BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueDental Prime PPO – Standard Option (50)
Summary of Benefits and Member Copayments

Annual Deductible	**In-Network | Out-of-Network**	Deductible is combined for all services for each calendar year per Member – maximum $75 per family in-network and $150 out-of-network
Amount	$25 | $50	
Max Per Family	$75 | $150	
Applies to All Benefits	No, waived on Class I	
Maximums		Annual maximum applies to Class II and Class III Benefits.
Annual	$2,000 | $1,000	
Lifetime Ortho	N/A	
Waiting Periods	None	

- If course of treatment is to exceed $300, prior review is requested.

ADA Code	**Description**	**In-Network Member Copayment**	**Out-of-Network Plan Allowance**
CLASS I – DIAGNOSTIC/PREVENTIVE			
D0120	Periodic Oral Evaluation - Established Patient	0	13
D0140	Limited Oral Evaluation - Problem Focused	0	17
D0145	Oral Eval For A Patient Under 3 Years Of Age And Counseling W/Primary Caregiver	0	23
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0	19
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0	34
D0170	Re-Evaluation - Limited, Problem Focused (Est Patient; Not Post-Operative Visit)	0	16
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	0	25
D0210	Intraoral - Complete Series Of Radiographic Images	0	36
D0220	Intraoral - Periapical First Radiographic Image	0	7
D0230	Intraoral - Periapical Each Additional Radiographic Image	0	5
D0240	Intraoral - Occlusal Radiographic Image	0	9
D0250	Extra-Oral - 2D Projection Radiographic Image Using Stationary Radiation Source	0	11
D0251	Extra-Oral Posterior Dental Radiographic Image	5	14
D0270	Bitewing - Single Radiographic Image	0	8
D0272	Bitewings - Two Radiographic Images	0	11
D0273	Bitewings - Three Radiographic Images	0	13
D0274	Bitewings - Four Radiographic Images	0	15
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	27	24

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D0330	Panoramic Radiographic Image	45	30
D0340	2D Cephalometric Radiographic Image-Acquisition, Measurement And Analysis	47	24
D0350	Oral/Facial Photographic 2D Imaging Obtained Intraorally Or Extraorally	20	14
D1110	Prophylaxis; Adult	0	26
D1110	Extra cleaning for diabetics and expectant mothers	0	26
D1120	Prophylaxis; Child	0	20
D1206	Topical Appliccation Of Fluoride Varnish;	10	14
D1208	Topical Application Of Fluoride - excluding varnish	10	10
D1351	Sealant - Per Tooth	0	14
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	0	14
D1354	Interim Caries Arresting Medicament Application	10	16
D1510	Space Maintainer-Fixed Unilateral	95	83
D1515	Space Maintainer-Fixed Bilateral	105	111
D1520	Space Maintainer - Removable - Unilateral	95	80
D1525	Space Maintainer - Removable - Bilateral	105	175
D1550	Re-Cement Or Re-Bond Space Maintainer	25	22
D1555	Removal Of Fixed Space Maintainer	25	21
D1575	Distal Shoe Space Maintainer – Fixed Unilateral	95	82
CLASS II – RESTORATIVE (FILLINGS)			
D2140	Amalgam - One Surface, Primary Or Permanent	27	13
D2150	Amalgam - Two Surfaces, Primary Or Permanent	32	16
D2160	Amalgam - Three Surfaces, Primary Or Permanent	42	19
D2161	Amalgam-Four Or More Surfaces Primary Or Permanent	52	23
D2330	Resin-Based Composite - One Surface, Anterior	32	15
D2331	Resin-Based Composite - Two Surfaces, Anterior	38	20
D2332	Resin-Based Composite - Three Surfaces, Anterior	47	23
D2335	Resin-Based Composite - 4 Or More Surfaces Or Involving Incisal Angle (Anterior)	75	28
D2390	Resin-Based Composite Crown Anterior	110	33
D2391	Resin-Based Composite - One Surface, Posterior	38	17
D2392	Resin-Based Composite - 2 Surfaces, Posterior	45	22
D2393	Resin-Based Composite - 3 Surfaces, Posterior	57	28
D2394	Resin-Based Composite - 4 Or More Surfaces, Posterior	100	33
CLASS III – CROWN & BRIDGE*			
D2510	Inlay-Metallic-One Surface	85	87
D2520	Inlay-Metallic-Two Surfaces	96	98
D2530	Inlay - Metallic - Three Or More Surfaces	120	112

