BlueCare Plus
Tennessee

BlueCare Plus (HMO D-SNP)℠
BlueCare Plus Choice (HMO D-SNP)℠

2022 Dental Benefits Guide

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This guide has info you need about your dental benefits, including what's covered and how often you can get covered dental care. To see the full details, look in your **Evidence of Coverage** (EOC).

You can find the EOC online at **bluecareplus.bcbst.com/yourmaterials**.

Questions? Give us a call.
1-800-332-5762, TTY **711**
We're here to help.

From **Oct. 1 to March 31**, you can call us seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

All services may not be covered — give us a call for more information. If you move from one dentist to another during one treatment, or if more than one dentist gives you care for one procedure, we'll only cover the cost of one dentist's care. Make sure you visit an in-network provider. Services at an out-of-network provider won't be covered. You don't have to get prior authorization for any procedure, but you should check with us first for treatments where the total charges may be more than $200. You'll have to pay for any non-covered services. If the services you get cost more than your maximum allowed amount, you'll be responsible for any extra charges. These benefits are subject to the Benefits Chart (what is covered) section of the Evidence of Coverage.

Covered Dental Services

Coverage A

Exams and Cleaning	One periodic exam every six months One emergency exam every 12 months One cleaning or periodontal maintenance visit every six months
X-rays	1 set (up to 4) of bitewing films every 12 months 1 panoramic X-ray OR full mouth set of X-rays in 36 months

Coverage B

Restorative Services	Amalgam and composite filling Palliative treatment (emergency relief of pain)
Endodontics (pulp of teeth)	Root canal treatment
Periodontics (tissue and bone that supports teeth)	Full mouth debridement Periodontal scaling and root planning
Oral Surgery	Extractions; oral surgery

Coverage C

Major Restorative and Prosthodontics	Removable full and partial dentures Crowns and fixed bridge Denture, reline or rebase

This is a summary of your dental benefits. To see the full details, look in your Evidence of Coverage (EOC) or the next pages in this guide.

Covered Services, Limitations and Exclusions

Coverage A /Preventive Services

Exams

Covered: Standard exams, including comprehensive, periodic, detailed/extensive and periodontal oral evaluations (exams). Emergency exams, limited oral evaluations (exams).
Limitations: No more than one periodic exam every 6 months. No more than one emergency exam every 12 months. No more than one comprehensive, detailed/extensive or periodontal exam every 36 months.
Exclusions: Re-evaluations and consultations.

Cleanings, Fluoride Treatment

Covered: Adult and child prophylaxis (cleaning). Child and adult fluoride treatments, performed with or without a cleaning.
Limitations: No more than one cleaning or periodontal maintenance procedure every 6 months. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics found under Coverage B. No more than one fluoride treatment every 12 months for members under age 19. Fluoride must be applied separately from cleaning paste.

X-rays

Covered: Full mouth series, intraoral and bitewing radiographs (X-rays).
Limitations: No more than one full mouth set of X-rays every 36 months. A full mouth set of X-rays is either an intraoral complete series or panoramic X-ray. Benefits provided for either include all necessary intraoral and bitewing films taken on the same day. No more than four bitewing films every 12 months. Bitewing films must be taken on the same date.
Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey X-ray films,

cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

Other Preventive Services

Covered: Some preventive services, including sealants, space maintainers.
Limitations: No more than one recementation every 12 months.
Exclusions: Nutritional and tobacco counseling, oral hygiene instructions.

Coverage B

Basic Restorative Services

Covered: Amalgam restorations, silver fillings, resin composite restorations (tooth-colored fillings), stainless steel crowns. Emergency pain relief. Repair of full and partial dentures.
Limitations: No more than one amalgam or resin restoration per tooth surface every 12 months. 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 every 24 months.
Excluded: Gold foil restorations.

Basic Endodontics

Covered: Pulpotomy, pulpal therapy. The benefits for basic endodontic treatment include X-rays, pulp vitality tests and sedative fillings provided with basic endodontic treatment.
Limitations: For primary teeth only. Not covered when performed with major endodontic treatment.
Exclusions: Pulpal debridement.

Major Endodontics

Covered: Root canal treatment and re-treatment, apexification, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap. The benefits for major endodontic treatment include X-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative filings, and temporary filling material provided with major endodontic treatment.
Limitations: No more than one root canal treatment, re-treatment or apexification per tooth every 60 months. No more than one apicoectomy per root per lifetime.
Exclusions: Implantation, canal

Covered Services, Limitations and Exclusions

preparation and incomplete endodontic therapy.

