# Schedule of benefits - Dental HMO Plan 106



The following co-payments apply only when performed by a PrimeCare plan general dentist

| COVERED BENEFITS | | COPAYMENT |
|---|---|---|
| | **Diagnostic Procedures** | |
| D0120 | periodic oral evaluation-established patient | $0 |
| D0140 | Limited oral evaluation-problem focused | $0 |
| D0150 | Comprehensive oral evaluation | $0 |
| | **Radiographs/Diagnostic Imaging (Including Interpretation)** | |
| D0210 | intraoral – complete series (including bitewings) | $25 |
| D0220 | intraoral – periapical first film | $0 |
| D0230 | intraoral – periapical each additional film | $0 |
| D0240 | intraoral – occlusal film | $10 |
| D0272 | bitewing – two films | $0 |
| D0274 | bitewing – four films | $0 |
| D0330 | panoramic film | $25 |
| D0350 | oral/facial photographic images | $10 |
| | **Test and Examinations** | |
| D0415 | collection of microorganisms for culture and sensitivity | $10 |
| D0460 | pulp vitality tests | $0 |
| D0470 | diagnostic casts | $25 |
| | **Preventative Procedures** | |
| D1110 | prophylaxis – adult *(Cleaning)* | $35 |
| D1120 | prophylaxis – child *(Cleaning)* | $30 |
| | **Other Preventative Services** | |
| D1310 | nutritional counseling for control of dental disease | $0 |
| D1320 | tobacco counseling for the control and prevention of oral disease | $0 |
| D1330 | oral hygiene instructions | $0 |
| D1351 | sealant – per tooth | $15 |
| | **Space Maintenance (Passive Appliances)** | |
| D1510 | space maintainer – fixed – unilateral | $135 |
| D1515 | space maintainer – fixed – bilateral | $135 |
| D1520 | space maintainer – removable – unilateral | $190 |
| D1525 | space maintainer – removable – bilateral | $190 |
| D1550 | re-cementation of space maintainer | $10 |

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| | **Restorative Procedures** | |
| *Amalgam Restorations (Including Polishing)* | | |
| D2140 | amalgam – one surface, primary or permanent | $45 |
| D2150 | amalgam – two surfaces, primary or permanent | $50 |
| D2160 | amalgam – three surfaces, primary or permanent | $60 |
| D2161 | amalgam – four or more surfaces, primary or permanent | $65 |
| | **Resin-based Composite Fillings Restorations – Direct** | |
| D2330 | resin-based composite – one surface, anterior | $55 |
| D2331 | resin-based compsite – two surface, anterior | $60 |
| D2332 | resin-based composite – three surfaces, anterior | $70 |
| D2335 | resin-based composite – four or more surfaces or involving incisal angle (anterior) | $95 |
| D2391 | resin-based composite-one surface, posterior | $65 |
| D2392 | resin-based composite – two surface, posterior | $80 |
| D2393 | resin-based composite – three surfaces, posterior | $115 |
| | **Crowns – Single Restorations Only *** | |
| D2710 | crown – resin based composite (indirect) | $195 |
| D2721 | crown – resin with predominantly base metal | $285 |
| D2740 | crown – porcelain/ceramic substrate | $575 |
| D2750 | crown – porcelain fused to high noble metal | $550 |
| D2751 | crown – porcelain fused to predominantly base metal | $375 |
| D2783 | crown – ¾ porcelain/ceramic | $575 |
| D2791 | crown – full cast predominantly base metal | $345 |
| D2810 | Crown – 3/4 cast metallic | $365 |
| | **Other Restorative Services** | |
| D2910 | recement inlay, onlay, or partial coverage restoration | $20 |
| D2920 | recement crown | $30 |
| D2930 | prefabricated stainless steel crown – primary tooth | $70 |
| D2931 | prefabricated stainless steel crown – permanent tooth | $85 |

