Schedule of Benefits
Gold SMP
(Who Pays What)
From 01/01/2023 through 12/31/2023

This Schedule of Benefits does not explain all benefits in detail. For a complete explanation of Your benefits, you should read Your entire Policy.

THIS PLAN UTILIZES A PROVIDER NETWORK

This plan uses a Provider Network to provide Covered Health Services to You, which means You will have less out-of-pocket expenses if You receive care from In-Network or Participating Providers.

You can review our provider network online at brighthealthcare.com or You can contact Bright HealthCare Member Services at (844) 926-4524 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 Percentage Copayment, Copayment, or non-covered charges.

Copayment
Copayments are the charges stated as a set dollar amount that You are required to pay for certain Covered Health Services. Copayment amounts accumulate towards Your Out-of-Pocket Maximum. Copayment charges for the calendar year will not exceed 200 percent of the total annual premium cost.

Percentage Copayment
Percentage Copayment is the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services.Percentage Copayment amounts accumulate towards Your Out-of-Pocket Maximum. Percentage Copayment charges will not exceed 50 percent of the total cost of services provided.

Out-of-Pocket Maximum
The Out-of-Pocket Maximum is the maximum amount of Deductible, Percentage Copayment, or Copayments You pay in a calendar year. All Deductible, Copayment and Percentage Copayment payments for In-Network Covered Health Services will apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met for a Covered Person, the Covered Person will haveno further obligation to pay Deductible, Copayment or Percentage Copayment amounts for Covered Health Services received from a participating Bright HealthCare Provider for the remainder of the Calendar Year.

For policies with two or more people, each Covered Person's Individual Out-of-Pocket Maximum applies to the Family Out-of-Pocket Maximum. Once a Covered Person has met his or her Out-of-Pocket Maximum, the Covered Person will have no further obligation to pay charges for In-Network Covered Health Services for the remainder of the Calendar Year. Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family policy will have no further obligation to pay charges for In-Network Covered Health Services.

Limitations/Exclusions
Some limitations are listed in this Schedule of Benefits. Refer to Your policy for a more comprehensive listing and description of services or items that are limited or excluded from covered by the Plan.

General Cost Share & Features	In Network	Non Network
Annual Deductible: Per Plan Year - Medical	$0/Individual; $0/Family	Not Covered
Out-of-Pocket Maximum: Per Plan Year	$7,000/Individual; $14,000/Family	Not Covered

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Benefit	In Network	Non Network
Allergy Services		
Physician Services	$40 per Visit	Not Covered
Allergy Testing	25%	Not Covered
Allergy Serum	25%	Not Covered

Benefit	In Network	Non Network
Autism Spectrum Disorder Services		
Outpatient Therapy Services *Services require Prior Authorization.*	25%	Not Covered
Autism - Applied Behavioral Analysis *Services require Prior Authorization.*	$0 per Visit	Not Covered

Benefit	In Network	Non Network
Chemotherapy & Radiation Treatment		
Chemotherapy Treatment *Services require Prior Authorization.*	25%	Not Covered
Radiation Treatment *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Chiropractic Care		
Spinal Manipulations *Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share.*	$0 per Visit	Not Covered
Diagnostic X-ray Services	25%	Not Covered

Benefit	In Network	Non Network
Convenience Care		
Convenience Care Clinic visit	$25 per Visit	Not Covered
Diagnostic Laboratory Services	$30 per Encounter	Not Covered

Benefit	In Network	Non Network
Dental Care		

Adult Dental Services		
Diagnostic and Preventive Services	$0 per Visit	Not Covered
Basic Dental Care	$50 per Visit	Not Covered
Major Dental Care	$690 per Visit	Not Covered
Orthodontia	Not Covered	Not Covered
Pediatric Dental Services for Dependent Children (through the end of the month in which they turn age 19)		
Diagnostic and Preventive Services *Limited to 2 Exam(s) per Year.*	$0 per Visit	Not Covered
Basic Dental Care *Limitations apply. Refer to Your Pediatric Dental Schedule of Benefits.*	$50 per Visit	Not Covered
Major Dental Care *Limitations apply. Refer to Your Pediatric Dental Schedule of Benefits.*	$690 per Visit	Not Covered
Medically Necessary Orthodontics and Prosthodontics *Limitations apply. Refer to Your Pediatric Dental Schedule of Benefits.*	$2800 per Visit	Not Covered

