Schedule of Benefits

Silver 70 HMO Plan

(Who Pays What)

From 01/01/2022 through 12/31/2022

THIS SCHEDULE OF BENEFITS IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

THIS PLAN UTILIZES A PROVIDER NETWORK

This plan uses a Network of Participating Providers to provide benefits to You. That means this Plan does not provide benefits for services You receive from Non-Network Providers, unless:

- You have a medical emergency;
- You are treated by a Non-Network Provider when you are receiving care at a Network Facility; or
- We authorize services out-of-network because the Medically Necessary services that You need are not available from a Participating Provider.

You can review our provider network online at www.brighthealthcare.com, or You can contact Bright HealthCare Customer Service at (855) 827-4448 to locate a provider or request a paper copy of the provider directory.

Deductible

A Deductible is the amount that a Covered Person must pay before Bright HealthCare pays any benefits for Covered Health Services. The Deductible amount does not include Coinsurance, Copayment, or non-covered charges.

Copayment

A Copayment is a specific dollar amount that You must pay for certain Covered Health Services.

Coinsurance

A Coinsurance is a percentage of charges for Covered Health Services that must be paid by a Covered Person. Coinsurance amounts do not include Deductible, Copayment, or charges for non-covered services.

Maximum Out-of-Pocket

The Maximum Out-of-Pocket is the maximum dollar amount that a Covered Person may pay in combined Deductible, Copayment and Coinsurance amounts per Calendar Year. All Deductible, Copayment and Coinsurance payments for In-Network Covered Health Services will apply to the Maximum Out-of-Pocket amount. Once the Maximum Out-of-Pocket amount has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Coinsurance amounts for Covered Health Services received from a participating Bright HealthCare Provider for the remainder of the Calendar Year. Refer to Your Policy to see how charges from Non-Network Providers may be covered.

For policies with two or more people, each person's Individual Out-of-Pocket maximum applies to the Family Maximum Out-of-Pocket. Once a Covered Person has met his or her Maximum Out-of-Pocket, covered In-Network services will be paid at 100% for that person. Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Maximum Out-of-Pocket, covered In-Network services for the family will be paid at 100%.

Limitations/Exclusions

Some limitations and exclusions are listed in this Schedule of Benefits. Refer to the Benefits/Coverage (What is Covered) and Limitations/Exclusions (What is Not Covered) sections of Your policy for a more comprehensive listing and description of services or items that are limited or not covered by the Plan.

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General Cost Share & Features	In Network	Non Network
Deductible: - Per Plan Year Medical Pharmacy Dental *Some services do not apply to the deductible, as indicated below.*	$3,700/Individual; $7,400 Family $10 Individual; $20 Family $0 Individual; $0 Family	Not covered
Out-of-Pocket Maximum: - Per Plan Year	$8,200/Individual; $16,400 Family	Not covered

Benefit	In Network	Non Network
Health care provider's office or clinic visit		
Primary care visit to treat an injury, illness, or condition	$35	Not covered
Other practitioner office visit	$35	Not covered
Specialist visit	$70	Not covered
Preventive care/screening/ immunization	No charge	Not covered

Benefit	In Network	Non Network
Tests		
Laboratory Tests	$40	Not covered
X-rays and Diagnostic Imaging	$85	Not covered
Imaging (CT/PET scans, MRIs) *Services require pre-authorization.*	$325	Not covered

Benefit	In Network Retail Pharmacy	Non Network Retail Pharmacy
Drugs to treat illness or condition *The copay or co-insurance applies to an up to 30-day prescription supply. The enrollee's cost share will be the lower of the pharmacy's retail price, or the applicable cost-share amount. Amounts paid by the enrollee will apply to the Deductible and Out-of-Pocket Maximum.*		
Tier 1	$15 after deductible	Not covered
Tier 2	$55 after deductible	Not covered
Tier 3	$85 after deductible	Not covered
Tier 4	20% up to $250 per prescription	Not covered

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Benefit	In Network	Non Network
Outpatient services		
Surgery facility fee *Services require pre-authorization.*	20%	Not covered
Physician/surgeon fees *Services require pre-authorization.*	20%	Not covered
Outpatient visit	20%	Not covered

Benefit	In Network	Non Network
Need immediate attention		
Emergency room facility fee (waived if admitted)	$400	$400
Emergency room physician fee (waived if admitted)	No charge	No charge
Medical transportation (including emergency and non-emergency)	$250	$250
Urgent care	$35	$40

Benefit	In Network	Non Network
Hospital stay		
Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) *Services require pre-authorization.*	20%	Not covered
Physician/surgeon fee *Services require pre-authorization.*	20%	Not covered

Benefit	In Network	Non Network
Mental Health and Substance Abuse Services		
Mental/behavioral health and substance use disorder outpatient office visits	$35	Not covered
Mental/behavioral health and substance use disorder other outpatient items and services	$35	Not covered

Benefit	In Network	Non Network
Pregnancy		
Prenatal care and preconception visits	No charge	Not covered

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Benefit	In Network	Non Network
Help recovering or other special health needs		
Home health care (cost share per visit)	$45	Not covered
Outpatient Rehabilitation and Habilitation services *Services require pre-authorization.*	$35	Not covered
Skilled nursing care *Services require pre-authorization.*	20%	Not covered
Durable medical equipment *Services require pre-authorization.*	20%	Not covered
Hospice service *Services require pre-authorization.*	No charge	Not covered

Benefit	In Network	Non Network
Child eye care – Coverage is available through the end of the month in which the dependent child turns 19.		
Eye Exam with Dilation, as necessary - *Limited to 1 refractive eye exam per calendar year*		
	No charge	Not covered
Eyeglasses - *1 pair of glasses per year (or a 1-year supply of contact lenses in lieu of glasses)*		
Includes single vision, conventional (lined) bifocal, conventional (lined) trifocal, lenticular, and standard progressive lenses. Frames are covered in full when provider designated frames are selected.	No charge	Not covered
Contact Lenses for Refraction (in lieu of contact lenses)		
Includes: • Extended wear disposables • Daily wear / disposables • Conventional • Medically Necessary contact lenses.	No charge	Not covered
Low Vision Services		
Exam	No charge	No charge
Low vision aids	25% copay up to $1,000 every 24 months	25% copay up to $1,000 every 24 months

