CareFirst
Family of health care plans

BlueDental EPO Member Copay Summary
(with Orthodontic Benefits)

The BlueDental EPO plan includes a Deductible, Annual Maximum and Lifetime Orthodontic Maximum.

- The **deductible ($25 individual / $75 family)** must be met prior to receiving coverage from CareFirst for dental services. Only services in Classes II, III, IV and V are subject to the deductible. The deductible does not apply to Preventive and Diagnostic services (Class I). To track your deductible, log in to *My Account*.
- The **annual maximum ($2000)** refers to the total amount that CareFirst will pay toward covered services. Once the annual maximum is met, CareFirst will no longer provide coverage for certain services. Only services in Classes II, III and IV are subject to the annual maximum. Class I and Class V services are excluded from the annual maximum.
- The **lifetime orthodontic maximum ($2000)** refers to the total amount that CareFirst will pay toward covered orthodontic (Class V) services over the lifetime of the member

A benefit waiting period may apply to Class III, IV and V services. Please check your member benefits contract for more information.

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
		CLINICAL ORAL EVALUATIONS	
I	D0120	Periodic oral examination—established patient	$0
	D0140	Limited oral evaluation—problem focused	$0
	D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0
	D0150	Comprehensive oral evaluation—new or established patient	$0
	D0160	Detailed and extensive oral evaluation—problem focused, by report	$0
	D0170	Re-evaluation—limited, problem focused (established patient; not post-operative visit)	$0
	D0171	Re-evaluation—post operative visit	$0
	D0180	Comprehensive periodontal evaluation—new or established patient	$0
		RADIOGRAPHS	
I	D0210	Intraoral—complete series of radiographic images	$0
	D0220	Intraoral—periapical first radiographic image	$0
	D0230	Intraoral—periapical each additional radiographic image	$0
	D0240	Intraoral—occlusal radiographic image	$0
	D0270	Bitewing, single radiographic image	$0
	D0272	Bitewings, two radiographic images	$0
	D0273	Bitewings, three radiographic images	$0
	D0274	Bitewings, four radiographic images	$0
	D0277	Vertical bitewings—7 to 8 radiographic images	$0
	D0330	Panoramic radiographic image	$0
	D0340	2D cephalometric radiographic image—acquisition, measurement, and analysis	$41

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
I	D0350	2D oral/facial photographic image obtained intraorally or extraorally	$16
	D0351	3D photographic image	$24
		TESTS AND LABORATORY EXAMINATIONS	
I	D0460	Pulp vitality tests	$17
	D0470	Diagnostic casts	$36
		DENTAL PROPHYLAXIS	
I	D1110	Prophylaxis – adult	$0
	D1120	Prophylaxis – child	$0
		TOPICAL FLOURIDE TREATMENT	
I	D1206	Topical application of fluoride varnish	$0
	D1208	Topical application of fluoride - excluding varnish	$0
		OTHER PREVENTIVE SERVICES	
I	D1330	Oral hygiene instructions	$15
	D1351	Sealant—per tooth	$18
	D1354	Interim caries arresting medicament application temporary crown (fractured tooth)	$11
		SPACE MAINTENANCE (PASSIVE APPLIANCES)	
I	D1510	Space maintainer—fixed—unilateral	$89
	D1516	Space maintainer—fixed—bilateral, maxillary	$127
	D1517	Space maintainer—fixed—bilateral, mandibular	$127
	D1520	Space maintainer—removable—unilateral	$89
	D1526	Space maintainer—removable—bilateral, maxillary	$132
	D1527	Space maintainer—removable—bilateral, mandibular	$132
	D1550	Re-cement or re-bond space maintainer	$28
	D1555	Removal of fixed space maintainer	$30
	D1575	Distal shoe space maintainer—fixed—unilateral	$81
		AMALGAM RESTORATIONS (INCLUDING POLISHING)	
II	D2140	Amalgam—one surface, primary or permanent	$34
	D2150	Amalgam—two surfaces, primary or permanent	$46
	D2160	Amalgam—three surfaces, primary or permanent	$45
	D2161	Amalgam—four or more surfaces, primary or permanent	$54
		RESIN RESTORATIONS	
II	D2330	Resin-based composite—one surface, anterior	$46
	D2331	Resin-based composite—two surfaces, anterior	$53
	D2332	Resin-based composite—three surfaces, anterior	$62
	D2335	Resin-based composite—four or more surfaces or involving incisal angle (anterior)	$76
	D2391	Resin-based composite—one surface, posterior	$55
	D2392	Resin-based composite—two surfaces, posterior	$73
	D2393	Resin-based composite—three surfaces, posterior	$79
	D2394	Resin-based composite—four or more surfaces, posterior	$101