Benefit	In Network	Non Network
Dialysis Services		
Dialysis Treatment *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Durable Medical Equipment		
Durable Medical Equipment and Devices *Services require Prior Authorization.*	25%	Not Covered
Diabetic Shoes *Services require Prior Authorization.* *Limited to 1 Item(s) per Year.*	25%	Not Covered
Ostomy Supplies *Services require Prior Authorization.*	25%	Not Covered
Equipment for the treatment of Positional Plagiocephaly *Services require Prior Authorization.* *Limited to 1 per lifetime.*	25%	Not Covered

Benefit	In Network	Non Network
Emergency Health Services		
Non-emergent services received in an emergency room are generally not covered. See Your Policy for the definition of Emergency Health Services and/or Emergency Care.		

Emergency Room Facility	$500 per Admission	$500 per Admission
Emergency Room Physician	$100 per Admission	$100 per Admission
Emergency Room Surgeon	$100 per Admission	$100 per Admission
Emergency Room Anesthesiologist	$100 per Encounter	$100 per Encounter
Laboratory Services	$30 per Admission	$30 per Admission
Radiology Services	25%	25%
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	25%
Emergency Room Ancillary Services	$100 per Encounter	$100 per Encounter
Emergency Ambulance Transport (Ground/Air/Water)	25%	25%

Benefit	In Network	Non Network
Genetic Testing and Counseling		
Genetic Testing and Counseling *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Hearing Services		
Hearing Screening *Limited to 1 preventive care hearing screening per calendar year to determine the need for hearing correction.*	$0 per Visit	Not Covered
Hearing Exam/Evaluation	$40 per Visit	Not Covered
Hearing Aids *Limited to 1 Item(s) per 3 years.*	25%	Not Covered

Benefit	In Network	Non Network
Home Health Care		
Home Health *Services require Prior Authorization.* *Limited to 60 Visit(s) per Year.*	25%	Not Covered
Home Infusion Therapy	25%	Not Covered

Benefit	In Network	Non Network
Hospice Care Services		
Hospice Care	25%	Not Covered
Bereavement Support Services	$0 per Visit	Not Covered

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Benefit	In Network	Non Network
Hospital Services & Inpatient Surgery, including Organ & Tissue Transplants *All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center.*		
Inpatient Hospital Facility/Surgery *Services require Prior Authorization.*	25%	Not Covered
Inpatient Habilitation/ Rehabilitation Facility *Services require Prior Authorization.*	25%	Not Covered
Skilled Nursing Facility *Services require Prior Authorization.* *Limited to 25 Visit(s) per Year.*	25%	Not Covered
Professional Fees *Services require Prior Authorization.*	$100 per Encounter	Not Covered
Surgeon Fees *Services require Prior Authorization.*	$100 per Encounter	Not Covered
Anesthesia	$100 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	$30 per Admission	Not Covered
Radiology Services	25%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	Not Covered
Ancillary Services	$100 per Encounter	Not Covered

Benefit	In Network	Non Network
Infertility Services		
Diagnosis and Management *Services require Prior Authorization.*	$40 per Visit	Not Covered
Treatment for Infertility	Not Covered	Not Covered
Artificial Insemination	Not Covered	Not Covered

Benefit	In Network	Non Network
Infusion Therapy		
Infusion Therapy	25%	Not Covered