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| | **Other Restorative Services Cont.** | |
| D2932 | prefabricated resin crown | $87 |
| D2940 | sedative filling | $25 |
| D2950 | core buildup, including any pins | $70 |
| D2951 | pin retention – per tooth, in addition to restoration | $25 |
| D2952 | post and core in addition to crown, indirectly fabricated | $115 |
| D2954 | prefabricated post and core in addition to crown | $80 |
| | **Endodontic Procedures** | |
| D3110 | pulp cap – direct (excluding final restoration) | $30 |
| D3120 | pulp cap – indirect (excluding final restoration) | $32 |
| D3220 | therapeutic pulpotomy (excluding final restoration) | $45 |
| D3221 | pulpal debridement, primary and permanent teeth | $45 |
| | **Endodontic Therapy** | |
| D3310 | root canal - anterior (excluding final restoration) | $225 |
| D3320 | root canal - bicuspid (excluding final restoration) | $275 |
| D3330 | root canal - molar (excluding final restoration) | $325 |
| | **Apicoectomy/Periradicular Services** | |
| D3410 | apicoectomy/periradicular surgery – anterior | $160 |
| D3421 | apicoectomy/periradicular surgery – bicuspid (first root) | $160 |
| D3425 | apicoectomy/periradicular surgery – molar (first root) | $160 |
| D3426 | apicoectomy/periradicular surgery (each additional root) | $160 |
| | **Periodontic Procedures** | |
| D4210 | gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant | $200 |
| D4211 | gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant | $75 |
| | **Non-Surgical Periodontal Service** | |
| D4250 | mucogingival surgery - per quadrent | $390 |
| D4260 | Osseous surgery (including flap entry and closure) - per quadrant | $390 |



*ACTUAL COST OF LAB ADDITIONAL FOR CROWNS AND PONTICS LIMITED TO $125

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| D4263 | bone replacement graft - first stie in quad | $180 |
| D4264 | bone replacement graft each additional site in quad | $105 |
| D4341 | periodontal scaling and root planing – four or more teeth per quadrant - *deep cleaning* | $90 |
| D4355 | full mouth debridement to enable comprehensive evaluation and diagnosis | $20 |
| D4381 | localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report | $58 |
| | **Prosthodontics – performed by a plan general dentist** | |
| *Complete Dentures (Including Routine Post-delivery Care)* | | |
| D5110 | complete denture – maxillary | $520 |
| D5120 | complete denture – mandibular | $520 |
| | **Partial Dentures (including Routine Post Delivery Care)** | |
| D5211 | maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | $400 |
| D5212 | mandibular partial denture – resin base (including any conventional clasps, rests and teeth) | $400 |
| D5213 | maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $600 |
| D5214 | mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $600 |
| D5410 | adjust complete denture – maxillary | $25 |
| D5411 | adjust complete denture – mandibular | $25 |
| D5421 | adjust partial denture – maxillary | $25 |
| D5422 | adjust partial denture – mandibular | $25 |
| | **Repairs to Complete Dentures** | |
| D5510 | repair broken complete denture base | $65 |
| D5520 | replace missing or broken teeth – complete denture (each tooth) | $50 |
| | **Repairs to Partial Dentures** | |
| D5610 | repair resin denture base | $55 |
| D5630 | repair or replace broken clasp | $65 |