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Benefit	In Network	Non Network
Child Dental Diagnostic and Preventive		
Oral Exam	No charge	Not covered
Preventive - Cleaning	No charge	Not covered
Preventive - X-ray	No charge	Not covered
Sealants per Tooth	No charge	Not covered
Topical Fluoride Application	No charge	Not covered
Space Maintainers - Fixed	No charge	Not covered

Benefit	In Network	Non Network
Child Dental Basic Services		
Restorative Procedures	20%	Not covered
Periodontal Maintenance Services	20%	Not covered

Benefit	In Network	Non Network
Child Dental Major Services		
Crowns and Casts	50%	Not covered
Endodontics	50%	Not covered
Periodontics (other than maintenance)	50%	Not covered
Prosthodontics	50%	Not covered
Oral Surgery	50%	Not covered

Benefit	In Network	Non Network
Child Orthodontics		
Medically necessary orthodontics	50%	Not covered

These endnotes and the Patient-Centered Benefit Plan Designs apply only to covered services.

Notes:

1. Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-Network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2. For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3. Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.

4. For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5. For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2022 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6. Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.
7. For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
8. Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
9. In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10. For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11. As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
12. A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2022 Dental Copay Schedule.
13. Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14. Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient- Centered Benefit Plan Designs.
15. Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16. Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17. Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
18. The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
19. The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.

20. The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
21. Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.
22. Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
23. Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low-cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
	3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

Some drugs may be subject to zero cost-sharing under the preventive services rules.
24. Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
25. A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
26. The health issuer may not impose a member cost share for Diabetes Self- Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
27. The cost sharing for hospice services applies regardless of the place of service.
28. For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
29. For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
30. For any benefit plan design in which a designation of Individual-Only or CCSB- Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
31. The Bronze and Bronze HDHP are contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue

procedure for the 2022 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.

LIBERTY Dental Plan of California, Inc.
Children's Dental HMO - Bright HealthCare IND Silver 70

Individual Out of Pocket Maximum: $8,200 per 2022 Calendar Year
Family Out of Pocket Maximum: $16,400 per 2022 Calendar Year

✓ Members must visit a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will determine a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the recommended covered services are medically necessary and outside the scope of a general dentist.

✓ This Benefit Schedule represents the Children's Dental HMO benefits covered as part of your Health Plan offered through Bright HealthCare. Any Co-payment for covered dental services will accrue towards the Health Plan's Calendar Year Out-of-Pocket Maximum (which is provided above for your reference). To verify your Out-of-Pocket Maximum you can refer to your Health Plan's Evidence of Coverage booklet, visit your health plan's website at www.brighthealthcare.com or call Member Services at 1.855.827.4448 (toll-free).

✓ Once your Out-of-Pocket costs for all Medical and Dental covered services reach the combined Out-of-Pocket Maximum, you cannot be charged for covered dental services you receive for the remainder of the Calendar year. The LIBERTY Dental Plan contracted dental office will be paid for covered services as contracted directly by LIBERTY. Charges for optional and non-covered services are not included in the calculation for the combined out-of-pocket maximum and would remain your financial responsibility. In a plan with two or more members, the first family Member to meet the individual Out-of-Pocket Maximum cannot be charged for covered services for the remainder of the Calendar year. The family Out-of-Pocket Maximum is met by combining eligible expenses of two or more covered family Members.

✓ This Benefit Schedule does not guarantee benefits. All services are subject to eligibility, exclusions and limitations and must be determined to be medically necessary at the time you receive the service. Additional requests, beyond the stated frequency limitations shall be considered for prior authorization when documented dental necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

✓ Dental procedures not listed on this Benefit Schedule may be available at the dental office's usual and customary fees.