Benefit	In Network	Non Network
Lab, X-Ray and Diagnostic Services		
Laboratory Services	$30 per Encounter	Not Covered
Radiology Services	25%	Not Covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Mental Health and Substance Use Services Bright HealthCare maintains compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) as well as any additional state parity requirements. Bright HealthCare will not impose more restrictive financial requirements or treatment limitations to mental health or substance use benefits than those on medical/surgical benefits.		
Inpatient Mental Health Care *Services require Prior Authorization.*	25%	Not Covered
Outpatient Mental Health Office Visit	$0 per Visit	Not Covered
Mental Health Telehealth Services	$0 per Visit	Not Covered
Bright Health Telehealth Services	$0 per Visit	Not Covered
Inpatient Substance Use Services *Services require Prior Authorization.*	25%	Not Covered
Outpatient Substance Use Office Visits	$0 per Visit	Not Covered
Other Outpatient Mental Health and Substance Use Services (non-office visits) *Services require Prior Authorization.*	$0 per Visit	Not Covered

Benefit	In Network	Non Network
Outpatient Surgery		
Outpatient Ambulatory Surgery *Services require Prior Authorization.*	$300 per Encounter	Not Covered
Surgeon Fees *Services require Prior Authorization.*	$100 per Encounter	Not Covered
Professional Fees *Services require Prior Authorization.*	$100 per Encounter	Not Covered
Anesthesia	$100 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	$30 per Encounter	Not Covered
Radiology Services	25%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	Not Covered
Ancillary Services	$100 per Encounter	Not Covered

Benefit	In Network	Non Network
Outpatient Therapy Services – Rehabilitative and Habilitative		

Rehabilitative Occupational and Rehabilitative Physical Therapy *Services require Prior Authorization. Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share.*	25%	Not Covered
Rehabilitative Speech Therapy *Services require Prior Authorization. Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share.*	25%	Not Covered
Cardiac Rehabilitation *Services require Prior Authorization.*	25%	Not Covered
Pulmonary Rehabilitation *Services require Prior Authorization.*	25%	Not Covered
Inhalation/Respiratory Therapy *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Physician's Office Services		
Primary Care Office Visits	$0 per Visit	Not Covered
Primary Care Telehealth	Same as Primary Care Office Visit	Not Covered
Bright Health Telehealth Services	$0 per Visit	Not Covered
Specialist Office Visits	$40 per Visit	Not Covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	$0 per Visit	Not Covered
Surgeon Fees	$100 per Visit	Not Covered
Anesthesia	$100 per Visit	Not Covered
Injections/Physician Administered Medications (with or without office visit)	$0 per Visit	Not Covered

Benefit	In Network	Non Network

Pregnancy/ Maternity Services		
Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean require pre- authorization. Services for newborn care after the mother's hospital discharge require Prior Authorization.		
Prenatal/Postnatal Care	$0 per Visit	Not Covered
Delivery Facility Fee	25%	Not Covered
Professional Fees	$100 per Encounter	Not Covered
Surgeon Fees	$100 per Encounter	Not Covered
Anesthesia	$100 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	$30 per Encounter	Not Covered
Radiology Services, including Ultrasound	25%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	Not Covered
Ancillary Services	$100 per Encounter	Not Covered

Prescription Drugs		
Retail Pharmacy		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$0/$10	Not Covered
Preferred Brand and Non-Preferred Generics	$50	Not Covered
Non-Preferred Brand and Non-Preferred Generics	$125	Not Covered
Specialty Medications	30%	Not Covered
Mail Order		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$0/$25	Not Covered
Preferred Brand and Non-Preferred Generics	$125	Not Covered
Non-Preferred Brand and Non-Preferred Generics	$312.50	Not Covered
Specialty Medications	30%	Not Covered

Benefit	**In Network**	**Non Network**
Preventive and Wellness Services		

Preventive Care Services, Screenings and Immunizations	$0 per Visit	Not Covered
Breast Cancer and Mammography Screening	$0 per Visit	Not Covered
Visit https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations for a list of Preventive and Wellness Services. You may also have additional preventive and wellness services available to you as required by state law.		

