

Dental HMO Basic Plan

Using your dental HMO plan

With our dental HMO plan, you'll have access to an extensive network of dental providers without paying deductibles or filling out claim forms. Plus, it's easy. First, choose a dental provider from our network during enrollment. Then, contact this dental provider for all of your dental care, including referrals for consultation with plan specialists and emergency services. If you have questions or want to switch providers, call Customer Service at **(800) 585-8111**.

Summary of benefits

Here are your covered services and copayments:

ADA Code	Service/Benefit	Member Copayment
9980	Office Visit	\$5
	Diagnosis	
0120/0150	Dental examination (routine)	No charge
0270/0272, 0274/0277	Bitewing X-rays (as necessary)	No charge
0330/0210	Full mouth X-rays or panoramic X-rays (as necessary)	No charge
0220/0230, 0240	Periapical or occlusal X-rays (as necessary)	No charge
0460	Pulp vitality tests	No charge
0470	Diagnostic casts	No charge
0474-0480, 0502	Histopathologic (laboratory) Examinations/procedures	No charge
9310	Specialist consultation (as necessary)	No charge
	Preventive	
1110/1120	Prophylaxis (cleaning and scaling)	No charge
1203	Fluoride treatment (eligible member to age 19)	No charge
1330	Oral hygiene and dietary instruction	No charge
1351	Sealants (per tooth) (eligible member to age 19)	No charge
	Restorative (includes local anesthetic)	
2140/2161	Amalgam restorations for treatment of caries	\$20 per surface
2330/2331, 2332/2335	Plastic or composite restorations for treatment of caries (anterior only)	\$20 per surface
	Plastic or composite restorations for treatment of caries (posterior only)	
2391	1 surface	\$75
2392	2 surfaces	\$90
2393	3 surfaces	\$115
2394	4 or more surfaces	\$140
2740/2783	Porcelain crowns (anterior through 2 nd bicuspid only)	\$350 each crown*
2750/2751, 2752	Porcelain with metal crowns (anterior through 2 nd bicuspid only)	\$350 each crown*

ADA Code	Service/Benefit	Member Copayment
2780/2781, 2782/2790 2791/2792/2794	Metal crowns	\$350 each crown*
2920	Recementation of crown	\$15
2930	Prefabricated stainless steel crown – primary tooth	\$30
2951	Pin buildup	\$25 per tooth
Periodontics (includes local anesthetic)		
4341	Scaling and root planing per quadrant (4 or more)	\$75 per quadrant
4342	Scaling and root planing (1–3 teeth)	\$38
4210	Gingivectomy/gingivoplasty (4 or more teeth)	\$200 per quadrant
4211	Gingivectomy/gingivoplasty (1–3 teeth)	\$40 per tooth
4260	Osseous surgery (4 or more teeth)	\$275 per quadrant
4261	Osseous surgery (1–3 teeth)	\$138
9951/9952	Equilibration	\$150 entire mouth
Prosthetics		
5110/5120, 5130/5140	Full upper or lower denture (includes adjustments for first 6 months post insertion)	\$400 per denture
5211/5212, 5213/5214	Upper or lower partial denture with metal lingual or palatal bar, clasps and acrylic saddles or base (includes adjustments for first 6 months post insertion)	\$450 per denture*
5225/5226	Upper or lower partial denture flexible base, including clasps, rests and teeth (includes adjustments for first 6 months post insertion)	\$450 per denture
5510/5520/5610	Denture repair (office)	\$100
5510/5520 5610/5620/5640	Denture repair (laboratory)	\$125
5650	Add tooth to existing partial denture	\$100
5660	Add clasp to existing partial denture	\$125
5730/5731, 5740/5741	Denture reline – chairside	\$125 per denture
5750/5751, 5760/5761	Denture reline – laboratory	\$150 per denture
5820/5821	Temporary partial stayplate (includes teeth and clasps)	\$125
5850/5851	Tissue conditioning	\$30 per denture unit
1510/1515, 1520/1525	Space maintainers (for primary teeth)	\$40 per tooth
Bridge abutments or pontics (per unit, includes local anesthetic)		
6750/6751/6752	Porcelain with metal crowns (anterior through 2 nd bicuspid only)	\$350 each crown*
6780/6781, 6782/6790 6791/6792/6794	Metal crowns	\$350 each crown*
6210/6212/6214 6240/6242	Pontics	\$350 each tooth replaced*
6930	Recement bridge	\$30
6980	Bridge repair procedure	Lab + \$30
Endodontics (includes local anesthetic)		
2952/6970	Cast post and core	\$125 in addition to crown*
2954/6972	Prefabricated post and core	\$125 in addition to crown*
2915	Recement cast or prefabricated post and core	\$5