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
		ONLAY RESTORATIONS	
IV	D2542	Onlay—metallic—two surfaces	$283
	D2543	Onlay—metallic—three surfaces	$363
	D2544	Onlay—metallic—four or more surfaces	$406
	D2642	Onlay—porcelain/ceramic—two surfaces	$321
	D2643	Onlay—porcelain/ceramic—three surfaces	$411
	D2644	Onlay—porcelain/ceramic—four or more surfaces	$415
	D2662	Onlay—resin-based composite—two surfaces	$321
	D2663	Onlay—resin-based composite—three surfaces	$384
	D2664	Onlay—resin-based composite—four or more surfaces	$415
		CROWNS—SINGLE RESTORATION ONLY	
IV	D2710	Crown—resin-based composite (indirect)	$246
	D2712	Crown—3/4 resin-based composite (indirect)	$317
	D2720	Crown—resin with high noble metal	$374
	D2721	Crown—resin with predominantly base metal	$352
	D2722	Crown—resin with noble metal	$374
	D2740	Crown—porcelain/ceramic substrate	$530
	D2750	Crown—porcelain fused to high noble metal	$460
	D2751	Crown—porcelain fused to predominantly base metal	$417
	D2752	Crown—porcelain fused to noble metal	$460
	D2780	Crown—3/4 cast high noble metal	$388
	D2781	Crown—3/4 cast predominately base metal	$370
	D2782	Crown—3/4 cast noble metal	$388
	D2783	Crown—3/4 porcelain/ceramic	$388
	D2790	Crown—full cast high noble metal	$424
	D2791	Crown—full cast predominantly base	$417
	D2792	Crown—full cast noble metal	$424
	D2794	Crown—titanium	$424
	D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression	$121
		OTHER RESTORATIVE SERVICES	
IV	D2910	Re-cement or re-bond inlay, onlay, or partial coverage restoration	$31
	D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$28
	D2920	Re-cement or re-bond crown	$28
	D2921	Reattachment of tooth fragment, incisal edge or cusp	$95
	D2930	Prefabricated stainless steel crown—primary tooth	$93
	D2931	Prefabricated stainless steel crown—permanent tooth	$93
	D2932	Prefabricated resin crown	$86
	D2933	Prefabricated stainless steel crown with resin window	$99

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
IV	D2934	Prefabricated esthetic coated stainless steel crown—primary tooth	$86
	D2940	Protective restoration	$29
	D2941	Interim therapeutic restoration—primary dentition	$33
	D2950	Core buildup, including any pins	$92
	D2951	Pin retention—per tooth, in addition to restoration	$19
	D2952	Post and core in addition to crown, indirectly fabricated	$143
	D2953	Each additional indirectly fabricated post—same tooth	$77
	D2954	Prefabricated post and core in addition to crown	$92
	D2957	Each additional prefabricated post- same tooth	$30
	D2961	Labial veneer (resin laminate)—laboratory	$303
	D2962	Labial veneer (porcelain laminate)—laboratory	$445
	D2971	Additional procedures to construct new crown under existing partial denture framework	$51
	D2980	Crown repair, necessitated by restorative material failure	$80
		PULP CAPPING	
III	D3110	Pulp cap—direct (excluding final restoration)	$19
	D3120	Pulp cap—indirect (excluding final restoration)	$16
		PULPOTOMY	
III	D3220	Therapeutic pulpotomy (excluding final restoration)- removal of pulp coronal to the dentinocemental junction and application of medicament	$67
	D3221	Pulpal debridement, primary and permanent teeth	$58
	D3222	Partial pulpotomy for apexogenesis	$137
		ENDODONTIC THERAPY ON PRIMARY TEETH	
III	D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)	$85
	D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)	$98
		ROOT CANAL / ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)	
III	D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$311
	D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$454
	D3330	Endodontic therapy, molar (excluding final restoration)	$529
	D3331	Treatment of root canal obstruction; non-surgical access	$67
	D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$126
	D3333	Internal root repair of perforation defects	$92
		ENDODONTIC RETREATMENT	
III	D3346	Retreatment of previous root canal therapy—anterior	$403
	D3347	Retreatment of previous root canal therapy—bicuspid	$463
	D3348	Retreatment of previous root canal therapy—molar	$570