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D2542	Onlay Metallic Two Surfaces	290	112
D2543	Onlay - Metallic- Three Surfaces	300	117
D2544	Onlay - Metallic- Four Or More Surfaces	330	120
D2610	Inlay - Porcelain/Ceramic - One Surface	370	101
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	390	109
D2630	Inlay - Porcelain/Ceramic - Three Or More Surfaces	410	116
D2642	Onlay- Porcelain/Ceramic - Two Surfaces	400	110
D2643	Onlay- Porcelain/Ceramic - Three Surfaces	410	119
D2644	Onlay- Porcelain/Ceramic - Four Or More Surfaces	430	129
D2650	Inlay - Resin-Based Composite - One Surface	195	68
D2651	Inlay - Resin-Based Composite - Two Surfaces	220	79
D2652	Inlay - Resin-Based Composite - Three Or More Surfaces	255	85
D2662	Onlay - Resin-Based Composite - Two Surfaces	230	77
D2663	Onlay - Resin-Based Composite - Three Surfaces	250	87
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	280	93
D2710	Crown - Resin-Based Composite (Indirect)	220	57
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	220	55
D2740	Crown-Porcelain/Ceramic Substrate	340	149
D2750	Crown - Porcelain Fused To High Noble Metal	380	153
D2751	Crown - Porcelain Fused To Predominantly Base Metal	330	140
D2752	Crown - Porcelain Fused To Noble Metal	360	144
D2780	Crown 3/4 Cast High Noble Metal	360	135
D2781	Crown 3/4 Cast Predominately Base Metal	340	131
D2782	Crown 3/4 Cast Noble Metal	310	149
D2783	Crown 3/4 Porcelain/Ceramic	360	135
D2790	Crown - Full Cast High Noble Metal	360	144
D2791	Crown-Full Cast Predominantly Base	320	126
D2792	Crown-Full Cast Noble Metal	340	140
D2794	Crown-titanium	415	131
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	15	10
D2915	Re-Cement Or Re-Bond Indirectly Fabricated Or Prefabricated Post And Core	15	10
D2920	Re-Cement Or Re-Bond Crown	15	10
D2929	Prefabricated Porcelain/Ceramic Crown - Primary Tooth	175	40
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	45	29
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	50	32
D2932	Prefabricated Resin Crown	85	36
D2933	Prefabricated Stainless Steel Crown With Resin Window	130	40

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D2934	Prefab Esthetic Coated Stainless Steel Crown Primary Tooth	200	40
D2940	Protective Restoration	20	11
D2950	Core Buildup, Including Any Pins When Required	50	28
D2951	Pin Retention - Per Tooth, In Addition To Restoration	14	6
D2952	Post And Core In Addition To Crown Indirectly Fabricated	85	43
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	95	21
D2954	Prefabricated Post And Core In Addition To Crown	80	34
D2957	Each Additional Prefabricated Post - Same Tooth	30	18
D2960	Labial Veneer (Resin Laminate) - Chairside	230	50
D2961	Labial Veneer (Resin Laminate) - Laboratory	250	97
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	290	105
D2971	Addtl Procedures To Construct New Crown Under Existing Partial Denture Framework	50	14
D2980	Crown Repair Necessitated By Restorative Material Failure	48	10
D2981	Inlay repair necessitated by restorative material failure	95	20
D2982	Onlay repair necessitated by restorative material failure	95	20
D2983	Veneer repair necessitated by restorative material failure	95	20
CLASS III – ENDODONTICS			
D3110	Pulp Cap - Direct (Excluding Final Restoration)	15	7
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	15	5
D3220	Therapeutic Pulpotomy (Excl Final Restoration)-Removal Of Pulp Coronal	25	16
D3221	Pulpal Debridement Primary And Permanent Teeth	88	18
D3230	Pulpal Therapy (Resorbable)-Anterior, Primary Tooth (Excl Final Restoration)	45	20
D3240	Pulpal Therapy (Resorbable)-Posterior, Primary Tooth (Excl Final Restoration)	40	22
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	150	97
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	210	108
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	350	126
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	75	39
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	280	107
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	305	127
D3348	Retreatment Of Previous Root Canal Therapy - Molar	380	135
D3351	Apexification/Recalcification- Initial Visit	90	29
D3352	Apexification/Recalcification - Interim Medication Replacement	90	20
D3353	Apexification/Recalcification - Final Visit	180	64