Benefit	In Network	Non Network
Prosthetics		
Prosthetic Limbs *Services require Prior Authorization.*	25%	Not Covered
Internally Implanted Prosthetic Devices *Services require Prior Authorization.*	25%	Not Covered
All other Prosthetic Devices *Services require Prior Authorization.*	25%	Not Covered
Wigs *Limited to 1 Item(s) per Year for covered persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation.*	$0	Not Covered

Benefit	In Network	Non Network
Sleep Studies		
Sleep Studies *Services require Prior Authorization.*	25%	Not Covered

Benefit	
Travel Expenses	
Travel Expenses (Lodging and Food)	We will reimburse up to the Federal CONUS rate for lodging and food for the city in which services are received.
Mileage for use of a motor vehicle	We will reimburse in accordance with the current IRS allowance per mile for medical travel.
Airfare	We will reimburse airfare limited to the cost of coach round-trip airfare to the facility, unless Medically Necessary to travel in a different capacity.

Benefit	In Network	Non Network
Urgent Care Services		
Urgent Care Facility Fee	$50 per Visit	$50 per Visit
Surgeon Fees	$100 per Visit	$100 per Visit
Anesthesia	$100 per Visit	$100 per Visit

Laboratory Services	$30 per Encounter	$30 per Encounter
Radiology Services	25%	25%
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	25%
Urgent Care Ancillary Services	$100 per Encounter	$100 per Encounter

Benefit	In Network	Non Network
Vision Services		
Adult Vision Services		
Routine Eye Exam	Refer to Your Adult Vision Schedule of Benefits	Refer to Your Adult Vision Schedule of Benefits
Eyeglasses	Refer to Your Adult Vision Schedule of Benefits	Refer to Your Adult Vision Schedule of Benefits
Contact Lenses	Refer to Your Adult Vision Schedule of Benefits	Refer to Your Adult Vision Schedule of Benefits
Pediatric Vision Services for Dependent Children (through the end of the month in which they turn age 19)		
Routine Eye Exam *Limited to 1 Exam(s) per Year.*	$0 per Visit	Not Covered
Eyeglasses *Limited 1 pair of eyeglasses per year in lieu of contact lenses. Refer to Your Pediatric Vision Schedule of Benefits for more information.*	$0	Not Covered
Contact Lenses *Limited a supply of contact lenses in lieu of eyeglasses. Refer to Your Pediatric Vision Schedule of Benefits for more information.*	$0	Not Covered
Low Vision Exam	$10	Not Covered
Low Vision Aids	Not Covered	Not Covered

Adult Vision Benefit
EyeMed Insight Plan H

Bright HealthCare

Vision Care Services	Member Cost In-Network	Member Out-of-Network Reimbursement* & Group Charge Out-of-Network
Exam with Dilation as Necessary	$10 Copay	$45
Retinal Imaging Benefit	Up to $39	N/A
Frames: Any available frame at provider location	$0 Copay; $130 Allowance, 20% off balance over $130	$60
Standard Plastic Lenses		
Single Vision	$25 Copay	$25
Bifocal	$25 Copay	$39
Trifocal	$25 Copay	$63
Lenticular	$25 Copay	$63
Standard Progressive Lens	$90 Copay	$39
Premium Progressive Lens	See attached Fixed Premium Progressive price list	$39
If a member seeks Standard Plastic Lenses in AK, CA, HI, OR, WA, Group Contracted Rate is $15 higher.		
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $130 allowance, 15% off balance over $130	$112
Disposable	$0 Copay; $130 allowance, plus balance over $130	$112
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	$90 Copay
Premium Progressives as Follows:	
Tier 1	$110 Copay
Tier 2	$120 Copay
Tier 3	$135 Copay
Tier 4	$90 Copay, 80% of charge less $120 allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge
Other Add-ons Price List	**Member Cost In-Network**
Photochromic (Plastic)	$75
Polarized	80% of charge
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.	
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.	

For a current listing of brands by tier, go to:
http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf

LIBERTY Dental Plan Corporation
Adult Dental Plan - Bright HealthCare

✓ Members must visit a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will determine a treatment plan or refer you to a contracted specialist if the covered services are medically necessary and outside the scope of a general dentist.

✓ Copayments apply when services listed on the Schedule of Benefits are provided by a contracted dentist. Services received on this plan do not accrue against your Out-of-Pocket Maximum.