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
III	D3351	Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$106
	D3352	Apexification/recalcification/pulpal regeneration—interim medication replacement	$93
	D3353	Apexification/recalcification - final visit (includes completed root canal therapy—apical closure/calcific repair of perforations, root resorption, etc.)	$106
		APICOECTOMY/PERIAPICAL SERVICES	
III	D3410	Apicoectomy/periradicular surgery—anterior	$305
	D3421	Apicoectomy/periradicular surgery—bicuspid (first root)	$284
	D3425	Apicoectomy/periradicular surgery—molar (first root)	$325
	D3426	Apicoectomy/periadicular surgery (each additional root)	$135
	D3427	Periradicular surgery without apicoectomy	$192
	D3428	Bone graft in conjunction with periradicular surgery—per tooth, single site	$308
	D3429	Bone graft in conjunction with periradicular surgery—each additional contiguous tooth in the same surgical site	$141
	D3430	Retrograde filling—per root	$112
	D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	$257
	D3450	Root amputation—per root	$132
		OTHER ENDODONTIC PROCEDURES	
III	D3920	Hemisection (including root removal), not including root canal therapy	$159
	D3950	Canal preparation and fitting of preformed dowel or post	$40
		SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES)	
III	D4210	Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant	$172
	D4211	Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant	$81
	D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$81
	D4240	Gingival flap procedure, including root planing—four or more contiguous teeth or tooth bounded spaces per quadrant	$267
	D4241	Gingival flap procedure, including root planing—one to three contiguous teeth or tooth bounded spaces per quadrant	$214
	D4249	Clinical crown lengthening—hard tissue	$293
	D4260	Osseous surgery (including elevation of full thickness flap entry and closure)—four or more contiguous teeth or tooth bounded spaces per quadrant	$478
	D4261	Osseous surgery (including elevation of full thickness flap entry and closure)—one to three contiguous teeth or tooth bounded spaces per quadrant	$333
	D4263	Bone replacement graft—first site in quadrant	$251
	D4264	Bone replacement graft— each additional site in quadrant	$123

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
III	D4265	Biologic materials to aid in soft and osseous tissue regeneration	$189
	D4266	Guided tissue regeneration—resorbable barrier, per site	$257
	D4267	Guided tissue regeneration—non-resorbable barrier, per site (includes membrane removal)	$277
	D4270	Pedicle soft tissue graft procedure	$278
	D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$360
	D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$223
	D4275	Non-autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in a graft	$366
	D4276	Combined connective tissue and double pedicle graft, per tooth	$366
	D4277	Free soft tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in a graft	$331
	D4278	Free soft tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth or edentulous tooth position in same graft site	$241
	D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in graft	$360
	D4285	Non-autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in graft	$366
	D4341	Periodontal scaling and root planing—four or more teeth per quadrant	$93
		ADJUNCTIVE PERIODONTAL SERVICES	
II	D4342	Periodontal scaling and root planing—one to three teeth per quadrant	$64
	D4346	Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation	$42
	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$63
	D4381	Localized delivery of antimicrobial agents, via a controlled release vehicle into diseased crevicular tissue, per tooth	$40
		OTHER PERIODONTAL SERVICES	
II	D4910	Periodontal maintenance	$60
		COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
IV	D5110	Complete denture—maxillary	$535
	D5120	Complete denture—mandibular	$535
	D5130	Immediate denture—maxillary	$569
	D5140	Immediate denture—mandibular	$569