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D3355	Pulpal Regeneration - Initial Visit	90	29
D3356	Pulpal Regeneration - Interim Medication Replacement	90	20
D3357	Pulpal Regeneration - Completion Of Treatment	180	64
D3410	Apicoectomy - Anterior	270	91
D3421	Apicoectomy - Bicuspid (First Root)	330	108
D3425	Apicoectomy - Molar (First Root)	365	113
D3426	Apicoectomy (Each Additional Root)	95	33
D3427	Periradicular Surgery Without Apicoectomy	100	28
D3430	Retrograde Filling-Per Root	60	28
D3450	Root Amputation-Per Root	100	57
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	85	44
CLASS III – PERIODONTICS			
D4210	Gingivectomy Or Gingivoplasty - 4 Or More Contiguous Teeth, Per Quadrant	200	56
D4211	Gingivectomy Or Gingivoplasty - 1 To 3 Contiguous Teeth, Per Quadrant	75	32
D4240	Gingival Flap Procedure, Incl Root Planing-4 Or More Contiguous Teeth, Per Quad	300	93
D4241	Gingival Flap Procedure, Incl Root Planing -1-3 Contiguous Teeth, Per Quadrant	200	43
D4245	Apically Positioned Flap	150	69
D4249	Clinical Crown Lengthening - Hard Tissue	200	92
D4260	Osseous Surg (Incl Elev Of A Full Thickness Flap/Closure)-4 Or More Contig Teeth	380	150
D4261	Osseous Surgery - One To Three Contiguous Teeth Or Tooth	350	92
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	233	47
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Addtl Site In Quadrant	188	38
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	243	49
D4267	Guided Tissue Regeneration - Non-Resorbable Barrier, Per Site	335	70
D4270	Pedicle Soft Tissue Graft Procedure	240	88
D4273	Autogenous Connective Tissue Graft Procedure (Incl Donor & Recipient Surg Sites)	325	113
D4274	Mesial/Distal Wedge Proc, Single Tooth (W/Surgical Procs In The Same Anat Area)	125	51
D4275	Non-Autogenous Connective Tissue Graft (Incl Recip Site & Donor Material)	341	68
D4276	Combined Connective Tissue And Double Pedicle Graft Per Tooth	65	84

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D4277	Free Soft Tissue Graft Proc (Incl Recipient & Donor Surgical Sites) First Tooth	215	114
D4278	Free Soft Tissue Graft Procedure (Incl Recipient & Donor Surgical Sites)	75	114
D4283	Autogenous Connective Tissue Graft Procedure (Incl Donor & Recipient Surg Sites)	268	114
D4285	Non-Autogenous Connective Tissue Graft Proc (Incl Recip Surg Site & Donor Matl)	392	114
D4320	Provisional Splinting-Intracoronal	115	50
D4321	Provisional Splinting-Extracoronal	105	45
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	40	26
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	45	17
D4346	Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation - Full Mouth, after oral Evaluation	30	16
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	40	18
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle	42	18
D4910	Periodontal Maintenance	60	15
CLASS III – PROSTHETICS (DENTURES)			
D5110	Complete Denture; Maxillary	420	163
D5120	Complete Denture - Mandibular	420	163
D5130	Immediate Denture - Maxillary	425	176
D5140	Immediate Denture - Mandibular	425	176
D5211	Maxillary Partial Denture - Resin Base	275	143
D5212	Mandibular Partial Denture-Resin Base	275	143
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases	480	154
D5214	Mandibular Partial Denture - Cast Metal Framework W/Resin Denture Bases	480	154
D5221	Immediate Maxillary Partial Denture-Resin Base (Incl Any Conv Clasp/Rests/Teeth)	440	123
D5222	Immediate Mandibular Partial Denture-Resin Base (Incl Any Conv Clasp/Rest/Teeth)	440	143
D5223	Immediate Maxillary Partial Denture -Cast Metal Framework W/Resin Denture Bases	445	161
D5224	Immediate Mandibular Partial Denture-Cast Metal Framework W/Resin Denture Bases	445	161
D5225	Maxillary Partial Denture - Flexible Base (Incl Any Clasps, Rests And Teeth)	470	117