✓ This Benefit Schedule represents the adult dental benefits offered through Bright HealthCare. For more information you can refer to your Health Plan's Certificate of Coverage, visit your health plan's website at www.brighthealthcare.com or call Member Services at 1.866.609.0426 (toll-free).

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

CDT Code	Description	General Dentist Member Responsibility	Specialist Member Responsibility	Limitation
	Diagnostic Services			
D0120	Periodic oral evaluation	no charge	Not Covered	2 of (D0120, D0150) every 12 months
D0140	Limited oral evaluation	no charge	$75.00	4 of (D0140, D0160, D0170, D0171) every 12 months
D0150	Comprehensive oral evaluation	no charge	Not Covered	2 of (D0120, D0150) every 12 months
D0160	Oral evaluation, problem focused	no charge	$138.00	4 of (D0140, D0160, D0170, D0171) every 12 months
D0170	Re-evaluation, limited, problem focused	no charge	$52.00	
D0171	Re-evaluation, post operative office visit	no charge	$52.00	
D0210	Intraoral, complete series of radiographic images	no charge	$88.00	1 of (D0210, D0330) every 36 months
D0220	Intraoral, periapical, first radiographic image	no charge	$35.00	6 of (D0220, D0230) 12 months
D0230	Intraoral, periapical, each add 'l radiographic image	no charge	$16.00	
D0270	Bitewing, single radiographic image	no charge	$17.25	1 of (D0270, D0272, D0274) per 12 months
D0272	Bitewings, two radiographic images	no charge	$29.60	
D0274	Bitewings, four radiographic images	no charge	$65.60	
D0330	Panoramic radiographic image	no charge	$100.00	1 of (D0210, D0330) every 36 months
D0460	Pulp vitality tests	no charge	$35.20	
D0470	Diagnostic casts	no charge	$71.25	
	Preventive Services			
D1110	Prophylaxis, adult	no charge	Not Covered	2 of (D1110, D1120) every 12 months
D1330	Oral hygiene instruction	no charge	Not Covered	
D1516	Space maintainer, fixed, bilateral, maxillary	$85	Not Covered	
D1517	Space maintainer, fixed, bilateral, mandibular	$85	Not Covered	
D1526	Space maintainer, removable, bilateral, maxillary	$150	Not Covered	
D1527	Space maintainer, removable, bilateral, mandibular	$150	Not Covered	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$30	Not Covered	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$30	Not Covered	
	Restorative Services			
D2140	Amalgam, one surface, primary or permanent	$20	Not Covered	of (D2140-D2332, D2391-D2394) per surface per tooth every 36 month
D2150	Amalgam, two surfaces, primary or permanent	$25	Not Covered	
D2160	Amalgam, three surfaces, primary or permanent	$30	Not Covered	
D2161	Amalgam, four or more surfaces, primary or permanent	$40	Not Covered	
D2330	Resin-based composite, one surface, anterior	$50	Not Covered	
D2331	Resin-based composite, two surfaces, anterior	$55	Not Covered	
D2332	Resin-based composite, three surfaces, anterior	$65	Not Covered	
D2391	Resin-based composite, one surface, posterior	$80	Not Covered	
D2392	Resin-based composite, two surfaces, posterior	$95	Not Covered	
