CareFirst BlueCross BlueShield
Medicare Advantage
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CareFirst Medicare Advantage

CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Dental Benefits Summary

DG02	**In-Network***
Plan Type	**Medicare Advantage HMO**
Individual Deductible:	$0
Network:	* CareFirst Advantage Providers are In - Network

- Members must receive covered services from in-network providers. Except in the highly limited circumstances as provided in the Evidence of Coverage, services provided by out-of-network providers are not covered. Members will be responsible for the full charge for services provided by out-of-network providers. Out-of-network providers are urged to contact Provider Services at [833-493-0535] before rendering services to a CareFirst BlueCross BlueShield Medicare Advantage member.
- Coverage for the benefits below are subject to the member eligibility and the terms of the Evidence of Coverage (EOC). If the Dental Procedure code is not listed below; it is not a covered benefit.

CDT CODE	PROCEDURE NAME	COPAY ($)
Oral Exams		
D0120	PERIODIC ORAL EXAMINATION—ESTABLISHED PATIENT	$20
D0140	LIMITED ORAL EVALUATION—PROBLEM FOCUSED	
D0150	COMPREHENSIVE ORAL EVALUATION—NEW OR ESTABLISHED PATIENT	
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION—PROBLEM FOCUSED, BY REPORT	
D0180	COMPREHENSIVE PERIODONTAL EVALUATION—NEW OR ESTABLISHED PATIENT	
Dental X-Rays		
D0210	INTRAORAL—COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$20
D0220	INTRAORAL—PERIAPICAL FIRST RADIOGRAPHIC IMAGE	
D0230	INTRAORAL—PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	

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CDT CODE	PROCEDURE NAME	COPAY ($)
D0270	BITEWING—SINGLE RADIOGRAPHIC IMAGE	
D0272	BITEWINGS—TWO RADIOGRAPHIC IMAGES	
D0273	BITEWINGS—THREE RADIOGRAPHIC IMAGES	
D0274	BITEWINGS—FOUR RADIOGRAPHIC IMAGES	
D0277	VERTICAL BITEWINGS—7 TO 8 RADIOGRAPHIC IMAGES	
D0330	PANORAMIC RADIOGRAPHIC IMAGE	
Prophylaxis – Routine Cleanings		
D1110	PROPHYLAXIS—ADULT	$20
Topical Fluoride Treatment		
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	$20
D1208	TOPICAL APPLICATION OF FLUORIDE—EXCLUDING VARNISH	
Non-Routine Services		
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION—PER TOOTH	$15
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN, MINOR PROCEDURE	$30
Basic Restorative Services - Fillings		
D2140	AMALGAM—ONE SURFACE, PRIMARY OR PERMANENT	$30
D2150	AMALGAM—TWO SURFACES, PRIMARY OR PERMANENT	$40
D2160	AMALGAM—THREE SURFACES, PRIMARY OR PERMANENT	$50
D2161	AMALGAM—FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	$60
D2330	RESIN-BASED COMPOSITE—ONE SURFACE, ANTERIOR	$30
D2331	RESIN-BASED COMPOSITE—TWO SURFACES, ANTERIOR	$40
D2332	RESIN-BASED COMPOSITE—THREE SURFACES, ANTERIOR	$50
D2335	RESIN-BASED COMPOSITE—FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	$60
D2391	RESIN-BASED COMPOSITE—ONE SURFACE, POSTERIOR	$30
D2392	RESIN-BASED COMPOSITE—TWO SURFACES, POSTERIOR	$40
D2393	RESIN-BASED COMPOSITE—THREE SURFACES, POSTERIOR	$50
D2394	RESIN-BASED COMPOSITE—FOUR OR MORE SURFACES, POSTERIOR	$60
Non-Surgical Periodontics		
D4341	PERIODONTAL SCALING AND ROOT PLANING—FOUR OR MORE TEETH PER QUADRANT	$50
D4342	PERIODONTAL SCALING AND ROOT PLANING—ONE TO THREE TEETH PER QUADRANT	$50
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION—FULL MOUTH, AFTER ORAL EVALUATION	$50
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE ORAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	$60
D4910	PERIODONTAL MAINTENANCE	$50
Non-Surgical Extractions		
D7111	EXTRACTION, CORONAL REMNANTS—PRIMARY TOOTH	$40
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	$50

Benefit Frequencies & Limitations

Class 1 - Preventive and Diagnostic Services:

1. Twice per benefit period (calendar year):
   a. oral exam
   b. routine cleaning
   c. topical fluoride
   d. x-rays

2. Application of caries arresting medicament limited to once per surface per lifetime

3. Palliative (emergency) treatment of dental pain available as required

Class 2 - Basic Services:

1. Direct placement fillings limited to:
   a. silver amalgam or composite resin
   b. one filling per surface per 12 months

2. Non-surgical periodontal services (one treatment per site) limited to:
   a. Once per 24 months for periodontal scaling and root planning services
   b. Once per 36 months for full mouth debridement
   c. Twice per benefit period for periodontal maintenance

3. Non-surgical extractions limited to once per tooth per lifetime