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D5226	Mandibular Partial Denture - Flexible Base (Incl Any Clasps, Rests And Teeth)	470	143
D5281	Removable Unilateral Partial Denture -One Piece Cast Metal (Incl Clasps & Teeth)	330	94
D5410	Adjust Complete Denture -Maxillary	20	8
D5411	Adjust Complete Denture - Mandibular	20	8
D5421	Adjust Partial Denture - Maxillary	20	8
D5422	Adjust Partial Denture - Mandibular	20	8
D5511	Repair broken complete denture base, mandibular	60	15
D5512	Repair broken complete denture base, maxillary	60	15
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	65	13
D5611	Repair resin partial denture base, mandibular	60	17
D5612	Repair resin partial denture base, maxillary	60	17
D5621	Repair cast partial framework, mandibular	60	19
D5622	Repair cast partial framework, maxillary	60	19
D5630	Repair Or Replace Broken Clasp - Per Tooth	60	20
D5640	Replace Broken Teeth-Per Tooth	65	14
D5650	Add Tooth To Existing Partial Denture	65	19
D5660	Add Clasp To Existing Partial Denture - Per Tooth	75	21
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	270	71
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	270	71
D5710	Rebase Complete Maxillary Denture	210	59
D5711	Rebase Complete Mandibular Denture	210	55
D5720	Rebase Maxillary Partial Denture	120	49
D5721	Rebase Mandibular Partial Denture	120	53
D5730	Reline Complete Maxillary Denture (Chairside)	100	33
D5731	Reline Complete Mandibular Denture (Chairside)	100	33
D5740	Reline Maxillary Partial Denture (Chairside)	100	31
D5741	Reline Mandibular Partial Denture (Chairside)	100	31
D5750	Reline Complete Maxillary Denture (Laboratory)	140	45
D5751	Reline Complete Mandibular Denture (Laboratory)	140	45
D5760	Reline Maxillary Partial Denture (Laboratory)	140	42
D5761	Reline Mandibular Partial Denture (Laboratory)	140	44
D5850	Tissue Conditioning, Maxillary	45	14
D5851	Tissue Conditioning, Mandibular	45	14
CLASS III – IMPLANT SERVICES			
D6010	Surgical Placement Of Implant Body; Endosteal Implant	1193	239

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D6055	Connecting Bar - Implant Supported Or Abutment Supported	334	67
D6056	Prefabricated Abutment - Includes Modification And Placement	234	47
D6057	Custom Fabricated Abutment - Includes Placement	545	129
D6058	Abutment Supported Porcelain/Ceramic Crown	730	159
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	685	157
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	620	148
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	665	151
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	655	151
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	620	129
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	640	137
D6065	Implant Supported Porcelain/Ceramic Crown	730	149
D6066	Implant Supported Porcelain Fused To Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	685	145
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	685	141
D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	730	151
D6069	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (High Noble Metal)	710	149
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Predom Base Metal)	640	141
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)	685	144
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	700	147
D6073	Abutment Supported Retainer For Cast Metal Fpd (Predominantly Base Metal)	640	133
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	685	143
D6075	Implant Supported Retainer For Cermic Fpd	730	149
D6076	Implant Supported Retainer For Porcelain Fused To Metal Fpd	685	145
D6077	Implant Supported Retainer For Cast Metal Fpd	685	141
D6080	Implant Maintenance Procedures When Prostheses Are Removed & Reinserted	68	14
D6081	Scaling and Debridement in the Presence of Inflammation or Mucositis of a Single Implant	45	17
D6091	Replace Semi-Precision Or Precision Att Of Implant/Abut Supported Prosthesis	298	60