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| | **Repairs to Partial Dentures Cont.** | |
| D5640 | replace broken teeth – per tooth | $55 |
| D5650 | add tooth to existing partial denture | $55 |
| D5660 | add clasp to existing partial denture | $75 |
| D5670 | replace all teeth and acrylic on cast metal framework (maxillary) | $275 |
| D5671 | replace all teeth and acrylic on cast metal framework (mandibular) | $275 |
| *Denture Rebase Proecures* | | |
| D5710 | rebase complete maxillary denture | $225 |
| D5711 | rebase complete mandibular denture | $225 |
| D5720 | rebase maxillary partial denture | $225 |
| D5721 | rebase mandibular partial denture | $225 |
| | **Denture Reline Procedures** | |
| D5730 | reline complete maxillary denture (chairside) | $95 |
| D5731 | reline complete mandibular denture (chairside) | $95 |
| D5740 | reline maxillary partial denture (chairside) | $95 |
| D5741 | reline mandibular partial denture (chairside) | $95 |
| D5750 | reline complete maxillary denture (laboratory) | $150 |
| D5751 | reline complete mandibular denture (laboratory) | $150 |
| D5760 | reline maxillary partial denture (laboratory) | $150 |
| D5761 | reline madibular partial denture (laboratory) | $150 |
| | **Interim Prosthesis** | |
| D5810 | interim complete denture (maxillary) | $400 |
| D5811 | interim complete denture (mandibular) | $400 |
| D5820 | interim partial denture (maxillary) | $230 |
| D5821 | interim partial denture (mandibular) | $230 |
| D5850 | tissue conditioning, maxillary | $45 |
| D5851 | tissue conditioning, mandibular | $45 |
| D5862 | precision attachment by report | $200 |
| | **Prosthodontics** | |
| *Fixed Partial Denture Pontics* | | |
| D6211 | pontic – cast predominantly base metal | $325 |

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| | **Prosthodontics Cont** | |
| D6241 | pontic – porcelain fused to predominantly base metal | $365 |
| D6245 | pontic – porcelain/ceramic | $575 |
| D6251 | pontic – resin with predominantly base metal | $265 |
| D6930 | recement fixed partial denture | $45 |
| | **Oral and Maxillofacial Surgery** | |
| D7210 | surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | $80 |
| D7220 | removal of impacted tooth – soft tissue | $95 |
| D7230 | removal of impacted tooth – partially bony | $135 |
| D7240 | removal of impacted tooth – completely bony | $170 |
| D7250 | surgical removal of residual tooth roots (cutting procedure) | $80 |
| | **Alveoloplasty – Surgical Preparation of Ridge for Dentures** | |
| D7310 | alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | $70 |
| | **Adjunctive General Services** | |
| *Unclassified Treatment* | | |
| D9110 | palliative (emergency) treatment of dental pain – minor procedure | $20 |
| | **Professional Visits** | |
| D9430 | office visits – per visit, per patient | $5 |
| | **Miscellaneous Services** | |
| | broken appointment (less than 24 hours notice given) | $25 |
| | duplication of x-rays | $20 |
| | emergency, out of area/non participasting provider (nc:not a covered benefit) | NC |
| | outpatient services/hospitalization & drug coverage (nc: not a covered benefit) | NC |
| | ambulance services/durable medical equipment (nc: not a covered benefit) | NC |
| | mental health/chemical dependency/home health services (nc: not a covered benefit) | NC |



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### Primecare Dental Limitations & Exclusions

1. Full mouth X-rays: Limited to one (1) set every three (3) years unless diagnostically necessary.
2. Bitewing X-Rays: Two (2) sets in any twelve (12) month period unless diagnostically necessary.
3. Sealants: Limited to molars, up to the 16th birthday.
4. Fluoride: Up to the 18th birthday two(2) in any twelve (12) month period.
5. Delivery of removable prosthodontics includes adjustments within six months of delivery date of service.
6. Periodontal scaling and root planning: Limited to four (4) quadrants per twenty-four (24) consecutive months in combination with routine prophylaxis.
7. The copayments listed for endodontic procedures do not include the cost of the final restoration.
8. Panoramic x-rays: One (1) in any three (3) year period unless diagnostically necessary.
9. Prophylaxis: covered once every six consecutive months.
10. Reline of a complete or partial denture: One (1) per denture in any twelve (12) month period, unless dentally necessary.
11. Rebase of a complete or partial denture: One (1) per denture in any twelve (12) month period, unless diagnostically necessary.
12. Replacement of partial or full dentures are covered once per arch every five (5) years, except when they cannot be made functional through reline or repairs.
13. Complete or partial dentures are not to exceed one per arch in a five (5) year period unless necessary due to natural tooth loss where the addition to an existing partial or denture is not feasible.
14. Treatment of malignancies, cysts, or neoplasm.
15. Periodontal grafting or splinting.
16. Extractions of impacted teeth with no radiographic evidence of pathology (disease). The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.
17. General anesthesia, analgesia, intravenous /intramuscular sedation or the services of an anesthesiologist.
18. Elective or cosmetic dentistry that are cosmetic in nature including, but not limited to bonding, bleaching teeth, personalization or dentures, posterior composites, porcelain veneers unless covered as a benefit.
19. Orthodontic treatment in process, or extractions for orthodontic purposes.
20. Procedures, appliances or restorations whose primary purpose is to change the vertical deminsion of occlusion, correct congenital development or medically induced dental disorders including but not limited to treatment of myofunctional, myoskeletal, or tempormandibular joint disorders unless otherwise specifically listed as a covered benefit on the plans schedule of benefits.
21. Precision attachments, stress breakers, magnetic retention or overdenture attachments.
22. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.