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
		PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
IV	D5211	Maxillary partial denture—resin base (including retentive/clasping materials, rests and teeth)	$379
	D5212	Mandibular partial denture—resin base (including retentive/clasping materials, rests and teeth)	$379
	D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$622
	D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$622
	D5221	Immediate maxillary partial denture—resin base (including any conventional clasps, rests, and teeth)	$379
	D5222	Immediate mandibular partial denture—resin base (including any conventional clasps, rests, and teeth)	$379
	D5223	Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$622
	D5224	Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$622
	D5225	Maxillary partial denture—flexible base (including any clasps, rests and teeth)	$541
	D5226	Mandibular partial denture—flexible base (including any clasps, rests and teeth)	$541
	D5282	Removable unilateral partial denture—one piece cast metal (including clasps and teeth), maxillary	$253
	D5283	Removable unilateral partial denture—one piece cast metal (including clasps and teeth), mandibular	$253
		ADJUSTMENTS TO REMOVABLE PROSTHESIS	
IV	D5410	Adjust complete denture—maxillary	$25
	D5411	Adjust complete denture—mandibular	$25
	D5421	Adjust partial denture—maxillary	$26
	D5422	Adjust partial denture—mandibular	$26
		REPAIRS TO COMPLETE DENTURES	
IV	D5511	Repair broken complete denture base, mandibular	$80
	D5512	Repair broken complete denture base, maxillary	$80
		REPAIRS TO PARTIAL DENTURES	
IV	D5611	Repair resin partial denture base, mandibular	$63
	D5612	Repair resin partial denture base, maxillary	$63
	D5621	Repair cast partial framework, mandibular	$75
	D5622	Repair cast partial framework, maxillary	$75
	D5630	Repair or replace broken retentive clasping materials—per tooth	$75
	D5640	Replace broken teeth—per tooth	$63
	D5650	Add tooth to existing partial denture	$69
	D5660	Add clasp to existing partial denture—per tooth	$81
	D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$203
	D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$203

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
		DENTURE REBASE PROCEDURES	
IV	D5710	Rebase complete maxillary denture	$189
	D5711	Rebase complete mandibular denture	$189
	D5720	Rebase maxillary partial denture	$175
	D5721	Rebase mandibular partial denture	$175
		DENTURE RELINE PROCEDURES	
IV	D5730	Reline complete maxillary denture (chairside)	$108
	D5731	Reline complete mandibular denture (chairside)	$108
	D5740	Reline maxillary partial denture (chairside)	$108
	D5741	Reline mandibular partial denture (chairside)	$108
	D5750	Reline complete maxillary denture (laboratory)	$162
	D5751	Reline complete mandibular denture (laboratory)	$162
	D5760	Reline maxillary partial denture (laboratory)	$162
	D5761	Reline mandibular partial denture (laboratory)	$162
		OTHER REMOVABLE PROSTHETIC SERVICES	
IV	D5850	Tissue conditioning, maxillary	$56
	D5851	Tissue conditioning, mandibular	$56
	D5863	Overdenture—complete maxillary	$895
	D5864	Overdenture—partial maxillary	$895
	D5865	Overdenture—complete mandibular	$895
	D5866	Overdenture—partial mandibular	$895
	D5875	Modification of removable prosthesis following implant surgery	$81
		IMPLANT SERVICES	
IV	D6010	Surgical placement of implant body—endosteal implant	$1,150
	D6011	Second stage implant surgery	$100
	D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$840
	D6013	Surgical placement of mini implant	$245
	D6040	Surgical placement—eposteal implant	$1,160
	D6055	Connecting bar—implant supported or abutment supported	$960
	D6056	Prefabricated abutment—includes modification and placement	$375
	D6057	Custom fabricated abutment—includes placement	$445
	D6058	Abutment supported porcelain/ceramic crown	$645
	D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$630
	D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$495
	D6061	Abutment supported porcelain fused to metal crown (noble metal)	$630
	D6062	Abutment supported cast metal crown (high noble metal)	$600
	D6063	Abutment supported cast metal crown (predominantly base metal)	$480
	D6064	Abutment supported cast metal crown (noble metal)	$600