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D6092	Re-Cement Or Re-Bond Implant/Abutment Supported Crown	50	12
D6093	Re-Cement Or Re-Bond Implant/Abutment Supported Fixed Partial Denture	60	18
D6094	Abutment Supported Crown - (Titanium)	685	140
D6096	Remove Broken Retaining Screw	200	36
D6110	Implant /Abutment Supported Removable Denture For Edentulous Arch - Maxillary	983	197
D6111	Implant /Abutment Supported Removable Denture For Edentulous Arch-Mandibular	983	197
D6112	Implant /Abut Supported Removable Denture For Partial Edentulous Arch-Maxillary	983	197
D6113	Implant/Abut Supported Removable Denture For Partial Edentulous Arch-Mandibular	983	197
D6194	Abutment Supported Retainer Crown For Fpd (Titanium)	685	140
CLASS III – BRIDGE & PONTICS*			
D6205	Pontic - Indirect Resin Based Composite	364	73
D6210	Pontic-Cast High Noble Metal	440	144
D6211	Pontic - Cast Predominantly Base Metal	320	126
D6212	Pontic-Cast Noble Metal	340	133
D6214	Pontic - Titanium	415	131
D6240	Pontic - Porcelain Fused To High Noble Metal	380	153
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	340	140
D6242	Pontic; Porcelain Fused To Noble Metal	340	149
D6245	Pontic-Porcelain Ceramic	345	144
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	205	45
D6548	Retainer Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	257	51
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	962	192
D6600	Retainer Inlay - Porcelain/Ceramic, Two Surfaces	330	92
D6601	Retainer Inlay - Porcelain/Ceramic, Three Or More Surfaces	340	96
D6602	Retainer Inlay - Cast High Noble Metal, Two Surfaces	330	135
D6603	Retainer Inlay - Cast High Noble Metal, Three Or More Surfaces	320	108
D6604	Retainer Inlay - Cast Predominantly Base Metal, Two Surfaces	340	96
D6605	Retainer Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	330	102
D6606	Retainer Inlay - Cast Noble Metal, Two Surfaces	330	95
D6607	Retainer Inlay - Cast Noble Metal, Three Or More Surfaces	340	105
D6608	Retainer Onlay - Porcelain/Ceramic, Two Surfaces	350	101
D6609	Retainer Onlay - Porcelain/Ceramic, Three Or More Surfaces	370	104
D6610	Retainer Onlay - Cast High Noble Metal, Two Surfaces	350	106

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D6611	Retainer Onlay - Cast High Noble Metal, Three Or More Surfaces	350	117
D6612	Retainer Onlay - Cast Predominantly Base Metal, Two Surfaces	350	105
D6613	Retainer Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	350	110
D6614	Retainer Onlay - Cast Noble Metal, Two Surfaces	320	104
D6615	Retainer Onlay - Cast Noble Metal, Three Or More Surfaces	330	109
D6624	Retainer Inlay - Titanium	410	98
D6634	Retainer Onlay - Titanium	410	103
D6710	Retainer Crown - Indirect Resin Based Composite	380	105
D6740	Retainer Crown - Porcelain/Ceramic	360	153
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	340	153
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	310	140
D6752	Retainer Crown - Porcelain Fused To Noble Metal	360	144
D6780	Retainer Crown - 3/4 Cast High Noble Metal	360	118
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	340	118
D6782	Retainer Crown - 3/4 Cast Noble Metal	340	124
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	350	122
D6790	Retainer Crown - Full Cast High Noble Metal	360	144
D6791	Retainer Crown - Full Cast Predominantly Base Metal	350	126
D6792	Retainer Crown - Full Cast Noble Metal	360	131
D6794	Retainer Crown - Titanium	380	131
D6920	Connector Bar	306	61
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	30	14
D6940	Stress Breaker	125	28
D6950	Precision Attachment	245	50
D6980	Fixed Partial Denture Repair Necessitated By Restorative Material Failure	76	15
CLASS III – ORAL SURGERY			
D7111	Extraction Coronal Remnants Deciduous Tooth	45	10
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	25	14
D7210	Extract, Erupted Tooth Req Removal Of Bone, & Incl Elev Of Mucoperiosteal Flap	30	30
D7220	Removal Of Impacted Tooth; Soft Tissue	40	30
D7230	Removal Of Impacted Tooth; Partially Bony	65	40
D7240	Removal Of Impacted Tooth; Completely Bony	80	48
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	128	58