| COVERED BENEFITS | COPAYMENT |
|---|---|

### Primecare Dental Limitations & Exclusions

26. (Dentures are considered to be started when the impressions area taken. Orthodontic treatment is considered to be started when the teeth are banded).
27. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliance.
28. Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit.
29. Any procedure or treatment unable to be performed in the dental office due to the general health or physical limitation of the member.
30. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
31. Oral surgery requiring the setting of bone fractures or dislocations, Hospitalization , Out- patient services, Ambulance services, Durable Medical Equipment, Mental Health services, Chemical dependency services, Home Health services.
32. Dispensing of drugs supplied in a dental office.
33. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.
34. Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
35. Root canal treatment started, but not completed, prior to the Member's legibility to receive benefits under this Plan.
36. (Root canal treatment is considered to be started when the pulp chamber is opened, and completed when the permanent root canal filling material is placed.)
37. Coverage is up to twenty-four (24) months of comprehensive orthodontic treatment. If treatment goes beyond twenty four (24) months is necessary, the Member will be responsible for additional

### Miscellaneous Information

## FAQ

**Q: How many times a year can I have my teeth cleaned?**
Primecare Dental covers routine cleanings at your selected general dental office twice a year. Some members may require more than a "routine" cleaning due to more involved dental needs. When more frequent cleanings or extensive treatment, such as periodontal scaling and root planning is required, your dentist may charge you in accordance with your dental plan. Please refer to your Schedule of Benefits for more details.

**Q: What is a pre-existing condition? Is it covered?**
A pre-existing condition is any dental or oral health condition, which existed before joining the plan. Primecare Dental does not exclude pre-existing conditions on the offered plan.

**Q: What is work in progress? Is it covered?**
Work in progress is dental work that was started prior to joining the plan. It is the

### Miscellaneous Information Cont.

## FAQ

**Q: Is Orthodontia Covered?**
No, If you are would like a plan that covers Orthodontia, please a customer service specialits for information of Othodontia Plans.

**Q: Do I need to obtain claim forms?**
There are NO claim forms to fill out.

**Q: Is there a waiting period?**
No, you can begin using your Primecare Dental plan once it becomes effective.

**Q: Is this insurance?**
The plans offered are dental HMO benefit plans.

**Q: Can I change my dentist once I am in the plan?**
Yes. You have control over the choice of selected general dental office, and you can make changes at any time before the 25th of each month. If you need or desire to change your selected general dental office, please contact Primecare Dental's

**Q: Do I need my Member ID Card to make an appointment with my assinged dental office?**
No, your ID card is not necessary to receive dental care. Your information and any covered dependents will appear by name on the eligibility roster we send to your assiged dental office every month.

**Q: What if I need to change my membership from Individual to Family Coverage?**
Please contact Primecare Dental's Member Services Department to add any family members to the plan.

**Q: How do I add or cancel coverage for a dependent?**
Please contact Primecare Dental Member Services and they will assist you in adding or canceling your membership for additional members.

**Q: Q: If I cancel the policy, will I receive a refund of the premium or processing fee?**


**Contact Us**

Toll Free: (800) 937-3400
Business hours are Monday - Friday, 8:00 a.m. - 5:00 p.m. PCT

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