CDT Code	Description	Member Responsibility	Limitation
DIAGNOSTIC & PREVENTIVE SERVICES			
	Diagnostic Services		
D0120	Periodic oral evaluation	no charge	1 (D0120) every 6 months per provider
D0140	Limited oral evaluation	no charge	1 (D0140) per patient per provider
D0145	Oral evaluation under age 3	no charge	
D0150	Comprehensive oral evaluation	no charge	1 (D0150) per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	no charge	1 (D0160) per patient per provider
D0170	Re-evaluation, limited, problem focused	no charge	up to 6 of (D0170, D0171)in a 3 month period, no more than 12 in a 12 months
D0171	Re-evaluation, post operative office visit	no charge	
D0180	Comprehensive periodontal evaluation	no charge	only be billed as D0150
D0190	Screening of a patient	not covered	
D0191	Assessment of a patient	not covered	
D0210	Intraoral, complete series of radiographic images	no charge	1 of (D0210, D0709) every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	no charge	20 of (D0220, D0230, D0707) 12 months, per provider
D0230	Intraoral, periapical, each add 'l radiographic image	no charge	
D0240	Intraoral, occlusal radiographic image	no charge	2 of (D0240, D0706) every 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	no charge	1 (D0250) per date of service
D0251	Extra-oral posterior dental radiographic image	no charge	1 of (D0251, D0705) per date of service
D0270	Bitewing, single radiographic image	no charge	1 of (D0270, D0708) per date of service
D0272	Bitewings, two radiographic images	no charge	1 (D0272) every 6 months per provider
D0273	Bitewings, three radiographic images	no charge	downcode to D0270 and D0272
D0274	Bitewings, four radiographic images	no charge	1 (D0274) every 6 months per provider, age 10 and over
D0277	Vertical bitewings, 7 to 8 radiographic images	no charge	downcode to D0274
D0310	Sialography	no charge	
D0320	TMJ arthrogram, including injection	no charge	3 (D0320) per date of service
D0322	Tomographic survey	no charge	2 (D0322) every 12 months per provider
D0330	Panoramic radiographic image	no charge	1 of (D0330, D0701) every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	no charge	2 of (D0340, D0702) every 12 months per provider
D0350	2D oral/facial photographic image, intra-orally/extra-orally	no charge	4 of (D0350, D0703) per date of service
D0351	3D photographic image	no charge	
D0419	Assessment of salivary flow by measurement	not covered	
D0431	Adjunctive pre-diagnostic test	not covered	
D0460	Pulp vitality tests	no charge	
D0470	Diagnostic casts	no charge	1 (D0470) per provider, only a benefit with covered Orthodontic services, for permanent dentition
D0502	Other oral pathology procedures, by report	no charge	
D0601	Caries risk assessment and documentation, low risk	no charge	
D0602	Caries risk assessment and documentation, moderate risk	no charge	
D0603	Caries risk assessment and documentation, high risk	no charge	
D0701	Panoramic radiographic image, image capture only	no charge	1 of (D0330, D0701) every 36 months per provider
D0702	2-D cephalometric radiographic image, image capture only	no charge	2 of (D0340, D0702) every 12 months per provider
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	no charge	4 of (D0350, D0703) per date of service
D0704	3-D photographic image, image capture only	no charge	
D0705	Extra-oral posterior dental radiographic image, image capture only	no charge	1 of (D0251, D0705) per date of service
D0706	Intraoral, occlusal radiographic image, image capture only	no charge	2 of (D0240, D0706) every 6 months per provider
D0707	Intraoral, periapical radiographic image, image capture only	no charge	20 of (D0220, D0230, D0707) every 12 months, per provider
D0708	Intraoral, bitewing radiographic image, image capture only	no charge	1 of (D0270, D0708) per date of service
D0709	Intraoral, complete series of radiographic images, image capture only	no charge	1 of (D0210, D0709) every 36 months per provider
D0999	Unspecified diagnostic procedure, by report	no charge	
	Preventive Services		
D1110	Prophylaxis, adult	no charge	1 of (D1110, D1120, D4346) every 6 months
D1120	Prophylaxis, child	no charge	
D1206	Topical application of fluoride varnish	no charge	1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	no charge	
D1310	Nutritional counseling for control of dental disease	no charge	
D1320	Tobacco counseling, control/prevention oral disease	no charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	no charge	
D1330	Oral hygiene instruction	no charge	
D1351	Sealant, per tooth	no charge	1 of (D1351,D1352) every 36 months 1st, 2nd, 3rd molars
D1352	Preventive resin restoration, permanent tooth	no charge	
D1353	Sealant repair, per tooth	no charge	1 (D1353) every 36 months 1st, 2nd, 3rd molars
D1354	Application of caries arresting medicament, per tooth	no charge	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first treatment only

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LIBERTY Dental Plan of California, Inc.
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CDT Code	Description	Member Responsibility	Limitation
	Preventive Services (continued)		
D1355	Caries preventive medicament application, per tooth	no charge	1 (D1355) per tooth every 6 months, subject to medical necessity review for the first treatment only
D1510	Space maintainer, fixed, unilateral, per quadrant	no charge	1 of (D1510, D1520) per quadrant per patient, under age 18
D1516	Space maintainer, fixed, bilateral, maxillary	no charge	1 of (D1516, D1526) under age 18
D1517	Space maintainer, fixed, bilateral, mandibular	no charge	1 of (D1517, D1527) under age 18
D1520	Space maintainer, removable, unilateral, per quadrant	no charge	1 of (D1510, D1520) per quadrant per patient under age 18
D1526	Space maintainer, removable, bilateral, maxillary	no charge	1 of (D1516, D1526) under age 18
D1527	Space maintainer, removable, bilateral, mandibular	no charge	1 of (D1517, D1527) under age 18
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	no charge	1 of (D1551, D1552) per arch every 12 months under age 18
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	no charge	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	no charge	1 (D1553) per quad every 12 months under age 18
D1556	Removal of fixed unilateral space maintainer, per quadrant	no charge	
D1557	Removal of fixed bilateral space maintainer, maxillary	no charge	
D1558	Removal of fixed bilateral space maintainer, mandibular	no charge	
D1575	Distal shoe space maintainer, fixed, per quadrant	no charge	
	Adjunctive General Services		
D9110	Palliative (emergency) treatment, minor procedure	no charge	1 (D9110) per date of service
D9311	Consultation with a medical health care professional	no charge	
D9995	Teledentistry, synchronous; real-time encounter	no charge	
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	no charge	
D9997	Dental case management, patients with special health care needs	no charge	
D9999	Unspecified adjunctive procedure, by report	no charge	
BASIC SERVICES			
	Restorative Services		
D2140	Amalgam, one surface, primary or permanent	20%	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months
D2150	Amalgam, two surfaces, primary or permanent	20%	
D2160	Amalgam, three surfaces, primary or permanent	20%	
D2161	Amalgam, four or more surfaces, primary or permanent	20%	
D2330	Resin-based composite, one surface, anterior	20%	
D2331	Resin-based composite, two surfaces, anterior	20%	
D2332	Resin-based composite, three surfaces, anterior	20%	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	20%	
D2390	Resin-based composite crown, anterior	20%	primary teeth - 1 (D2390) per tooth every 12 months permanent teeth - 1 (D2390) per tooth every 36 months
D2391	Resin-based composite, one surface, posterior	20%	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months
D2392	Resin-based composite, two surfaces, posterior	20%	
D2393	Resin-based composite, three surfaces, posterior	20%	
D2394	Resin-based composite, four or more surfaces, posterior	20%	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	20%	1 (D2910) per tooth every 12 months, per provider
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	20%	
D2920	Re-cement or re-bond crown	20%	after 12 months of initial placement with same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp	20%	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	20%	1 of (D2928, D2931) per tooth every 36 months
D2929	Prefabricated porcelain/ceramic crown, primary tooth	20%	1 of (D2929, D2930) per tooth every 12 months
D2930	Prefabricated stainless steel crown, primary tooth	20%	
D2931	Prefabricated stainless steel crown, permanent tooth	20%	1 of (D2928, D2931) per tooth every 36 months
D2932	Prefabricated resin crown	20%	primary - 1 of (D2932, D2933) per tooth every 12 months permanent - 1 of (D2932, D2933) per tooth every 36 months
D2933	Prefabricated stainless steel crown with resin window	20%	
D2940	Protective restoration	20%	1 (D2940) per tooth every 6 months, per provider
D2941	Interim therapeutic restoration, primary dentition	20%	
D2949	Restorative foundation for an indirect restoration	20%	
D2950	Core buildup, including any pins when required	20%	
D2951	Pin retention, per tooth, in addition to restoration	20%	1 (D2951) per tooth
D2952	Post and core in addition to crown, indirectly fabricated	20%	1 (D2952) per tooth
D2953	Each additional indirectly fabricated post, same tooth	20%	
D2954	Prefabricated post and core in addition to crown	20%	1 (D2954) per tooth
D2955	Post removal	20%	
D2957	Each additional prefabricated post, same tooth	20%	
D2971	Additional procedure to construct new crown, existing partial denture frame	20%	
D2980	Crown repair necessitated by restorative material failure	20%	after 12 months of initial crown placement with same provider
D2999	Unspecified restorative procedure, by report	20%	
	Periodontal Services		
GUIDELINE: No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	20%	1 of (D4341, D4342) per site quad, every 24 months, age 13 and over
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	20%	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	20%	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	20%	1 of (D1110, D1120, D4346) every 6 months
D4381	Localized delivery of antimicrobial agent/per tooth	20%	
D4910	Periodontal maintenance	20%	1 (D4910) every 3 months
MAJOR SERVICES			
	Major Restorative Services		
D2542	Onlay, metallic, two surfaces	not covered	
D2543	Onlay, metallic, three surfaces	not covered	
D2544	Onlay, metallic, four or more surfaces	not covered	
D2642	Onlay, porcelain/ceramic, two surfaces	not covered	
D2643	Onlay, porcelain/ceramic, three surfaces	not covered	
D2644	Onlay, porcelain/ceramic, four or more surfaces	not covered	
D2662	Onlay, resin-based composite, two surfaces	not covered	

