PREMERA | BLUE CROSS

Dental Care

Applies to: All Premera Blue Cross Medicare Advantage plans

Dental Care

Dental care includes items and services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.

Original Medicare

Original Medicare will pay for dental services that are an integral part either of a covered procedure, such as reconstruction of the jaw following accidental injury, or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Original Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such an examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

Statutory Dental Exclusion

Section 1862 (a)(12) of the federal Social Security Act prohibits payment under Medicare Parts A and B for expenses incurred by a Medicare member "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under Part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his or her underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

Services Excluded Under Part B

These two categories of services are excluded from coverage under Medicare Part B:

- A primary service, regardless of cause or complexity, provided for the care, treatment, removal or replacement of teeth or structures directly supporting teeth, such as preparation of the mouth for dentures or removal of diseased teeth in an infected jaw.
- A secondary service related to the teeth or structures directly supporting the teeth unless it's incident to and an integral part of a covered primary service necessary to treat a non-dental condition, such as tumor removal. This service must be performed at the same time as the covered primary service and by the same physician or dentist. In those cases, in which these requirements are met, and the secondary services are covered, the Medicare payment amount should not include the cost of dental appliances, such as dentures, even though the covered service resulted in the need for the teeth to be replaced, the cost of preparing the mouth for dentures or the cost of directly repairing teeth or structures directly supporting teeth, such as alveolar process.

Exceptions to Excluded Services

- The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a rural health clinic and federally qualified health center prior to a heart valve replacement.
- Medicare Dental Covered Copayment

Plan Name	Allowance	Copay/Comprehensive Deductible
Classic (HMO,) Total Health (HMO)	$1,500	$0/$25
HMO $0	$1,000	$0/$25

Premera Blue Cross Medicare Advantage HMO Plans Enhanced Dental Benefit

Premera Blue Cross Medicare Advantage HMO Plans are Medicare Advantage plans, which provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single healthcare plan. This flexibility allows Premera Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for preventive and comprehensive dental care is provided to all members under HMO $0, Classic HMO, Total Health HMO plans. Because Original Medicare does not cover preventive and comprehensive dental care, the scope of benefit, reimbursement methodology, maximum allowed payment amounts, and member cost sharing are determined by Premera Blue Cross.

Conditions for Payment

The table below specifies payment conditions for dental care.

- Description of dental procedure: Easy to interpret description of the dental procedure.
- Frequency: How often Premera Blue Cross will pay for the dental procedure.
- Criteria and exclusions: Conditions under which Premera Blue Cross would pay for the procedure and situations where Premera Blue Cross would NOT pay for the procedure.
- In-network copayment: *If you choose to see an out-of-network dentist, you might be billed for charges above what the plan pays.

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Preventive Services (Deductible does not apply)			
Prophylaxis (cleaning)	Two per calendar year	Not covered if member has periodontal maintenance done	$0 copay*

PREMERA | BLUE CROSS

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Periodontal maintenance	Three per calendar year	Covers periodontal maintenance. Only covered with history of scaling and root planing (deep cleaning) or periodontal surgery	$0 copay*
Fluoride	Two per calendar year	Covers topical application of fluoride (either varnish or excluding varnish)	$0 copay*
Periodic oral exam	Up to two periodic oral evaluation per calendar year		$0 copay*
Limited oral evaluation (problem focused)	One evaluation per 12 months		$0 copay*
Comprehensive oral exam	One comprehensive exam per 36 months		$0 copay*
Detailed and extensive oral evaluation—problem focused by report	One per lifetime		$0 copay*
Re-evaluation—limited, problem focused (established patient)	One per lifetime		$0 copay*
Comprehensive periodontal exam	One per calendar year		$0 copay*
Bitewing X-rays	One set per calendar year	Not covered in the same year as a full mouth set of X-rays	$0 copay*
Full-mouth complete set	One procedure every 60 months		$0 copay*

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Panoramic film X-ray for evaluation of the teeth and mouth	One procedure every 60 months		$0 copay*
Comprehensive Dental Services (Annual deductible applies) Periodontics Services			
Periodontal scaling and root planning	One every two years, per quadrant		$0 copay*
Scaling in presence of generalized moderate or severe gingival inflammation, full mouth.	Once per two years		$0 copay*
Periodontal Surgery			
Occlusal adjustment performed with covered surgery	No Limit		$0 copay*
Gingivectomy	One surgical procedure is covered per lifetime; Gingivectomy or gingivoplasty; osseous surgery including flap entry and closure		$0 copay*
Osseous surgery including flap entry and closure			$0 copay*
Pedicle or free soft tissue graft	One per lifetime		$0 copay*
Full mouth debridement	One per lifetime		$0 copay*

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Diagnostic Services			
Intraoral X-rays: Periapical X-rays or Occlusal X-rays	One procedure code per calendar year		$0 copay*
Restorative Services			
Restorations (fillings): amalgam (Silver) and/or composite	One per tooth per 24 months		$0 copay*
Recementing a crown that has fallen off	One per 12 months		$0 copay*
Recementing bridges, inlays, onlays and crowns	After 12 months of insertion and per 12 months per tooth thereafter		$0 copay*
Pins when preparing a tooth for a crown	Bundled with crown code and pins (when required)		$0 copay*
Buildup of filling around a post to prepare the tooth for a crown	One combo per tooth every 5 years		$0 copay*
Crowns	One per tooth every 5 years	Does not cover crowns for cosmetic reasons or for closing gaps. veneers are not covered	$0 copay*