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	25	25
D7251	Coronectomy - Intentional Partial Tooth Removal	270	62
D7270	Tooth Reimplantation/Stabilization Of Accidentally Evulsed Or Displaced Tooth	50	51
D7280	Exposure Of An Unerupted Tooth	125	43
D7285	Incisional Biopsy Of Oral Tissue-Hard (Bone, Tooth)	115	39
D7286	Incisional Biopsy Of Oral Tissue-Soft	75	39
D7288	Brush Biopsy Transepithelial Sample Collection	25	10
D7292	Placement Of Temp Anchorage Device Req Flap; Incl Device Removal	360	72
D7293	Placement Of Temporary Anchorage Device Requiring Flap; Includes Device Removal	229	46
D7294	Placement Of Temporary Anchorage Device Without Flap; Includes Device Removal	166	33
D7310	Alveoloplasty In Conjunction W Extractions - 4/More Teeth/Spaces Per Quad	90	30
D7311	Alveoloplasty In Conjunction W Extractions 1-3 Teeth/Spaces Per Quadrant	65	22
D7320	Alveoloplasty Not In Conjunction W Extractions - 4/More Teeth/Spaces Per Quad	90	34
D7321	Alveoloplasty Not In Conjunction W Extractions 1-3 Teeth/Spaces Per Quadrant	50	36
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	230	73
D7472	Removal Of Torus Palantinus	225	102
D7473	Removal Of Torus Mandibularis	200	107
D7485	Reduction Of Osseous Tuberosity	225	83
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	40	22
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	40	42
D7880	Occlusal Orthotic Device, By Report	0	68
D7881	Occlusal Orthotic Device Adjustment	41	8
D7960	Frenulectomy-Aka Frenectomy Or Frenotomy - Separate Procedure Not Incidental	280	65
D7963	Frenuloplasty	280	66
D7970	Excision Of Hyperplastic Tissue - Per Arch	221	44
D7971	Excision Of Pericoronal Gingiva	102	20
D7972	Surgical Reduction Of Fibrous Tuberosity	183	37
D7979	Non-surgical Sialolithotomy	48	10
CLASS IV – ORTHODONTIA			
D8010	Limited Orthodontic Treatment Of Primary Dentition	N/A	N/A
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	N/A	N/A

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ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	N/A	N/A
D8040	Limited Orthodontic Treatment Of The Adult Dentition	N/A	N/A
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	N/A	N/A
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	N/A	N/A
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	N/A	N/A
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	N/A	N/A
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	N/A	N/A
D8210	Removable Appliance Therapy	N/A	N/A
D8220	Fixed Appliance Therapy	N/A	N/A
D8680	Orthodontic Retention (Removal Of Appliances/Construct & Placement Of Retainers)	N/A	N/A
ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	20	10
D9223	Deep Sedation/General Anesthesia-Each 15 Minute Increment	50	14
D9239	Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	50	11
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia-Each 15 Minute Increment	56	11
D9310	Consult - Dx Service Provided By Dentist/Phys Other Than Requesting Dentist/Phys	25	12
D9440	Dental Office Visit - After Regularly Scheduled Hours	0	31
D9610	Therapeutic Parenteral Drug Single Administration	15	7
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	0	12
D9940	Occlusal Guards, By Report	220	57
D9995	Teledentistry – synchronous; real-time encounter	20	4
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	20	4

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In-Network Providers

"In-network" dental providers have contracts with Blue Cross Blue Shield of Arizona (BCBSAZ) or with BCBSAZ's independent dental network vendor. In-network providers accept member copayment as payment in full for covered dental services, and file a member's claims with BCBSAZ. Members usually have lower out-of-pocket costs with in-network providers.

Out-of-Network Providers

"Out-of-network" providers have no contract with BCBSAZ or with BCBSAZ's independent dental network vendor. Out-of-network providers set their own rates, can collect up to full billed charges from members, and have no obligation to file members' claims. If you visit an out-of-network provider, BCBSAZ will pay the provider the fee listed in the "Out-of-Network Plan Allowance" column and the member may be billed for any difference between the billed amount and the "Out-of-Network Plan Allowance."

Example

The following example shows how use of an in-network provider may save you money. This example assumes:

- you have already met your annual deductible
- your dentist's billed charge is $100
- the in-network member copayment is $20
- the out-of-network plan allowance is $15

In-Network Provider		Out-of-Network Provider	
Billed charge	$100	Billed charge	$100
In-network member copayment	$20	Out-of-network plan allowance	$15
BCBSAZ pays	$80	BCBSAZ pays	$15
		Difference of billed charge	$85
Your Out-of-Pocket Cost:	*$20*	*Your Out-of-Pocket Cost:*	*$85*

While your actual expenses will vary, in this example you would have saved $65 by using an in-network provider.