ADA Code	Service/Benefit	Member Copayment
3110/3120	Pulp capping	\$20
3220	Pulpotomy	\$35
3310/3346	Root canal filling (anterior tooth)	\$175
3320/3347	Root canal filling (bicuspid tooth)	\$350
3330/3348	Root canal filling (molar tooth)	\$525
3410/3421, 3425	Apicoectomy (anterior/bicuspid/molar)	\$75 first root
3426	Apicoectomy (bicuspid/molar)	\$75 each additional root
3920	Hemisection (not including root canal)	\$125
Oral Surgery (includes local anesthetic)		
7140	Routine extraction	\$40 per tooth
7111	Routine removal of coronal remnants	\$20 per tooth
7210	Surgical removal	\$75 per tooth
7220	Removal of tooth (soft tissue impaction)	\$100 per tooth
7230	Removal of tooth (partial bony impaction)	\$150 per tooth
7240/7241	Removal of tooth (complete bony impaction)	\$225 per tooth
7310/7320	Alveoloectomy with/without extractions	\$75 per quadrant
7311	Alveoloectomy with extractions (1–3 teeth)	\$38
7321	Alveoloectomy without extraction (1–3 tooth spaces)	\$38
7250	Surgical removal of residual tooth roots	\$75
7285/7286/7287	Biopsy of oral tissue	\$60
7288	Brush biopsy (cell sample collection)	\$30
Emergency		
Emergency oral exam including palliative treatment (if treatment includes a listed procedure regular copayment also applies)		
9110 (9430)	During regular dental center office hours	\$20
9110 (9440)	After office hours	\$40
Other		
9999	Failed appointment (without 24-hour notice)	\$20
Orthodontics		
8070/8080, 8090	Orthodontic treatment to correct malocclusion, limited to one continuous two-year course of treatment per eligible child through age 18**	\$2,350
8090	Orthodontic treatment to correct malocclusion, limited to one continuous two-year course of treatment per eligible member age 19 years or older**	\$2,650
8680	Retainers	\$125 per retainer
8660	Orthodontic initial consultation	No charge

* Precious metals, if used, will be charged to the member at the dentist's cost.

** Note: In order to be covered, orthodontic treatment:

- 1) Must be received in one continuous course of treatment;
- 2) Must be received in consecutive months; and
- 3) Must not exceed 24 consecutive months.

Note: ADA codes are the American Dental Association codes.

General Exclusions and Limitations

A. General Exclusions

Unless otherwise specifically mentioned elsewhere in the contract, this plan does not provide benefits for:

1. Dental services not appearing on the Schedule of Benefits;
2. Dental treatment that has been previously started by another dentist prior to your eligibility to receive benefits under this plan;
3. Dental services for cosmetic purposes;
4. Dental services performed in a hospital or any related hospital fee;
5. Treatment to correct congenital and developmental malformations including but not limited to cleft palate, anodontia and mandibular prognathism, and enamel hypoplasia;
6. Treatments which, in the professional judgment of the attending dentist, have a poor prognosis when an alternative treatment with more favorable prognosis is available;
7. The placement of bone grafts or extra oral substances in the treatment of periodontal disorders;
8. Reimbursement to you or another dental office for the cost of services from dentists other than the selected dental provider or other plan-authorized provider, except:
 - a. When such reimbursement is expressly authorized by the plan; or
 - b. As cited under the emergency services provision;
9. Treatment for any condition for which benefits could be recovered under any workers' compensation or occupational disease law, if no claim is made for such benefits;
10. Treatment for which payment is made by any governmental agency, including any foreign government;
11. TMJ (temporomandibular joint) disorder or dysfunction;
12. Dental implants, transplants or ridge augmentations or removal of implants;
13. General anesthesia; including intravenous and inhalation sedation, except when medically necessary;
14. Charges for broken or missed appointments;
15. Prophylaxis more than twice per calendar year;
16. Precious metals (if used, will be charged to the patient at the dentist's cost);
17. A prosthetic appliance solely for the purpose of replacement will be limited to once in every five-year period;
18. Removal of 3rd molar (wisdom teeth) other than for dental necessity;
19. Referral of a dependent child age 6 and older to a pedodontist (specialist in children's dentistry);
20. Treatment as a result of accidental injury shall only be covered secondary to medical insurance or any other primary insurance with accidental coverage;
21. Services, procedures, or supplies which are reasonably necessary for the care of the member's dental condition according to broadly accepted standards of professional care or which are experimental or Investigational in nature or which do not have uniform professional endorsement.