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CDT Code	Description	Member Responsibility	Limitation
	Major Restorative Services (continued)		
D2663	Onlay, resin-based composite, three surfaces	not covered	
D2664	Onlay, resin-based composite, four or more surfaces	not covered	
D2710	Crown, resin-based composite (indirect)	50%	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D2712	Crown, ¾ resin-based composite (indirect)	50%	
D2720	Crown, resin with high noble metal	not covered	
D2721	Crown, resin with predominantly base metal	50%	
D2722	Crown, resin with noble metal	not covered	
D2740	Crown, porcelain/ceramic	50%	
D2750	Crown, porcelain fused to high noble metal	not covered	
D2751	Crown, porcelain fused to predominantly base metal	50%	
D2752	Crown, porcelain fused to noble metal	not covered	
D2753	Crown, porcelain fused to titanium and titanium alloys	not covered	
D2780	Crown, ¾ cast high noble metal	not covered	
D2781	Crown, ¾ cast predominantly base metal	50%	
D2782	Crown, ¾ cast noble metal	not covered	
D2783	Crown, ¾ porcelain/ceramic	50%	
D2790	Crown, full cast high noble metal	not covered	
D2791	Crown, full cast predominantly base metal	50%	
D2792	Crown, full cast noble metal	not covered	
D2794	Crown, titanium and titanium alloys	not covered	
	Endodontic Services		
D3110	Pulp cap, direct (excluding final restoration)	50%	
D3120	Pulp cap, indirect (excluding final restoration)	50%	
D3220	Therapeutic pulpotomy (excluding final restoration)	50%	1 (D3220) per primary tooth
D3221	Pulpal debridement, primary and permanent teeth	50%	1 (D3221) per tooth
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	50%	1 (D3222) per tooth
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	50%	1 of (D3230, D3240) per tooth
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	50%	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	50%	1 of (D3310, D3320, D3330) per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	50%	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	50%	
D3331	Treatment of root canal obstruction; non-surgical access	50%	
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	not covered	
D3333	Internal root repair of perforation defects	50%	
D3346	Retreatment of previous root canal therapy, anterior	50%	1 of (D3346-D3348) after 12 months of initial treatment
D3347	Retreatment of previous root canal therapy, premolar	50%	
D3348	Retreatment of previous root canal therapy, molar	50%	
D3351	Apexification/recalcification, initial visit	50%	1 (D3351) per tooth
D3352	Apexification/recalcification, interim medication replacement	50%	1 (D3352) per tooth
D3353	Apexification/recalcification, final visit	not covered	
D3410	Apicoectomy, anterior	50%	
D3421	Apicoectomy, premolar (first root)	50%	
D3425	Apicoectomy, molar (first root)	50%	
D3426	Apicoectomy, (each additional root)	50%	
D3430	Retrograde filling, per root	50%	
D3450	Root amputation, per root	not covered	
D3471	Surgical repair of root resorption, anterior	50%	
D3472	Surgical repair of root resorption, premolar	50%	
D3473	Surgical repair of root resorption, molar	50%	
D3910	Surgical procedure for isolation of tooth with rubber dam	50%	
D3920	Hemisection, not including root canal therapy	not covered	
D3950	Canal preparation and fitting of preformed dowel or post	not covered	
D3999	Unspecified endodontic procedure, by report	50%	
	Periodontal Services		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	50%	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	50%	
D4240	Gingival flap procedure, four or more teeth per quadrant	not covered	
D4241	Gingival flap procedure, one to three teeth per quadrant	not covered	
D4249	Clinical crown lengthening, hard tissue	50%	
D4260	Osseous surgery, four or more teeth per quadrant	50%	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4261	Osseous surgery, one to three teeth per quadrant	50%	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	not covered	
D4264	Bone replacement graft, retained natural tooth, each additional site	not covered	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	50%	
D4266	Guided tissue regeneration, resorbable barrier, per site	not covered	
D4267	Guided tissue regeneration, non-resorbable barrier, per site	not covered	
D4270	Pedicle soft tissue graft procedure	not covered	
D4273	Autogenous connective tissue graft procedure, first tooth	not covered	
D4275	Non-autogenous connective tissue graft, first tooth	not covered	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4920	Unscheduled dressing change (other than treating dentist or staff)	50%	1 (D4920) per patient per provider, age 13 and over
D4999	Unspecified periodontal procedure, by report	50%	
	Removable Prosthodontic Services		
D5110	Complete denture, maxillary	50%	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5120	Complete denture, mandibular	50%	
D5130	Immediate denture, maxillary	50%	1 (D5130) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.