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
IV	D6065	Implant supported porcelain/ceramic crown	$645
	D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$645
	D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$645
	D6075	Implant supported retainer for ceramic fpd	$645
	D6076	Implant supported retainer for porcelain fused to metal fpd (titanium, titanium alloy, or high noble metal)	$650
	D6077	Implant supported retainer for cast metal fpd (titanium, titanium alloy, or high noble metal)	$650
	D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prosthesis and abutments	$160
	D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$55
	D6090	Repair implant supported prosthesis, by report	$310
	D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$325
	D6092	Recement or re-bond implant/abutment supported crown	$30
	D6093	Recement or re-bond implant/abutment supported fixed partial denture	$80
	D6094	Abutment supported crown (titanium)	$545
	D6095	Repair implant abutment, by report	$290
	D6100	Implant removal, by report	$800
	D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$210
	D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces including flap entry and closure	$250
	D6103	Bone graft for repair of peri-implant defect—does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	$360
	D6104	Bone graft at time of implant placement	$160
	D6190	Radiographic/surgical implant index, by report	$100
	D6205	Pontic—indirect resin based composite	$282
		FIXED PARTIAL DENTURE PONTICS	
IV	D6210	Pontic—cast high noble metal	$424
	D6211	Pontic—cast predominantly base metal	$417
	D6212	Pontic—cast noble metal	$424
	D6214	Pontic—titanium	$424
	D6240	Pontic—porcelain fused to high noble metal	$514

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
IV	D6241	Pontic—porcelain fused to predominantly base metal	$506
	D6242	Pontic—porcelain fused to noble metal	$514
	D6245	Pontic—porcelain/ceramic	$525
	D6250	Pontic—resin with high noble metal	$454
	D6251	Pontic—resin with predominantly base metal	$446
	D6252	Pontic—resin with noble metal	$454
		RETAINERS	
IV	D6545	Retainer—cast metal for resin bonded fixed prosthesis	$207
	D6548	Retainer—porcelain/ceramic for resin bonded fixed prosthesis	$244
	D6549	Resin retainer—for resin bonded fixed prosthesis	$237
	D6602	Retainer inlay—cast high noble metal, two surfaces	$296
	D6603	Retainer inlay—cast high noble metal, three or more surfaces	$334
	D6604	Retainer inlay—cast predominantly base metal, two surfaces	$296
	D6605	Retainer inlay—cast predominantly base metal, three or more surfaces	$334
	D6606	Retainer inlay—cast noble metal, two surfaces	$296
	D6607	Retainer inlay—cast noble metal, three or more surfaces	$334
	D6610	Retainer onlay—cast high noble metal, two surfaces	$336
	D6611	Retainer onlay—cast high noble metal, three or more surfaces	$375
	D6612	Retainer onlay—cast predominantly base metal, two surfaces	$336
	D6613	Retainer onlay—cast predominantly base metal, three or more surfaces	$375
	D6614	Retainer onlay—cast noble metal, two surfaces	$336
	D6615	Retainer onlay—cast noble metal, three or more surfaces	$375
	D6624	Retainer inlay—titanium	$334
	D6634	Retainer onlay—titanium	$375
	D6710	Retainer crown—indirect resin based composite	$317
	D6720	Retainer crown—resin with high noble metal	$420
	D6721	Retainer crown—resin with predominantly base metal	$403
	D6722	Retainer crown—resin with noble metal	$420
		FIXED PARTIAL DENTURE RETAINERS—CROWN	
IV	D6750	Retainer crown—porcelain fused to high noble metal	$424
	D6751	Retainer crown—porcelain fused to predominantly base metal	$417
	D6752	Retainer crown—porcelain fused to noble metal	$424
	D6780	Retainer crown—3/4 cast high noble metal	$403
	D6781	Crown—3/4 cast predominantly based metal	$370
	D6782	Crown—3/4 cast noble metal	$403
	D6783	Crown—3/4 porcelain/ceramic	$423
	D6790	Retainer crown—full cast high noble metal	$420
	D6791	Retainer crown—full cast predominantly base metal	$403
	D6792	Retainer crown—full cast noble metal	$420