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Extraction Services/Oral Surgery			
Oral surgery, including postoperative care for: • Removal of teeth, including impacted teeth • Extraction of tooth root • Alveolectomy, alveoplasty, and frenectomy • Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy • Tooth reimplantation and/or stabilization, tooth transplantation • Excision of a tumor or cyst and incision and drainage of an abscess or cyst	Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal - One per tooth per lifetime Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/or stabilization; tooth transplantation; excision of a tumor or cyst and incision and no limit for drainage of an abscess or cyst		$0 copay*

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Endodontics Services			
Root canal	One initial root canal procedure and one retreatment procedure per tooth per lifetime	This is a root canal performed on a tooth for the first time or as retreatment to a tooth that had a root canal completed previously. Does not include root canals performed from the root tip by access through the gums, incomplete root canal treatment, or internal root repair of perforation defects	$0 copay*
Pulpotomy	No limit		$0 copay*
Apicoectomy			$0 copay*
Retrograde fillings	Per root per lifetime		$0 copay*
Medicine placed under fillings to promote pulp healing	Unlimited per plan year to plan annual maximum	Covers pulp capping for an exposed or nearly exposed pulp. Does not cover bases and liners when all caries has been removed	$0 copay*
Prosthodontics Services			
Complete denture: maxillary (upper) or mandibular (lower)	One upper complete and/or one lower complete denture every seven years, including routine post-delivery care		$0 copay*

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Prosthodontics Services			
Complete denture: maxillary (upper) or mandibular (lower)	One upper complete and/or one lower complete denture every seven years, including routine post-delivery care		$0 copay*
Partial dentures: Resin or metal, maxillary (upper) or mandibular (lower) or maxillary (upper) or mandibular (lower)	One upper and/or one lower partial denture every seven years	Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement	$0 copay*
Complete denture and partial denture adjustment	Two per denture and partial denture per year		$0 copay*
Complete or partial denture reline or rebase	One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement unless an immediate prosthesis replacing at least 3 teeth)		$0 copay*
Recementation	One procedure per calendar year		$0 copay*
Repair of dentures or fixed bridgework	One per denture/bridgework per 24 months		$0 copay*
Non-Routine Services			
Teledentistry	Two per calendar year		$0 copay*

Description of dental procedure	Frequency	Criteria and exclusions	In-network copayment
Pain management	Unlimited per plan year to plan annual maximum	Only if no services other than exam and X-rays were performed on the same date of service	$0 copay*
Deep sedation/general anesthesia		In conjunction with covered oral surgery or periodontal surgery	$0 copay*
Local anesthesia			$0 copay*
Intravenous moderate (conscious) sedation/analgesia			$0 copay*

Reimbursement

Premera Blue Cross Medicare Advantage HMO plan's maximum payment amount for dental care is available on our provider website, https://www.premera.com/wa/provider/medicare-advantage/dental/. Contracted providers agree to accept our allowed amount as payment in full when they perform covered preventive services. This represents payment in full and providers are not allowed to balance bill the member the difference between the allowed amount and the charge.

Member Cost Sharing

- Premera Blue Cross Medicare Advantage HMO members' deductible responsibilities do not apply to preventive dental care listed above for in-network providers. Deductible applies to all other covered services.
- Premera Blue Cross Medicare Advantage HMO members do have an annual maximum as listed below.

Plan	Annual Deductible Preventive/Comprehensive	Annual Maximum
HMO $0 (H7245-001)	$0/$25	$1,000
Classic HMO (H7245-002), Total Health HMO (H7245-005)	$0/$25	$1,500

- Premera Blue Cross Medicare Advantage HMO members are responsible for any amount above the Premera Blue Cross Medicare Advantage HMO allowed amount for a covered service when using an out-of-network provider. Cost sharing refers to a flat-dollar copayment, a percentage coinsurance, or a deductible. Providers can only collect the appropriate Premera Blue Cross Medicare Advantage HMO cost sharing amounts from the member.
- If the member elects to receive a non-covered service, they are responsible for the entire charge associated with the non-covered service.
- Cost share amounts incurred by the member under this benefit do not count toward the plan's medical deductible or the combined maximum out of pocket limit as listed in the Evidence of Coverage document.
- To verify benefits and cost shares, providers can visit https://www.premera.com/wa/provider/medicare-advantage/dental/ and sign in to access secure dental tools and resources.

Billing Instructions for Providers

1. Bill services on the American Dental Association claim form.
2. Review MA dental utilization guidelines
3. Include member ID number starting with and including ZNP
4. Report your National Provider Identifier on all claims.
5. Submit claims electronically. For more information on how to send an electronic claim visit https://www.premera.com/wa/provider/electronic-transactions/
6. Mail paper claims to:
   Premera Blue Cross
   PO Box 91059
   Seattle, WA 98111-9159

Revision History

Policy number: PMA-HMO 1002
Created: 12/03/2021
Effective: 01/01/2024