D2393	Resin-based composite, three surfaces, posterior	$115	Not Covered	
D2394	Resin-based composite, four or more surfaces, posterior	$135	Not Covered	
D2510	Inlay, metallic, one surface	$360	Not Covered	
D2520	Inlay, metallic, two surfaces	$360	Not Covered	
D2530	Inlay, metallic, three or more surfaces	$360	Not Covered	
D2740	Crown, porcelain/ceramic	$450	$849.85	1 of (D2740-D2792, D6210-D6792) per tooth every 5 year period
D2750	Crown, porcelain fused to high noble metal	$465	$846.40	
D2751	Crown, porcelain fused to predominantly base metal	$375	$831.20	
D2752	Crown, porcelain fused to noble metal	$395	$811.90	
D2790	Crown, full cast high noble metal	$425	$776.25	
D2791	Crown, full cast predominantly base metal	$375	$794.65	
D2792	Crown, full cast noble metal	$395	$811.90	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$35	$62.10	
D2920	Re-cement or re-bond crown	$35	$64.40	
D2930	Prefabricated stainless steel crown, primary tooth	$95	$175.95	
D2950	Core buildup, including any pins when required	$120	$172.00	1 of (D2950, D2951) per tooth every 5 year period
D2951	Pin retention, per tooth, in addition to restoration	$30	$33.35	
D2952	Post and core in addition to crown, indirectly fabricated	$150	$272.55	
D2954	Prefabricated post and core in addition to crown	$120	$213.00	
	Endodontic Services			
D3220	Therapeutic pulpotomy (excluding final restoration)	$50	$113.00	1 (D3220) per tooth every 5 year period
D3221	Pulpal debridement, primary and permanent teeth	$125	$118.75	1 (D3221) per tooth every 5 year period
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$160	$578.00	1 of (D3310, D3320, D3330) per tooth every 5 year period
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$275	$655.00	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$450	$875.00	
D3346	Retreatment of previous root canal therapy, anterior	$310	$765.00	1 of (D3346, D3347, D3348) per tooth every 5 year period
D3347	Retreatment of previous root canal therapy, premolar	$410	$858.00	
D3348	Retreatment of previous root canal therapy, molar	$510	$1,050.00	
D3410	Apicoectomy, anterior	$190	$572.00	1 of (D3410, D3421, D3425) per tooth every 5 year period
D3421	Apicoectomy, premolar (first root)	$190	$638.00	
D3425	Apicoectomy, molar (first root)	$190	$726.00	
	Periodontal Services			
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$175	$428.95	1 of (D4210, D4211, D4240, D4249, D4260, D4261) per site/quad every 5 year period
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$60	$209.00	
D4240	Gingival flap procedure, four or more teeth per quadrant	$155	$480.00	
D4249	Clinical crown lengthening, hard tissue	$170	$506.00	
D4260	Osseous surgery, four or more teeth per quadrant	$475	$750.00	
D4261	Osseous surgery, one to three teeth per quadrant	$475	$461.00	
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	$60	$188.80	1 of (D4341, D4342) per site quad, every 36 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$65	$91.00	

