, onlay, veneer and bridge repair and re-cementation after 12-months from the date of initial placement. One denture adjustment in any 6-month period and only after 6-months from the date of initial placement. One denture reline, rebase, or tissue conditioning in any 36-month period. One implant per tooth per lifetime. One bone graft for implant per tooth per lifetime. One implant debridement per tooth per lifetime. Initial placement or replacement of implant supported prosthesis after 60-months from the date of any corresponding major restoration.

Exclusions: Provisional and interim restorations. Other major restorative services including protective restoration and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal. Crown preparation, temporary or prefabricated crowns, impressions and cementation. Post and core services not performed in conjunction with a Covered crown or bridge.

BASIC ENDODONTICS

Covered: Pulpotomy, pulpal therapy for primary teeth but not when performed in conjunction with major endodontic treatment.

Exclusions: Pulpal debridement. Pulp vitality tests. Protective restorations.

MAJOR ENDODONTICS

Covered: One root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, hemisection, pulp cap or root amputation) per tooth in any 60-month period. One apicoectomy per root per lifetime. Retrograde filling if done on same date of service as apicoectomy.

Exclusions: Guided tissue regeneration. Intentional re-implantation (including necessary splinting). Canal preparation. Incomplete endodontic therapy. Pulp vitality test. Protective restorations.

BASIC PERIODONTICS

Covered: One periodontal scaling and root planing per quadrant in any 24- month period. One full mouth debridement per lifetime. Periodontal maintenance no sooner than 90 days after completion of any one of the Basic Periodontic Covered Services above. Periodontal maintenance will replace a prophylaxis or scaling. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a prophylaxis or periodontal maintenance procedure.

Exclusions: Provisional splinting, and antimicrobial medication and dressing changes. Periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.

MAJOR PERIODONTICS

Covered: One major surgical periodontal procedure, including gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, per quadrant in any 36-month period. One crown lengthening per tooth in any 36-month period. One bone and tissue grafting per site in any 36-month period.

Exclusions: Tissue regeneration and apically positioned flap procedure.

BASIC ORAL SURGERY

Covered: Non-surgical or simple extractions (pulling teeth).

MAJOR ORAL SURGERY

Covered: Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.

Exclusion: 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. Harvesting of bone for use in autogenous grafting.

ORTHODONTIC SERVICES (MANY PLANS DO NOT PROVIDE ORTODONTIC COVERAGE)

Covered: Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

Exclusions: Replacement or repair of any lost, stolen and damaged appliance. Surgical procedures to aid in orthodontic treatment.

OTHER EXCLUSIONS FROM COVERAGE

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. Services or supplies not listed as Covered Services under Attachment A, Covered Services and Limitations on Covered Services.
3. Charges for services performed by You or Your spouse, or Your 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 or for 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 no Coverage existed hereunder.
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, carrier, or plan. For example, removal 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. Courses of treatment undertaken before You become Covered under this program.
10. Any services performed after You cease to be eligible for Coverage, except as shown under the Payment for Services Rendered after Termination of Coverage section.
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 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.
13. 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.
14. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
15. 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.)
16. Replacement of tooth structure lost from wear or attrition.
17. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
18. 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.
19. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
20. Diagnostic dental services such as diagnostic tests and oral pathology services.
21. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as stated elsewhere in this EOC).
22. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
23. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.
24. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.
25. Dental consultations including but not limited to re-evaluations, teledentistry, nutritional and tobacco counseling and oral hygiene instruction.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 800-848-0298-1

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)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

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).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه- اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید .

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.