compbenefits
vision
dental

SCHEDULE OF BENEFITS – Citrus Health Care

Adult Medicaid Plan

		Member Copayment
	DIAGNOSTIC	
D0120	Periodic oral evaluation (2 per calendar year)	No Charge
D0140	Limited oral evaluation, problem focused	No Charge
D0150	Comprehensive oral evaluation	No Charge
	RADIOGRAPHS	
D0210	Intraoral – complete series (including bitewings) (1 per 36 months)	No Charge
D0220	Intraoral – periapical first film	No Charge
D0230	Intraoral – periapical each additional film	No Charge
D0240	Intraoral – occlusal film	No Charge
D0290	Posterior – anterior or lateral skull and facial bone survey film	No Charge
D0330	Panoramic film (once per 36 months)	No Charge
	PREVENTIVE	
D1110	Prophylaxis – adult (2 per calendar year)	No Charge
	RESTORATIVE (FILLINGS)	
D2140	Amalgam – one surface, permanent	No Charge
D2150	Amalgam – two surfaces, permanent	No Charge
D2160	Amalgam – three surfaces, permanent	No Charge
D2391	Resin-based composite, one surface	No Charge
D2392	Resin-based composite, two surfaces, posterior	No Charge
D2393	Resin-based composite, three surfaces, posterior	No Charge
	PROSTHODONTICS (REMOVABLE)	
	COMPLETE DENTURES	
D5110	Complete denture – maxillary	No Charge
D5120	Complete denture – mandibular	No Charge
D5130	Immediate denture – maxillary	No Charge
D5140	Immediate denture – mandibular	No Charge
	PARTIAL DENTURES	
D5211	Upper partial- resin base (including any conventional clasps, rests and teeth)	No Charge
D5212	Lower partial- resin base (including any conventional clasps, rests and teeth)	No Charge
D5213	Lower partial denture	No Charge
D5214	Upper partial denture	No Charge
	ADJUSTMENTS TO DENTURES	
D5410	Adjustment, complete denture – maxillary first 3 adjustments, new or existing	No Charge
D5411	Adjustment, complete denture – mandibular first 3 adjustments, new or existing	No Charge
D5421	Adjust partial denture – maxillary first 3 adjustments, new or existing	No Charge
D5422	Adjust partial denture – mandibular first 3 adjustments, new or existing	No Charge
	REPAIRS TO COMPLETE DENTURES	
D5510	Repair broken complete denture base	No Charge
D5520	Replace missing or broken teeth – complete	No Charge
	REPAIRS TO PARTIAL DENTURES	
D5610	Repair resin denture base	No Charge
D5620	Repair cast framework	No Charge
D5630	Repair or replace broken clasp	No Charge
D5640	Repair broken teeth – per tooth	No Charge
D5650	Add tooth to existing partial denture	No Charge
D5660	Add clasp to existing partial denture	No Charge

		Member Copayment
	DENTURE REBASE AND RELINE	
D5730	Reline complete maxillary denture (chairside)	No Charge
D5731	Reline complete mandibular denture (chairside)	No Charge
D5740	Reline maxillary partial denture (chairside)	No Charge
D5741	Reline mandibular partial denture (chairside)	No Charge
D5750	Reline complete maxillary denture (laboratory)	No Charge
D5751	Reline complete mandibular denture (laboratory)	No Charge
D5760	Reline maxillary partial denture (laboratory)	No Charge
D5761	Reline mandibular partial denture (laboratory)	No Charge
D5820	Interim partial denture (maxillary)	No Charge
	ORAL SURGERY	
	SIMPLE EXTRACTIONS	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps)	No Charge
	SURGICAL EXTRACTIONS	
D7210	Surgical removal of erupted tooth	No Charge
D7220	Removal of impacted tooth – soft tissue	No Charge
D7230	Removal of impacted tooth – partially bony	No Charge
D7240	Removal of impacted tooth – completely bony	No Charge
D7241	Removal of impacted tooth – completely bony, with unusual surgical complication	No Charge
D7250	Surgical removal of residual tooth roots	No Charge
	OTHER SURGICAL PROCEDURES	
D7260	Oral antral fistula closure	No Charge
D7261	Primary closure of sinus perforation	No Charge
D7310	Alveoloplasty in conjunction with extraction, per quadrant	No Charge
D7320	Alveoloplasty not in conjunction with extractions, per quadrant	No Charge
D7510	Incision & drainage of abscess – intraoral soft tissue	No Charge
D7520	Incision & drainage of abscess – extraoral soft tissue	No Charge
D7970	Excision of hyperplastic tissue – per arch	No Charge
D7999	Unspecified oral surgery procedure, by report	No Charge
	ADJUNCTIVE GENERAL SERVICES	
D9230	Analgesia (nitrous oxide)	No Charge
D9241	Intravenous conscious sedation/analgesia- first 30 minutes	No Charge
D9242	Intravenous conscious sedation/analgesia- each additional 15 minutes	No Charge
D9248	Non-intravenous conscious sedation	No Charge
D9999	Unspecified adjunctive procedure, by report	No Charge

Choice of Dentist
You must select a Participating General Dentist or Specialist from the CompBenefits directory of Participating Dentists to receive your benefits. Participating dental offices are privately owned and operated by a licensed dentist and a staff of professional auxiliaries.