Basic Periodontics

Covered: Some non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance.

Limitations: No more than one periodontal scaling and root planing per quadrant every 24 months. No more than one full mouth debridement per lifetime. No more than one cleaning or periodontal maintenance procedure every 6 months. Cleanings are subject to additional limitations listed under Coverage A/ Preventive Services, and may be subject to a different coverage level under your EOC. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of the treatment. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided if 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: Some surgical periodontics, including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery, and bone and tissue grafting. Benefits provided for major periodontics include services related to 90 days of postoperative care.

Limitations: No more than one major periodontal surgical procedure every 36 months.

Exclusions: Tissue regeneration and apically positioned flap procedure.

Basic Oral Surgery

Covered: Some non-surgical or simple extractions. Benefits provided for basic oral surgery include suturing and postoperative care.

Exclusions: General anesthesia or

intravenous sedation when performed with basic oral surgery.

Major Oral Surgery

Covered: Some surgical extractions (including removal of impacted teeth and wisdom teeth) and other oral surgical procedures. Benefits provided for major oral surgery include local anesthesia, suturing and postoperative care.
Limitations: Benefits for general anesthesia or intravenous (IV) sedation are provided only with major oral surgery procedures and only when provided by a dentist licensed to administer them.
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.

Coverage C

Major Restorative Services

Covered: Some single tooth restorations, including crowns (resin, porcelain, ¾ cast and full cast), inlays and onlays (metallic, resin and porcelain) and veneers.
Limitations: Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when the teeth can't be adequately restored with an amalgam or resin composite restoration (filling). For permanent teeth only. Replacement of single tooth restorations covered only after 60 months from the date of initial placement. Exclusions: Provisional restorations and crowns. Cast crowns or laminate veneers for members age 11 and under.

Prosthodontic Services

Covered: Complete, immediate and partial dentures.
Limitations: While constructing a denture, if the member and dentist decide on a personalized restoration or to use a special technique, the benefits will only cover the standard procedure or materials. Replacement of removable dentures covered only after 60 months from the date of initial placement.
Exclusions: Interim (temporary) dentures.

Other Major Restorative and Prosthodontic Services

Covered: Some crown and bridge

Covered Services, Limitations and Exclusions

services, including core buildups, post and core, recementation and repair. Denture services, including adjustment, relining, rebasing and tissue connecting. Implants are covered once per lifetime. Implant supported prosthesis is limited to 1 in 60 months. The benefits provided for crown and bridge restorations include the services of crown preparation, temporary or prefabricated crowns, impressions and cementation.

Limitations: Benefits won't be provided for a core build-up separate from those provided for crown construction, except in circumstances where benefits are provided for a crown because of severe carious lesions or a fracture so extensive that retaining the crown wouldn't be possible. Post and core services are covered only when performed with a covered crown or bridge. Crown and bridge repair and recementation 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 every 36 months.

Exclusions: Other major restorative services, including sedative fillings and coping. Other prosthodontic services, including overdenture, precision attachments, connector bard, stress breakers and coping metal.

Other Exclusions From Coverage

Regardless of any other reference in this Dental Product Guide, benefits are not provided for any of the following:

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 dentist beyond the scope of his or her license;

4) Dental services which are free, or for which you aren't required or legally

obligated to pay for, or for which no charge would be imposed 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 BlueCare Plus 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, unless benefits are otherwise payable;

8) Courses of treatment started before you became covered under this plan;

9) Any services performed after you're no longer covered by this plan;

10) Dental care or treatment not specifically listed in your Evidence of Coverage as being covered;

11) Any treatment or service that the plan determines isn't necessary dental care, that doesn't offer a favorable prognosis, that doesn't 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 doesn't 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 services rendered in a hospital or other surgical 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 doesn't exclude those services provided under orthodontic benefits (if applicable);

15) Replacement of tooth structure lost from wear or attrition;

Covered Services, Limitations and Exclusions

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 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 oral surgery);
20) Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management and bleaching;
21) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

For you. With you. We're right here.

Questions? Please call us.
1-800-332-5762, TTY **711**

bluecareplus.bcbst.com

BlueCare Plus Tennessee

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ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان.
اتصل برقم 1-800-332-5762, TTY 711.

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