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
IV	D6793	Provisional retainer crown-further treatment or completion of diagnosis necessary prior to final impression	$225
	D6794	Retainer crown—titanium	$420
		OTHER FIXED PARTIAL DENTURE SERVICES	
IV	D6930	Re-cement or re-bond fixed partial denture	$49
	D6980	Fixed partial denture repair necessitated by restorative material failure	$99
	D6985	Pediatric partial denture, fixed	$304
		EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED AND ROUTINE POST-OPERATIVE CARE)	
II	D7111	Extraction, coronal remnants—deciduous tooth	$41
	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$55
		SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED AND ROUTINE POST-OPERATIVE CARE)	
III	D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and excluding elevation of mucoperiosteal flap if indicated	$108
	D7220	Removal of impacted tooth—soft tissue	$114
	D7230	Removal of impacted tooth—partially bony	$160
	D7240	Removal of impacted tooth—completely bony	$198
	D7241	Removal of impacted tooth—completely bony, with unusual surgical complications	$230
	D7250	Surgical removal of residual tooth roots (cutting procedure)	$106
	D7260	Oroantral fistula closure	$317
	D7261	Primary closure of a sinus perforation	$207
	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$244
		OTHER SURGICAL PROCEDURES	
III	D7280	Surgical access of an unerupted tooth	$216
	D7285	Incisional biopsy of oral tissue—hard (bone, tooth)	$113
	D7286	Incisional biopsy of oral tissue—soft	$92
	D7287	Exfoliative cytological sample collection	$4
	D7288	Brush biopsy—transepithelial sample collection	$83
		ALVEOLOPLASTY—SURGICAL PREPARATION OF RIDGE FOR DENTURES	
III	D7310	Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	$91
	D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$60
	D7320	Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	$161
	D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$106

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
III	D7471	Removal of lateral exostosis (maxilla or mandible)	$172
	D7472	Removal of torus palatinus	$178
	D7473	Removal of torus mandibularis	$207
		SURGICAL INCISION	
III	D7510	Incision and drainage of abscess—intraoral soft tissue.	$75
	D7520	Incision and drainage of abscess—extraoral soft tissue	$126
		OTHER REPAIR PROCEDURES	
III	D7960	Frenulectomy also known as frenectomy or frenotomy—separate procedure not incidental to another	$150
	D7963	Frenuloplasty	$150
	D7970	Excision of hyperplastic tissue—per arch	$173
	D7971	Excision of pericoronal gingiva	$71
		LIMITED ORTHODONTIC TREATMENT	
V	D8010	Limited orthodontic treatment of the primary dentition	$310
	D8020	Limited orthodontic treatment of the transitional dentition	$310
	D8030	Limited orthodontic treatment of the adolescent dentition	$310
	D8040	Limited orthodontic treatment of the adult dentition	$310
	D8050	Interceptive orthodontic treatment of the primary dentition	$310
	D8060	Interceptive orthodontic treatment of the transitional dentition	$310
		COMPREHENSIVE ORTHODONTIC TREATMENT	
V	D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,576
	D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,576
	D8090	Comprehensive orthodontic treatment of the adult dentition	$2,576
		MINOR TREATMENT TO CONTROL HARMFUL HABITS	
V	D8210	Removable appliance therapy	$260
	D8220	Fixed appliance therapy	$324
		OTHER ORTHODONTIC SERVICES	
V	D8660	Pre-orthodontic treatment examination to monitor growth and development	$40
	D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$150
		UNCLASSIFIED TREATMENT	
I	D9110	Palliative (emergency) treatment of dental pain, minor procedure	$34
III	D9120	Fixed partial denture sectioning	$61
		ANESTHESIA	
III	D9210	Local anesthesia not in conjunction with operative or surgical procedures	$21
I	D9219	Evaluation for moderate sedation or general anesthesia	$25
III	D9223	Deep sedation/general anesthesia—each 15 minute increment	$74
	D9239	Intravenous moderate (conscious) sedation/analgesia—first 15 minutes	$74
	D9243	Intravenous moderate (conscious) sedation/analgesia—each 15 minute increment	$62
	D9248	Non-intravenous conscious sedation	$86