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CDT Code	Description	Member Responsibility	Limitation
	Removable Prosthodontic Services (continued)		
D5140	Immediate denture, mandibular	50%	1 (D5140) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5211	Maxillary partial denture, resin base	50%	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5212	Mandibular partial denture, resin base	50%	
D5213	Maxillary partial denture, cast metal, resin base	50%	
D5214	Mandibular partial denture, cast metal, resin base	50%	
D5221	Immediate maxillary partial denture, resin base	50%	1 of (D5221-D5224) per arch per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5222	Immediate mandibular partial denture, resin base	50%	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	50%	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	50%	
D5225	Maxillary partial denture, flexible base	not covered	
D5226	Mandibular partial denture, flexible base	not covered	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	not covered	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	not covered	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	not covered	
D5286	Removable unilateral partial denture, one piece resin, per quadrant	not covered	
D5410	Adjust complete denture, maxillary	50%	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider
D5411	Adjust complete denture, mandibular	50%	
D5421	Adjust partial denture, maxillary	50%	
D5422	Adjust partial denture, mandibular	50%	
D5511	Repair broken complete denture base, mandibular	50%	1 (D5511) per date of service per provider, 2 every 12 months per provider
D5512	Repair broken complete denture base, maxillary	50%	1 (D5512) per date of service per provider, 2 every 12 months per provider
D5520	Replace missing or broken teeth, complete denture	50%	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider
D5611	Repair resin partial denture base, mandibular	50%	1 (D5611) per date of service per provider, 2 every 12 months per provider
D5612	Repair resin partial denture base, maxillary	50%	1 (D5612) per date of service per provider, 2 every 12 months per provider
D5621	Repair cast partial framework, mandibular	50%	1 (D5621) per date of service per provider, 2 every 12 months per provider
D5622	Repair cast partial framework, maxillary	50%	1 (D5622) per date of service per provider, 2 every 12 months per provider
D5630	Repair or replace broken retentive clasping materials, per tooth	50%	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider
D5640	Replace broken teeth, per tooth	50%	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider
D5650	Add tooth to existing partial denture	50%	3 (D5650) per arch per provider per date of service, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	50%	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	not covered	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	not covered	
D5710	Rebase complete maxillary denture	not covered	
D5711	Rebase complete mandibular denture	not covered	
D5720	Rebase maxillary partial denture	not covered	
D5721	Rebase mandibular partial denture	not covered	
D5730	Reline complete maxillary denture, direct	50%	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5731	Reline complete mandibular denture, direct	50%	
D5740	Reline maxillary partial denture, direct	50%	
D5741	Reline mandibular partial denture, direct	50%	
D5750	Reline complete maxillary denture, indirect	50%	
D5751	Reline complete mandibular denture, indirect	50%	
D5760	Reline maxillary partial denture, indirect	50%	
D5761	Reline mandibular partial denture, indirect	50%	
D5850	Tissue conditioning, maxillary	50%	2 (D5850) every 36 months
D5851	Tissue conditioning, mandibular	50%	2 (D5851) every 36 months
D5862	Precision attachment, by report	50%	
D5863	Overdenture, complete, maxillary	50%	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5864	Overdenture, partial, maxillary	50%	
D5865	Overdenture, complete, mandibular	50%	
D5866	Overdenture, partial, mandibular	50%	
D5876	Add metal substructure to acrylic full denture (per arch)	not covered	
D5899	Unspecified removable prosthodontic procedure, by report	50%	
	Maxillofacial Prosthetic Services		
D5911	Facial moulage (sectional)	50%	
D5912	Facial moulage (complete)	50%	
D5913	Nasal prosthesis	50%	
D5914	Auricular prosthesis	50%	
D5915	Orbital prosthesis	50%	
D5916	Ocular prosthesis	50%	
D5919	Facial prosthesis	50%	
D5922	Nasal septal prosthesis	50%	
D5923	Ocular prosthesis, interim	50%	
D5924	Cranial prosthesis	50%	
D5925	Facial augmentation implant prosthesis	50%	
D5926	Nasal prosthesis, replacement	50%	
D5927	Auricular prosthesis, replacement	50%	
D5928	Orbital prosthesis, replacement	50%	
D5929	Facial prosthesis, replacement	50%	
D5931	Obturator prosthesis, surgical	50%	
D5932	Obturator prosthesis, definitive	50%	
D5933	Obturator prosthesis, modification	50%	2 (D5933) every 12 months
D5934	Mandibular resection prosthesis with guide flange	50%	
D5935	Mandibular resection prosthesis without guide flange	50%	
D5936	Obturator prosthesis, interim	50%	