LIBERTY Dental Plan Corporation
Adult Dental Plan - Bright HealthCare

CDT Code	Description	General Dentist Member Responsibility	Specialist Member Responsibility	Limitation
	Periodontal Services (continued)			
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$70	$72.45	1 (D4346) every 24 months
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	$65	$117.60	1 (D4355) every 12 months
D4381	Localized delivery of antimicrobial agent/per tooth	$20	$125.00	
D4910	Periodontal maintenance	$65	$87.40	2 (D4910) every 12 months
D4921	Gingival irrigation, per quadrant	$15	$135.00	1 (D4920) per site/quad every 12 months
	Removable Prosthodontic Services			
D5110	Complete denture, maxillary	$485	$1,044.80	1 of (D5110-D5120, D5130-D5140, D5211-D5214, D5810-D5821) per arch every 5 year period
D5120	Complete denture, mandibular	$485	$936.00	
D5130	Immediate denture, maxillary	$485	$984.40	
D5140	Immediate denture, mandibular	$485	$909.65	
D5211	Maxillary partial denture, resin base	$430	$898.40	
D5212	Mandibular partial denture, resin base	$430	$898.40	
D5213	Maxillary partial denture, cast metal, resin base	$560	$1,158.40	
D5214	Mandibular partial denture, cast metal, resin base	$560	$1,108.00	
D5410	Adjust complete denture, maxillary	$30	$48.30	
D5411	Adjust complete denture, mandibular	$30	$49.45	
D5421	Adjust partial denture, maxillary	$30	$47.15	
D5422	Adjust partial denture, mandibular	$30	$47.15	
D5511	Repair broken complete denture base, mandibular	$65	$126.40	
D5512	Repair broken complete denture base, maxillary	$65	$126.40	
D5520	Replace missing or broken teeth, complete denture	$65	$117.60	1 (D5520) every 24 months
D5630	Repair or replace broken retentive clasping materials, per tooth	$75	$142.60	
D5640	Replace broken teeth, per tooth	$65	$81.65	
D5650	Add tooth to existing partial denture	$65	$112.70	
D5660	Add clasp to existing partial denture, per tooth	$75	$149.50	
D5710	Rebase complete maxillary denture	$175	$336.95	1 of (D5710-D5761) every 24 months. Covered 6 months after initial placement of appliance
D5711	Rebase complete mandibular denture	$175	$346.15	
D5720	Rebase maxillary partial denture	$175	$350.75	
D5721	Rebase mandibular partial denture	$175	$343.85	
D5730	Reline complete maxillary denture, direct	$100	$252.00	
D5731	Reline complete mandibular denture, direct	$100	$252.00	
D5740	Reline maxillary partial denture, direct	$100	$235.20	
D5741	Reline mandibular partial denture, direct	$100	$235.20	
D5750	Reline complete maxillary denture, indirect	$150	$268.80	
D5751	Reline complete mandibular denture, indirect	$150	$268.80	
D5760	Reline maxillary partial denture, indirect	$150	$270.25	
D5761	Reline mandibular partial denture, indirect	$150	$268.80	
D5810	Interim complete denture, maxillary	$255	$630.00	1 of (D5110-D5120, D5130-D5140, D5211-D5214, D5810-D5821) per arch every 5 year period
D5811	Interim complete denture, mandibular	$255	$630.00	
D5820	Interim partial denture, maxillary	$210	$310.50	
D5821	Interim partial denture, mandibular	$210	$331.20	
D5850	Tissue conditioning, maxillary	$50	$85.10	
D5851	Tissue conditioning, mandibular	$50	$83.95	
	Fixed Prosthodontic Services			
D6210	Pontic, cast high noble metal	$405	$657.80	1 of (D2740-D2792, D6210-D6792) per tooth every 5 year period
D6211	Pontic, cast predominantly base metal	$360	$635.95	
D6212	Pontic, cast noble metal	$385	$663.55	
D6240	Pontic, porcelain fused to high noble metal	$405	$726.80	
D6241	Pontic, porcelain fused to predominantly base metal	$360	$650.90	
D6242	Pontic, porcelain fused to noble metal	$385	$652.05	
D6251	Pontic, resin with predominantly base metal	$400	$538.20	
D6750	Retainer crown, porcelain fused to high noble metal	$405	$765.90	
D6751	Retainer crown, porcelain fused to predominantly base metal	$360	$714.15	
D6752	Retainer crown, porcelain fused to noble metal	$385	$703.80	
D6790	Retainer crown, full cast high noble metal	$405	$694.60	
D6791	Retainer crown, full cast predominantly base metal	$360	$680.80	
D6792	Retainer crown, full cast noble metal	$385	$725.65	
D6930	Re-cement or re-bond fixed partial denture	$50	$88.55	
	Oral & Maxillofacial Services			
GUIDELINE: The surgical removal of third molar wisdom teeth are a covered benefit at the below copayment at a general dentist's office or if performed at a specialist's office the service will be covered at the specialist's copayment.				
D7111	Extraction, coronal remnants, primary tooth	$35	$200.00	
D7140	Extraction, erupted tooth or exposed root	$30	$200.00	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$55	$285.00	
D7220	Removal of impacted tooth, soft tissue	$70	$300.00	
D7230	Removal of impacted tooth, partially bony	$90	$375.00	
D7240	Removal of impacted tooth, completely bony	$110	$410.00	
D7250	Removal of residual tooth roots (cutting procedure)	$45	$285.00	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$55	$226.00	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$90	$310.00	
D7510	Incision & drainage of abscess, intraoral soft tissue	$40	$300.00	
	Adjunctive General Services			
D9110	Palliative (emergency) treatment, minor procedure	no charge	$70.00	
D9215	Local anesthesia in conjunction with operative or surgical procedures	no charge	no charge	inclusive/not payable separately
GUIDELINE: Services covered when dispensed in a dental office by a practitioner acting within the scope of his/her licensure.				
D9222	Deep sedation/general anesthesia, first 15 minute increment	$150	$175.00	Prior Authorization Required
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$25	$175.00	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	$50.00	3 (D9230) every 12 months
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$150	$144.00	Prior Authorization Required
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$55	$144.00	