Optional Pre-determination

If your dentist has recommended services and you are concerned about coverage or costs, your dentist can ask BCBSAZ for a pre-treatment estimate, called a "pre-determination." BCBSAZ will review your dentist's proposed treatment and send your dentist information explaining what services will be covered and your estimated out-of- pocket costs for these services. A pre-determination can help you better understand what will be covered and the amount you will need to pay.

Prevention + 1 Program

All diabetic and pregnant members are eligible for coverage of one additional dental cleaning procedure or one additional periodontal maintenance procedure. For members who have enrolled in the program, extended preventive benefits will remain available for the duration of these conditions.

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Rollover Benefits	A Member may be eligible for a rollover of a portion of his or her unused Annual Maximum for Class I, II and III Services (In-network only). If a Member submits at least one in-network claim for a covered cleaning during a Calendar Year and, in that Calendar Year, receives Benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Rollover Benefit Threshold, he or she may be entitled to Rollover Benefits. Rollover Benefits can accrue and are tracked by the Plan. If a Member reaches his or her Annual Maximum for Class I, II and III Services, Plan will pay Benefits up to the Rollover Maximum. The amount of Rollover Benefits may not be greater than the Rollover Maximum. A Member's Rollover Benefits may be eliminated, and the accrued benefit lost, if there is a break in coverage of any length of time, for any reason, or if the Rollover Benefit Threshold is exceeded in any given Calendar Year. Under this Contract, the Rollover Benefit Threshold and Rollover Maximum are as follows: Rollover Benefit Threshold $1,000 Calculated at 50% of Annual Maximum Rollover Maximum $2,500 Calculated at 125% of Annual Maximum Rollover Benefit is calculated at 50% of Annual Maximum less Benefits paid.

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BCBSAZ Prime PPO Limitations and Exclusions

Type I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. One full mouth or panoramic x-ray per 60 months
4. Periapical x-rays
5. Bitewing x-rays, 2 per Calendar Year
6. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients); Prevention Reward: Primary subscriber will receive a $20 payment from BCBSAZ for each family member that receives two cleanings during the plan year from a participating PPO network dentist. Contact your Benefit Administrator for details.
7. One topical fluoride per Calendar Year, to age 16
8. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)
9. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Type II. Basic Services:

1. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
2. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)

Type III. Major Services:

1. Simple extraction of teeth
2. One study model per 36 months
3. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
4. Restoration services, limited to:
    a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth
    b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced
    c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
    d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
5. Crown build-up for non-vital teeth
6. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
7. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
    b. Pulpotomy
    c. Apicoectomy
    d. Retrograde fillings, per root per lifetime
8. Periodontic services, limited to:
    a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
    b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
    c. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years
    d. Occlusal adjustment performed with covered surgery
    e. Gingivectomy
    f. Osseous surgery including flap entry and closure
    g. One pedicle or free soft tissue graft per site per lifetime
    h. One appliance (night guards) per 5 years within 6 months of osseous surgery
    i. One full mouth debridement per lifetime
    j. Antibiotic injections administered by a dentist
9. Oral surgery, including postoperative care for:
    a. Removal of teeth, including impacted teeth
    b. Extraction of tooth root
    c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
    d. Alveolectomy, alveoplasty, and frenectomy
    e. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
    f. Tooth reimplantation and/or stabilization; tooth transplantation
    g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One repair of dentures or fixed bridgework per 24 months
    e. One relining or rebasing of existing removable dentures per 24 months
11. Implants and related services

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12. Occlusal orthotic device for TMD (D7880), by report, one per five years
13. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)
14. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery, or periodontal surgery, or implant placement procedures

Type IV. Orthodontia Services Not Covered:
Diagnostic services, active and retention treatment to include removable, fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:
1. Services which are covered under Medicare, worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony (except for D7880).
11. Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

THIS IS ONLY A BRIEF SUMMARY OF THIS BENEFIT PLAN. A COMPLETE LISTING OF ALL BENEFITS, LIMITATIONS AND EXCLUSIONS IS IN THE BENEFIT PLAN BOOKLET AND IS AVAILABLE PRIOR TO ENROLLMENT UPON REQUEST. IF THE BENEFITS ON THIS SUMMARY DIFFER FROM THOSE STATED IN THE BENEFIT PLAN BOOKLET, THE TERMS OF THE BENEFIT PLAN BOOKLET APPLY.

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