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CDT Code	Description	Member Responsibility	Limitation
	Maxillofacial Prosthetic Services (continued)		
D5937	Trismus appliance (not for TMD treatment)	50%	
D5951	Feeding aid	50%	under age 18
D5952	Speech aid prosthesis, pediatric	50%	under age 18
D5953	Speech aid prosthesis, adult	50%	age 18 and over
D5954	Palatal augmentation prosthesis	50%	
D5955	Palatal lift prosthesis, definitive	50%	
D5958	Palatal lift prosthesis, interim	50%	
D5959	Palatal lift prosthesis, modification	50%	2 (D5959) every 12 months
D5960	Speech aid prosthesis, modification	50%	2 (D5960) every 12 months
D5982	Surgical stent	50%	
D5983	Radiation carrier	50%	
D5984	Radiation shield	50%	
D5985	Radiation cone locator	50%	
D5986	Fluoride gel carrier	50%	
D5987	Commissure splint	50%	
D5988	Surgical splint	50%	
D5991	Vesiculobullous disease medicament carrier	50%	
D5999	Unspecified maxillofacial prosthesis, by report	50%	
	Implant Services		
D6010	Surgical placement of implant body, endosteal	50%	
D6011	Second stage implant surgery	50%	
D6013	Surgical placement of mini implant	50%	
D6040	Surgical placement: eposteal implant	50%	
D6050	Surgical placement: transosteal implant	50%	
D6055	Connecting bar, implant supported or abutment supported	50%	
D6056	Prefabricated abutment, includes modification and placement	50%	
D6057	Custom fabricated abutment, includes placement	50%	
D6058	Abutment supported porcelain/ceramic crown	50%	
D6059	Abutment supported porcelain fused to high noble crown	50%	
D6060	Abutment supported porcelain fused to base metal crown	50%	
D6061	Abutment supported porcelain fused to noble metal crown	50%	
D6062	Abutment supported cast metal crown, high noble	50%	
D6063	Abutment supported cast metal crown, base metal	50%	
D6064	Abutment supported cast metal crown, noble metal	50%	
D6065	Implant supported porcelain/ceramic crown	50%	
D6066	Implant supported crown, porcelain fused to high noble alloys	50%	
D6067	Implant supported crown, high noble alloys	50%	
D6068	Abutment supported retainer, porcelain/ceramic FPD	50%	
D6069	Abutment supported retainer, metal FPD, high noble	50%	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	50%	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	50%	
D6072	Abutment supported retainer, cast metal FPD, high noble	50%	
D6073	Abutment supported retainer, cast metal FPD, base metal	50%	
D6074	Abutment supported retainer, cast metal FPD, noble	50%	
D6075	Implant supported retainer for ceramic FPD	50%	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	50%	
D6077	Implant supported retainer for metal FPD, high noble alloys	50%	
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	50%	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	50%	
D6082	Implant supported crown, porcelain fused to predominantly base alloys	50%	Only a Plan Benefit when exceptional medical conditions are met
D6083	Implant supported crown, porcelain fused to noble alloys	50%	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	50%	
D6085	Interim implant crown	50%	
D6086	Implant supported crown, predominantly base alloys	50%	
D6087	Implant supported crown, noble alloys	50%	
D6088	Implant supported crown, titanium and titanium alloys	50%	
D6090	Repair implant supported prosthesis, by report	50%	
D6091	Replacement part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	50%	
D6092	Re-cement or re-bond implant/abutment supported crown	50%	
D6093	Re-cement or re-bond implant/abutment supported FPD	50%	
D6094	Abutment supported crown, titanium, and titanium alloys	50%	
D6095	Repair implant abutment, by report	50%	
D6096	Remove broken implant retaining screw	50%	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	50%	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	50%	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	50%	
D6100	Surgical removal of implant body	50%	
D6110	Implant/abutment supported removable denture, maxillary	50%	
D6111	Implant/abutment supported removable denture, mandibular	50%	
D6112	Implant/abutment supported removable denture, partial, maxillary	50%	
D6113	Implant/abutment supported removable denture, partial, mandibular	50%	
D6114	Implant/abutment supported fixed denture, maxillary	50%	
D6115	Implant/abutment supported fixed denture, mandibular	50%	
D6116	Implant/abutment supported fixed denture for partial, maxillary	50%	
D6117	Implant/abutment supported fixed denture for partial, mandibular	50%	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	50%	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	50%	
D6122	Implant supported retainer for metal FPD, noble alloys	50%	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	50%	

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Bright HealthCare

CDT Code	Description	Member Responsibility	Limitation
	Implant Services (continued)		
D6190	Radiographic/surgical implant index, by report	50%	Only a Plan Benefit when exceptional medical conditions are met
D6191	Semi-precision abutment, placement	50%	
D6192	Semi-precision attachment, placement	50%	
D6194	Abutment supported retainer crown, FPD titanium, titanium and titanium alloys	50%	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	50%	
D6199	Unspecified implant procedure, by report	50%	
	Fixed Prosthodontic Services		
D6205	Pontic, indirect resin based composite	not covered	
D6210	Pontic, cast high noble metal	not covered	
D6211	Pontic, cast predominantly base metal	50%	1 of (D2710-D2791, D6211-D6791) per tooth per 5 year period age 13 and over
D6212	Pontic, cast noble metal	not covered	
D6214	Pontic, titanium, and titanium alloys	not covered	
D6240	Pontic, porcelain fused to high noble metal	not covered	
D6241	Pontic, porcelain fused to predominantly base metal	50%	
D6242	Pontic, porcelain fused to noble metal	not covered	
D6243	Pontic, porcelain fused to titanium and titanium alloys	not covered	
D6245	Pontic, porcelain/ceramic	50%	
D6250	Pontic, resin with high noble metal	not covered	
D6251	Pontic, resin with predominantly base metal	50%	
D6252	Pontic, resin with noble metal	not covered	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	not covered	
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	not covered	
D6549	Resin retainer, for resin bonded fixed prosthesis	not covered	
D6608	Retainer onlay, porcelain/ceramic, two surfaces	not covered	
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	not covered	
D6610	Retainer onlay, cast high noble metal, two surfaces	not covered	
D6611	Retainer onlay, cast high noble metal, three or more surfaces	not covered	
D6612	Retainer onlay, cast base metal, two surfaces	not covered	
D6613	Retainer onlay, cast base metal, three or more surfaces	not covered	
D6614	Retainer onlay, cast noble metal, two surfaces	not covered	
D6615	Retainer onlay, cast noble metal three or more surfaces	not covered	
D6634	Retainer onlay, titanium	not covered	
D6710	Retainer crown, indirect resin based composite	not covered	
D6720	Retainer crown, resin with high noble metal	not covered	
D6721	Retainer crown, resin with predominantly base metal	50%	
D6722	Retainer crown, resin with noble metal	not covered	
D6740	Retainer crown, porcelain/ceramic	50%	
D6750	Retainer crown, porcelain fused to high noble metal	not covered	
D6751	Retainer crown, porcelain fused to predominantly base metal	50%	
D6752	Retainer crown, porcelain fused to noble metal	not covered	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	not covered	
D6781	Retainer crown, ¾ cast predominantly base metal	50%	
D6782	Retainer crown, ¾ cast noble metal	not covered	
D6783	Retainer crown, ¾ porcelain/ceramic	50%	
D6784	Retainer crown ¾, titanium and titanium alloys	50%	
D6791	Retainer crown, full cast predominantly base metal	50%	
D6794	Retainer crown, titanium and titanium alloys	not covered	
D6930	Re-cement or re-bond fixed partial denture	50%	
D6980	Fixed partial denture repair, restorative material failure	50%	
D6999	Unspecified fixed prosthodontic procedure, by report	50%	
	Oral & Maxillofacial Services		
GUIDELINE: The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists			
D7111	Extraction, coronal remnants, primary tooth	50%	
D7140	Extraction, erupted tooth or exposed root	50%	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	50%	
D7220	Removal of impacted tooth, soft tissue	50%	
D7230	Removal of impacted tooth, partially bony	50%	
D7240	Removal of impacted tooth, completely bony	50%	
D7241	Removal impacted tooth, complete bony, complication	50%	
D7250	Removal of residual tooth roots (cutting procedure)	50%	
D7260	Oroantral fistula closure	50%	
D7261	Primary closure of a sinus perforation	50%	
D7270	Tooth reimplantation and/or stabilization, accident	50%	1 (D7270) per arch
D7280	Exposure of an unerupted tooth	50%	
D7283	Placement, device to facilitate eruption, impaction	50%	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	50%	1 (D7285) per arch per date of service
D7286	Incisional biopsy of oral tissue, soft	50%	up to 3 (D7286) per date of service
D7287	Exfoliative cytological sample collection	not covered	
D7288	Brush biopsy, transepithelial sample collection	not covered	
D7290	Surgical repositioning of teeth	50%	1 (D7290) per arch, for active orthodontic treatment only
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	50%	1 (D7291) per arch, for active orthodontic treatment only
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	50%	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	50%	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	50%	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	50%	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	50%	1 (D7340) per arch every 5 year period
D7350	Vestibuloplasty, ridge extension	50%	1 (D7350) per arch
D7410	Excision of benign lesion, up to 1.25 cm	50%	
D7411	Excision of benign lesion, greater than 1.25 cm	50%	