B. Orthodontic Exclusions

1. Treatment in progress (after banding) at inception of eligibility;
2. Surgical orthodontics incidental to orthodontic treatment;
3. Treatment of myofunctional therapy;
4. Changes in treatment necessitated by an accident;
5. Retreatment of orthodontic cases; when plan concurs with the professional judgment of attending dentist that there is a poor prognosis;
6. Treatment of TMJ (temporomandibular joint) disorder;
7. Special orthodontic appliances, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
8. X-rays for orthodontic purposes (to include full mouth screen and cephalometrics);
9. Replacement of lost or stolen appliance, or repair of same if broken through no fault of orthodontist;
10. Charges for records fee – to include but not limited to cephalometric tracing, photos, models and radiographs (initial, progressive and final, as deemed necessary);
11. Charges for broken or missed appointment;
12. Treatment exceeding twenty-four (24) months.

C. Dental Necessity Exclusion

All services must be a dental necessity as defined in the *Evidence of Coverage*. The fact that a dentist or other plan provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine dental necessity even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude benefits for services which are not of dental necessity.

Limitations

All benefits are subject to the following limitations:

A. Prosthodontics

A prosthetic appliance solely for the purpose of replacing an existing, lost or stolen appliance will be provided once in a five-year period. A five-year period will be measured from the date the existing appliance was last supplied, whether under the contract or under any prior dental care policy.

Partial dentures. If a satisfactory result can be achieved by a cast chrome or acrylic partial denture, but the member and dentist select a more complicated precision case, the obligation of the plan will be any of the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the member.

Complete dentures. If a satisfactory result can be achieved through the utilization of standard procedures and materials, and if the member and the dental provider select a personalized appliance or one involving specialized techniques, the obligation of the plan will be any of the procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the member.

B. Restorative

Metal, baked porcelain restorations, crowns and jackets; amalgam, composite or plastic (anterior only) will be the materials used to restore the tooth. Judgment for materials used will be solely that of the dental provider providing the covered service. For crowns, a five-year period will be measured from the date the existing crown was last supplied, whether under this contract or under any prior dental care policy.

C. Mouth Rehabilitation

If the member and the dental provider select a course of mouth rehabilitation, the obligation of the plan will be to cover only those benefits appropriate to those procedures necessary to eliminate oral disease and replace missing teeth. The balance of the treatment, including costs to increase vertical dimension of the occlusion or to restore tooth loss by attrition or erosion, will remain the responsibility of the member.

D. Pedodontics

Referral of dependent children to a pedodontist will be covered by the plan for children through age 5 with prior approval of the plan. Benefits are not applicable for pedodontic care provided by a plan specialist for children age 6 and older unless of dental necessity, or the child will not allow the general dentist to treat after two attempts. All such exceptions must be approved by the plan.

Many benefits have pre-determined annual schedules and frequency limitations based on last delivery date and dental necessity. If you are unsure about the frequency of when a benefit can be accessed, you can call **(800) 585-8111**.

This is only a summary of the Blue Shield Dental HMO Basic Plan. Please refer to the plan contract and the *Evidence of Coverage* for a detailed description of covered benefits and limitations.