CLASS	CDT CODE	PROCEDURE NAME	COPAY ($)
		PROFESSIONAL CONSULATION	
I	D9310	Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician	$39
		MISCELLANEOUS SERVICES	
I	D9910	Application of desensitizing medicament	$24
	D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$14
	D9932	Cleaning and inspection of removable complete denture, maxillary	$14
	D9933	Cleaning and inspection of a removable complete denture, mandibular	$14
	D9934	Cleaning and inspection of a removable partial denture, maxillary	$14
	D9935	Cleaning and inspection of a removable partial denture, mandibular	$14

Limitations & Exclusions

(in addition to those found in the Evidence of Coverage)

Limitations

A. Covered dental services must be performed by or under the supervision of a dentist, within the scope of practice for which licensure or certification has been obtained.

B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures, bridges, or implants, including precision attachments and custom denture teeth.

C. If a member switches from one Dentist to another during a course of treatment, or if more than one dentist renders services for one dental procedure, CareFirst shall pay as if only one dentist rendered the service.

D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).

E. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a member's condition, benefits will be based upon the lowest cost alternative. CareFirst benefits will cover treatment based upon the CareFirst allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the subscriber to the less expensive procedure. However, if the subscriber and the dentist choose the more expensive procedure, the subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

F. Dental procedures not listed on the Schedule of Benefits and Copayments will be provided at the dentist's charges unless written approval is received from CareFirst.

G. The American Dental Association (ADA) may periodically change the current dental terminology (CDT) codes or definitions listed in the ADA publications. If such changes result in different CDT codes being used by preferred dentists or participating dentists to describe the covered dental services listed in the Schedule of Benefits and Copayments, the member copayments will be determined by CareFirst. CareFirst will notify the subscriber of such changes when applicable.

H. All services listed on the Schedule of Benefits and Copayments will be provided by a participating dentist or a preferred dentist.

I. Oral examination, routine teeth cleaning (prophylaxis), topical fluoride up to age 19, and pulp vitality tests not related to accidental injury or trauma or emergency limited to twice per benefit period.

Exclusions

Benefits will not be provided for:

A. Replacement of a denture, bridge, dental implant, or crown as a result of loss or theft.

B. Replacement of an existing denture, bridge, dental implant, or crown that is determined by CareFirst to be satisfactory or repairable.

C. Replacement of dentures, bridges, dental implants, or crowns within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the Evidence of Coverage.

D. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys.

E. Gold foil fillings. All member copayments listed on the Schedule of Benefits and Copayments are exclusive of gold.

F. Dental services in connection with birth defects or mainly for cosmetic reasons; with the following exceptions:

1. Benefits will be provided for dental services received by the member due to trauma to whole sound natural teeth when the dental services are received after the effective date of coverage under the Evidence of Coverage only if the member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst, and

2. Benefits will be provided for dental services in connection with birth defects, including cleft lip or cleft palate or both, only if the member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst.

G. Periodontal appliances.

H. Prescription drugs, including, but not limited to antibiotics administered by the member, inhalation of nitrous oxide, injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a covered dental service in the Description of Covered Services.

I. Splinting.

J. Nightguards, occlusal guards, or other oral orthotic appliances.

K. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a covered dental service in the Description of Covered Services.

L. Intentional tooth reimplantation or transplantation.

M. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning.

N. Additional fees charged for visits by a dentist to the member's home, to a hospital, to a nursing home, or for office visits after the dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the dentist's office during normal office hours.

O. Transseptal fiberotomy or vestibuloplasty.

P. Orthognathic surgery or other oral surgery covered under the member's medical benefit plan.

Q. Services not specifically listed in the Description of Covered Services as a covered dental service, even if medically necessary.

R. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).

S. Separate billings for dental care services or supplies furnished by an employee of a dentist which are normally included in the dentist's charges and billed for by them.

T. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.