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CDT Code	Description	Member Responsibility	Limitation
	Oral & Maxillofacial Services (continued)		
D7412	Excision of benign lesion, complicated	50%	
D7413	Excision of malignant lesion, up to 1.25 cm	50%	
D7414	Excision of malignant lesion, greater than 1.25 cm	50%	
D7415	Excision of malignant lesion, complicated	50%	
D7440	Excision of malignant tumor, up to 1.25 cm	50%	
D7441	Excision of malignant tumor, greater than 1.25 cm	50%	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	50%	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	50%	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	50%	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	50%	
D7465	Destruction of lesion(s) by physical or chemical method, by report	50%	
D7471	Removal of lateral exostosis, maxilla or mandible	50%	1 (D7471) per quadrant
D7472	Removal of torus palatinus	50%	1 (D7472) per lifetime
D7473	Removal of torus mandibularis	50%	1 (D7473) per quadrant
D7485	Reduction of osseous tuberosity	50%	1 (D7485) per quadrant
D7490	Radical resection of maxilla or mandible	50%	
D7510	Incision & drainage of abscess, intraoral soft tissue	50%	1 (D7510) per quadrant, same date of service
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	50%	1 (D7511) per quadrant, same date of service
D7520	Incision & drainage of abscess, extraoral soft tissue	50%	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	50%	
D7530	Remove foreign body, mucosa, skin, tissue	50%	1 (D7530) per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	50%	1 (D7540) per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	50%	1 (D7550) per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	50%	
D7610	Maxilla, open reduction (teeth immobilized, if present)	50%	
D7620	Maxilla, closed reduction (teeth immobilized, if present)	50%	
D7630	Mandible, open reduction (teeth immobilized, if present)	50%	
D7640	Mandible, closed reduction (teeth immobilized, if present)	50%	
D7650	Malar and/or zygomatic arch, open reduction	50%	
D7660	Malar and/or zygomatic arch, closed reduction	50%	
D7670	Alveolus, closed reduction, may include stabilization of teeth	50%	
D7671	Alveolus, open reduction, may include stabilization of teeth	50%	
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	50%	
D7710	Maxilla, open reduction	50%	
D7720	Maxilla, closed reduction	50%	
D7730	Mandible, open reduction	50%	
D7740	Mandible, closed reduction	50%	
D7750	Malar and/or zygomatic arch, open reduction	50%	
D7760	Malar and/or zygomatic arch, closed reduction	50%	
D7770	Alveolus, open reduction stabilization of teeth	50%	
D7771	Alveolus, closed reduction stabilization of teeth	50%	
D7780	Facial bones, complicated reduction with fixation and multiple approaches	50%	
D7810	Open reduction of dislocation	50%	
D7820	Closed reduction of dislocation	50%	
D7830	Manipulation under anesthesia	50%	
D7840	Condylectomy	50%	
D7850	Surgical discectomy, with/without implant	50%	
D7852	Disc repair	50%	
D7854	Synovectomy	50%	
D7856	Myotomy	50%	
D7858	Joint reconstruction	50%	
D7860	Arthrotomy	50%	
D7865	Arthroplasty	50%	
D7870	Arthrocentesis	50%	
D7871	Non-arthroscopic lysis and lavage	50%	
D7872	Arthroscopy, diagnosis, with or without biopsy	50%	
D7873	Arthroscopy: lavage and lysis of adhesions	50%	
D7874	Arthroscopy: disc repositioning and stabilization	50%	
D7875	Arthroscopy: synovectomy	50%	
D7876	Arthroscopy: discectomy	50%	
D7877	Arthroscopy: debridement	50%	
D7880	Occlusal orthotic device, by report	50%	
D7881	Occlusal orthotic device adjustment	50%	
D7899	Unspecified TMD therapy, by report	50%	
D7910	Suture of recent small wounds up to 5 cm	50%	
D7911	Complicated suture, up to 5 cm	50%	
D7912	Complicated suture, greater than 5 cm	50%	
D7920	Skin graft (identify defect covered, location and type of graft)	50%	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	50%	
D7940	Osteoplasty, for orthognathic deformities	50%	
D7941	Osteotomy, mandibular rami	50%	
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	50%	
D7944	Osteotomy, segmented or subapical	50%	
D7945	Osteotomy, body of mandible	50%	
D7946	LeFort I (maxilla, total)	50%	
D7947	LeFort I (maxilla, segmented)	50%	
D7948	LeFort II or LeFort III, without bone graft	50%	
D7949	LeFort II or LeFort III, with bone graft	50%	
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	50%	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	50%	

