

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 (<i>Cleaning</i>)	\$35
D1120 prophylaxis – child (<i>Cleaning</i>)	\$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

COVERED BENEFITS	COPAYMENT
Restorative Procedures	
<i>Amalgam Restorations (Including Polishing)</i>	
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 composite – 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

COVERED BENEFITS	COPAYMENT
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 quadrant	\$390
D4260 Osseous surgery (including flap entry and closure) - per quadrant	\$390

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COVERED BENEFITS	COPAYMENT
D4263 bone replacement graft - first site 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 - <i>deep cleaning</i>	\$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	
<i>Complete Dentures (Including Routine Post-delivery Care)</i>	
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

COVERED BENEFITS	COPAYMENT
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
<i>Denture Rebase Procedures</i>	
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 mandibular 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	
<i>Fixed Partial Denture Pontics</i>	
D6211 pontic – cast predominantly base metal	\$325

COVERED BENEFITS	COPAYMENT
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	
<i>Unclassified Treatment</i>	
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 participating 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

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

COVERED BENEFITS COPAYMENT

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 relines 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 assinged 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

Mail to:
 10700 Civic Center Dr. Ste 100-A
 Rancho Cucamonga, CA 91730

Email Us: Customerservice@primecaredental.net