CDT Code	Description	General Dentist Member Responsibility	Specialist Member Responsibility	Limitation
	Adjunctive General Services (continued)			
D9310	Consultation, other than requesting dentist	no charge	$150.00	
D9944	Occlusal guard, hard appliance, full arch	$250	$457.70	
D9951	Occlusal adjustment, limited	$35	$80.50	
D9952	Occlusal adjustment, complete	$225	$458.85	
D9995	Teledentistry, synchronous; real-time encounter	no charge	$28.75	
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for susequent review	no charge	$28.75	

Important:

If a Member decides to receive Dental Services that are not covered under this Agreement, the contracted dentist may charge the Member his or her usual and customary rate for those services. Prior to providing a Member with Dental Services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. For more information about the Dental Services that are covered under this Agreement, please call customer service at 1.866.609.0426 (toll-free).

This Agreement covers the dental services for Members when they are performed by a licensed contracted dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for a Member's dental condition, the Plan will cover the least expensive treatment.

Pretreatment Estimate:

A pretreatment estimate is a valuable tool for You and Your Member. It gives You and the Member an idea of what the Member's Out-of-Pocket costs will be. This allows You and Your Member to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontal, prosthetic, or orthodontic care. The pretreatment estimate is recommended, but not required for a Member to get benefits for Covered Services. A pretreatment estimate does not authorize treatment or determine its Medical Necessity, and does not guarantee benefits. The estimate will be based on a Member's current eligibility and the Agreement benefits in effect at the time the estimate is sent to us. This is an estimate only. Our final payment will be based on the claim that is sent to Us at the time of the completed dental care service(s). Sending in other claims or changes to a Member's eligibility or to the Agreement may affect our final payment.

Members can ask their dentist to send a pretreatment estimate on their behalf, or send it directly to Us. Please include the procedure codes for the services to be performed for a Member. If a Member has questions on where to send the estimate, call Us at the number on the back of their ID card.

General Exclusions:

1. Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health.
2. Oral Surgery requiring the setting of fractures of dislocations.
3. Any treatment, which cannot be performed because of the general health physical limits of the eligible Member, as indicated by said Member's personal physical, a participating dentist or
4. Any dental procedure not specifically listed in the benefit schedule.
5. Cost of hospitalization (hospitals, outpatient surgery center or other similar facility), including dentist and/or physician charges, medications and pharmaceuticals.
6. Procedures performed before a person becomes a Member or after termination from the plan.
7. Any treatment paid for by Workers' Compensation or employer's liability laws, by a federal or state government agency or other insurance coverage carried by the Member. Any treatment
8. Any dental care provided by a non-participating general dentist or dental specialist.
9. Services resulting from any act of war, declared or not, or resulting from military services.
10. The participating dentist shall have the right to refuse treatment to a Member who fails to follow a prescribed course of treatment.
11. Any dental treatment started prior to the Member's effective date for eligibility of benefits including but not limited to teeth prepared for crowns, root canals in progress and orthodontics.
12. Any procedure that in the professional opinion of the participating dentist or dental specialist or LDP's Dental Consultant: has poor probability for success based on the condition of the tooth or teeth or surrounding structures; is inconsistent with generally accepted standards for dentistry.
13. Consultations for non-covered benefits.
14. Implant placement or removal, appliances placed on or services associated with implants.
15. Restorations placed solely for cosmetic reasons.
16. Treatment or extraction of non-infected primary teeth when normal loss is imminent.
17. Accidental injury defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth.
18. Any dental procedure or treatment unable to be formed in the dental office due to the general health or physical limitations of the member including but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.