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CDT Code	Description	Member Responsibility	Limitation
	Oral & Maxillofacial Services (continued)		
D7952	Sinus augmentation via a vertical approach	50%	
D7955	Repair of maxillofacial soft and/or hard tissue defect	50%	
D7961	Buccal / labial frenectomy (frenulectomy)	50%	1 (D7961) per arch per date of service
D7962	Lingual frenectomy (frenulectomy)	50%	1 (D7962) per arch per date of service
D7963	Frenuloplasty	50%	1 (D7963) per arch per date of service
D7970	Excision of hyperplastic tissue, per arch	50%	1 (D7970) per arch per date of service
D7971	Excision of pericoronal gingiva	50%	
D7972	Surgical reduction of fibrous tuberosity	50%	1 (D7972) per arch per date of service
D7979	Non – surgical sialolithotomy	50%	
D7980	Surgical sialolithotomy	50%	
D7981	Excision of salivary gland, by report	50%	
D7982	Sialodochoplasty	50%	
D7983	Closure of salivary fistula	50%	
D7990	Emergency tracheotomy	50%	
D7991	Coronoidectomy	50%	
D7995	Synthetic graft, mandible or facial bones, by report	50%	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	50%	1 (D7997) per arch per date of service
D7999	Unspecified oral surgery procedure, by report	50%	
	Orthodontic Services		
For Pediatric Dental, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	50% per course of treatment, regardless of plan year, as long as member remains enrolled in the plan	age 13 and over
D8210	Removable appliance therapy		1 (D8210) per patient, age 6 through 12
D8220	Fixed appliance therapy		1 (D8220) per patient, age 6 through 12
D8660	Pre-orthodontic treatment examination to monitor growth and development		1 (D8660) every 3 months for a maximum of 6
D8670	Periodic orthodontic treatment visit		1 (D8670) per calendar quarter
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		1 (D8680) per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance, maxillary		1 of (D8696, D8697) per arch
D8697	Repair of orthodontic appliance, mandibular		
D8698	Re-cement or re-bond fixed retainer, maxillary		1 of (D8698, D8699) per arch per provider
D8699	Re-cement or re-bond fixed retainer, mandibular		
D8701	Repair of fixed retainer, includes reattachment, maxillary		
D8702	Repair of fixed retainer, includes reattachment, mandibular		
D8703	Replacement of lost or broken retainer, maxillary		1 of (D8703, D8704) per arch
D8704	Replacement of lost or broken retainer, mandibular		
D8999	Unspecified orthodontic procedure, by report		
	Adjunctive General Services		
D9120	Fixed partial denture sectioning	50%	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	50%	1 (D9210) per date of service
D9211	Regional block anesthesia	50%	
D9212	Trigeminal division block anesthesia	50%	
D9215	Local anesthesia in conjunction with operative or surgical procedures	50%	
GUIDELINE: Deep Sedation and IV Conscious Sedation are covered benefits when it is documented local anesthesia is not possible, in such cases as a severe mental or physical handicap, extensive surgical procedures, an uncooperative child, an acute infection at the injection site, or a failure of a local anesthetic to control pain. Services covered when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.			
D9222	Deep sedation/general anesthesia, first 15 minute increment	50%	
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	50%	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	50%	
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	50%	
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	50%	
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	50%	
D9310	Consultation, other than requesting dentist	50%	
D9410	House/extended care facility call	50%	
D9420	Hospital or ambulatory surgical center call	50%	
D9430	Office visit, observation, regular hours, no other services	50%	1 (D9430) per date of service per provider
D9440	Office visit, after regularly scheduled hours	50%	1 (D9440) per date of service per provider
D9450	Case presentation, detailed & extensive treatment	not covered	
D9610	Therapeutic parenteral drug, single administration	50%	4 (D9610) per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	50%	4 (D9612) per date of service
D9910	Application of desensitizing medicament	50%	1 (D9910) per tooth every 12 months, for permanent teeth only
D9930	Treatment of complications, post surgical, unusual, by report	50%	1 (D9930) per date of service per provider
D9942	Repair and/or reline of occlusal guard	not covered	
D9943	Occlusal guard adjustment	not covered	
D9944	Occlusal guard, hard appliance, full arch	not covered	
D9945	Occlusal guard, soft appliance, full arch	not covered	
D9946	Occlusal guard, hard appliance, partial arch	not covered	
D9950	Occlusion analysis, mounted case	50%	1 (D9950) every 12 months, age 13 and over
D9951	Occlusal adjustment, limited	50%	1 (D9951) per quad every 12 months per provider, age 13 and over
D9952	Occlusal adjustment, complete	50%	1 (D9952) every 12 months, age 13 and over

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General Exclusions:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
5. Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
6. Hospital charges of any kind are not covered by the Dental Plan. Refer to your Health Plan's Evidence of Coverage for benefit information.
7. Major surgery for fractures and dislocations.
8. Loss or theft of dentures or bridgework.
9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
10. Any service that is not specifically listed as a covered benefit unless service qualifies under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.
11. Malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Additional treatment costs incurred because a dental procedure is unable to be preformed in the dentists office due to the general health and physical limitations of the patient.
14. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
15. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

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