U. Services or supplies that are experimental or investigational in nature.

V. Services for injuries and conditions which are covered under Workers' Compensation or employers' liability laws.

W. Services which are provided without cost to the member by any municipality, county or other political subdivision (with the exception of Medicaid).

X. Services which, in the opinion of the dental director, are not medically necessary for the member's dental health.

Y. Cosmetic, elective, or aesthetic dentistry, which in the opinion of the dental director are not necessary for the member's dental health;

Z. Oral surgery requiring the setting of fractures or dislocations.

AA. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations unless specifically listed as a covered dental service in the Description of Covered Services.

AB. Hospitalization for any dental procedure.

AC. General anesthesia.

AD. Services which are obtained from a non-participating dentist unless specifically listed as a covered dental service in the Description of Covered Services.

AE Additional fees charged for dental services which cannot be performed in the dental office of a participating dentist or preferred dentist due to the special needs or health related conditions of the member. CareFirst shall provide the benefits for the covered dental service as if the dental services were rendered in the dentist's office during normal office hours. Any additional facility and professional fees charged shall be the member's responsibility.

AF. Any service, supply or item that is not medically necessary for the member's dental health. Although a service may be listed as covered, benefits will be provided only if the service is medically necessary for the member's dental health as determined by CareFirst.

AG. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

AH. The repair or replacement of any orthodontic appliance.

AI. Any orthodontic services after the last day of the month in which covered services ended except as specifically described in the Description of Covered Services and the Evidence of Coverage.

AJ. Class III, Class IV, and Class V services incurred during a member's benefit waiting period (if applicable).

This chart is for comparison purposes only and does not create rights that are not covered through the benefit plan. Always refer to your benefits contract to view services and procedures covered under your plan.

Note: The American Dental Association (ADA) periodically reviews and changes the current dental terminology (CDT) codes. Your benefit contract includes language that allows the DHMO plan to keep your member copayment schedules up to date in accordance with the ADA's most recent CDT code changes. Therefore, this document may include some CDT codes that are or are not on your original benefits contract. To view your plan's schedule of benefits, log in to *My Account*.

These benefits are issued under policy form numbers:

Maryland:

CareFirst of Maryland, Inc.: CFMI/DENTAL/GC (1/19); CFMI/BLUEDENTAL EPO EOC (1/19); CFMI/BLUEDENTAL EPO DOCS (1/19); CFMI/BLUEDENTAL EPO DOCS LG (7/19); CFMI/BLUEDENTAL EPO SOB I-V (1/19); CFMI/BLUEDENTAL EPO SOB I-V LG (7/19); CFMI/ELIG/D-V (7/09) and any amendments. Group Hospitalization and Medical Services, Inc.: MD/CF/DENTAL/GC (1/19); MD/ CF/BLUEDENTAL EPO EOC (1/19); MD/CF/BLUEDENTAL EPO DOCS (1/19); MD/CF/BLUEDENTAL EPO DOCS LG (7/19); MD/CF/BLUEDENTAL EPO SOB I-V (1/19); MD/CF/BLUEDENTAL EPO SOB I-V LG (7/19); MD/CF/ELIG (R. 1/08) and any amendments.

District of Columbia:

DC/CF/DENTAL/GC (1/19); DC/CF/BLUEDENTAL EPO EOC (1/19); DC/CF/BLUEDENTAL EPO DOCS (1/19); DC/CF/BLUEDENTAL EPO DOCS LG (7/19); DC/CF/BLUEDENTAL EPO SOB I-V (1/19); DC/CF/BLUEDENTAL EPO SOB I-V LG (7/19); DC/ CF/ELIG (9/04) and any amendments.

Virginia:

VA/CF/DENTAL/GC (1/19); VA/CF/BLUEDENTAL EPO EOC (1/19); VA/CF/BLUEDENTAL EPO DOCS (R. 4/19); VA/CF/BLUEDENTAL EPO DOCS LG (7/19); VA/CF/BLUEDENTAL EPO SOB I-V (R. 4/19); VA/CF/BLUEDENTAL EPO SOB I-V LG (7/19); VA/ CF/ELIG (R. 1/12) and any amendments.

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