Making an Appointment with your Dentist
You may schedule an appointment by calling a participating dental office after your CITRUS HEALTH CARE™ coverage effective date. When you call to schedule your appointment, be sure to notify the office that you are a member of the CITRUS HEALTH CARE/CompBenefits dental plan.

Specialist Care Referral
Certain dental procedures such as Oral Surgery, Endodontics, and Periodontics may require the service of a specialist. In those cases, your Participating General Dentist may refer you to a Participating Specialist (where one is available). The listed co-payments apply to services provided by Participating Specialists. Please verify that the specialist is participating with your CITRUS HEALTH CARE™ before beginning treatment.

Canceling Appointments
The time set aside for a patient is very valuable to a dentist. Therefore, if you cannot keep an appointment, notify the dental office a minimum of 24 hours in advance. If you do not notify the office, charges will be made for broken appointments.

Emergency Care within the Service Area
In the event of an emergency, first contact your participating dentist office. If you are unable to reach your dentist or any participating dental office, call the CompBenefits toll-free 24-hour Hotline and you will be instructed how to receive necessary emergency dental care. CompBenefits toll-free 24-hour Emergency Hotline: 800-451-2521

Reimbursement for Out-of-Area Emergency Care
You are covered for emergency dental treatment while temporarily more than 50 miles from your participating dentist. In the event of an emergency, obtain treatment to relieve your pain/discomfort only. Pay for the services rendered and submit the receipt to CompBenefits with your name, social security number, address and phone number. CompBenefits will reimburse no less than 75% of the reasonable charges for covered services and supplies, subject to applicable Copayments, up to $100 per claim.

Member Support
CompBenefits is responsible for all administrative functions of the program. If you have an inquiry or grievance, submit it in writing to:

CompBenefits
Grievance and Appeals Dept.
5775 Blue Lagoon Drive #400
Miami, FL 33126

Or, call CompBenefits' Customer Care Department, Monday through Friday, 8 am to 6 pm:
Toll-free: 800-451-2521

EXCLUSIONS AND LIMITATIONS
General Exclusions
1. Services performed by a general dentist or specialty care dentist that is not contracted with CompBenefits without prior approval by CompBenefits (except for out of area emergency services).
2. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
3. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
4. Any dental services, or appliances which are determined to be not reasonable and/or necessary fro maintaining or improving the member's dental health, as determined by CompBenefits' General Dentist.
5. Services for injuries or conditions that are covered under Workers' Compensation or Employers' Liability Laws.
6. Services that are provided without cost to the member by any municipality, county or other political subdivision.
7. Cosmetic, elective or aesthetic dentistry.
8. Any procedure of implantation or experimental procedures, and/or procedures not generally performed in general dental offices.

9. Treatment of malignancies, cysts, or neoplasms.
10. General anesthesia.
11. Orthognathic surgery.
12. Cost of dental care covered under automobile, medical and no-fault or similar type insurance.

LIMITATIONS

General

1. Services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
2. The services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
3. The services must be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.
4. Unspecified procedures are not covered without a report demonstrating services provided are covered under the terms of the exclusions and limitations.
5. Non-intravenous conscious sedation is limited to three (3) times per 366-day period, per member.
6. Intravenous conscious sedation is limited to medically necessary covered oral surgery.

Preventive

1. Periodic oral examinations and routine prophylaxis are limited to two (2) per calendar year.

Diagnostic

1. Full mouth or panoramic x-rays are limited to one per 36 months, unless related to the preparation of the mouth for dentures.

Restorative

1. Amalgam or composite restorations for one and two surfaces are limited to 3 per year. Amalgam or composite restorations for three or more surfaces are limited to one per year.

Prosthodontics

1. Complete dentures and any covered partial dentures may be reimbursed once for an upper, a lower or a complete set per lifetime of the recipient. The dentist must establish if the group policy has previously provided a denture benefit prior to delivery of a new complete or partial denture. Replacement complete or partial dentures will not be covered unless the treating dentist has determined that the existing denture in unacceptable, and cannot be made serviceable: 1) due to the condition of the patient; or 2) due to the condition of the denture.
2. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery for a complete or partial denture and within three (3) months of delivery for an immediate denture.
3. No partial dentures for a single tooth will be covered unless replacing an anterior tooth. Reimbursement for an all-acrylic interim partial (flipper) is limited to the replacement of anterior teeth in any instance.
4. Partial dentures are not covered where there are at least eight posterior teeth in occlusion.
5. Relines include all necessary adjustments for a period of six (6) months from the date of the reline. A reline using a "light-cured" technique is a chairside reline. Relines are limited to once per denture per 366 days. Initial relines are limited to no earlier than three (3) months after the date of insertion for immediate dentures and limited to no earlier than six (6) months after seating for a complete denture.
6. Tissue conditioning relines are not covered.
7. Denture adjustments performed on the same date of service as relines or repairs are not covered.

Oral Surgery

1. Covered services for oral surgery are limited to alleviation of pain or infection and are limited to extractions and the incision and drainage of an abscess, unless essential to the preparation of the mouth for dentures. All covered services include local anesthetic and routine post-operative care.