CareSource®

INDIANA, OHIO AND WEST VIRGINIA

MARKETPLACE PLANS

DENTAL QUICK REFERENCE GUIDE

NOTE: All Kentucky dental benefits are handled through Avēsis. For Kentucky dental information, please access the Avēsis Provider Portal at avesis.com/commercial/providers/index.aspx.

CareSource®

Health Care with Heart

At CareSource®, our goal is to help you improve and maintain the dental health of our members. This guide shares information about covered services, authorization requirements and claim submissions. For topics not addressed in this guide, consult your provider manual on **CareSource.com.**

DENTAL BENEFIT ELIGIBILITY

CareSource Marketplace plans are available with and without dental and vision coverage.

CareSource ID cards indicate “Dental and Vision” for members who elect this coverage. ID cards also indicate the Marketplace plan level (e.g., Bronze, Silver, Gold and Catastrophic) that determines copays and coinsurance.

CareSource provides pediatric dental benefits for children up to the end of the month in which they turn 19 years of age. Some services require a copay and coinsurance.

Adult dental benefits are provided to CareSource Marketplace members 19 years or older who have elected to include dental and vision coverage in their Marketplace plan at an extra cost. These optional services go beyond the Essential Health Benefits required.

Gold, Limited and Bronze Plan	Gold and Limited*	Simple Choice Bronze	Bronze	Bronze HSA
Preventative / Diagnostic Cost Share	$35	$35 Copay	$20 Copay	50% Coinsurance after Deductible
Basic Restorative Cost Share	$35	$35 Copay	$20 Copay	50% Coinsurance after Deductible
Major Restorative Cost Share	40% Coinsurance not Subject to Deductible	40% Coinsurance not Subject to Deductible	40% Coinsurance not Subject to Deductible	50% Coinsurance after Deductible
Orthodontic Cost Share	50% Coinsurance not Subject to Deductible	50% Coinsurance not Subject to Deductible	50% Coinsurance not Subject to Deductible	50% Coinsurance after Deductible
Cosmetic Orthodontia Lifetime Limit	$1,700	$1,700	$1,700	$1,700
Individual / Family Deductible	$1500 / $3000	$6650 / $13,300	$4000 / $8000	$4000 / $8000

All benefits are subject to the definitions, limitations and exclusions in the Evidence of Coverage (EOC) and are payable only when they are deemed medically necessary for the prevention, diagnosis, care or treatment of a covered service and meet generally accepted dental protocols.

DENTAL COPAYS/ COINSURANCE

Please verify member ID cards, confirm eligibility and use the grids below to determine dental coverage and member cost sharing.

Pediatric Dental Copays, Coinsurance and Deductibles

The following grids show 2018 pediatric dental copays, coinsurance and deductible amounts for each . Marketplace plan type.

Silver Plans	Silver	Federal Simple Choice Silver	Low Premium Silver	Silver 1
Preventative / Diagnostic Cost Share	$0 Copay	$30 Copay	15% Coinsurance Subject to Deductible (OH/KY/WV) 15% Coinsurance NOT Subject to Deductible (IN)	$0 Copay
Basic Restorative Cost Share	$0 Copay	$30 Copay	15% Coinsurance Subject to Deductible (OH/KY/WV) 15% Coinsurance NOT Subject to Deductible (IN)	$0 Copay
Major Restorative Cost Share	25% Coinsurance not Subject to Deductible	20% Coinsurance not Subject to Deductible	15% Coinsurance not Subject to Deductible	20% Coinsurance not Subject to Deductible
Orthodontic Cost Share	40% Coinsurance not Subject to Deductible	40% Coinsurance not Subject to Deductible	15% Coinsurance not Subject to Deductible	30% Coinsurance not Subject to Deductible
Cosmetic Orthodontia Lifetime Limit	$2,000	$2,000	$2,000	$2,000
Individual / Family Deductible	$3900 / $7800	$3500 / $7000	$61500 / $12,300	$3900 / $7800

Federal Simple Choice Silver 1	Low Premium Silver 1	Silver 2	Federal Simple Choice Silver 2	Low Premium Silver 2	Silver 3	Federal Simple Choice Silver 3	Low Premium Silver 3
$30 Copay	15% Coinsurance Subject to Deductible (OH/KY/WV) 15% Coinsurance NOT Subject to Deductible (IN)	$0 Copay	$10 Copay	10% Coinsurance Subject to Deductible (OH/KY/WV) 10% Coinsurance NOT Subject to Deductible (IN)	$0 Copay	$5 Copay	5% Coinsurance Subject to Deductible (OH/KY/WV) 5% Coinsurance NOT Subject to Deductible (IN)
$30 Copay	15% Coinsurance Subject to Deductible (OH/KY/WV) 15% Coinsurance NOT Subject to Deductible (IN)	$0 Copay	$10 Copay	10% Coinsurance Subject to Deductible (OH/KY/WV) 10% Coinsurance NOT Subject to Deductible (IN)	$0 Copay	$5 Copay	5% Coinsurance Subject to Deductible (OH/KY/WV) 5% Coinsurance NOT Subject to Deductible (IN)
20% Coinsurance not Subject to Deductible	15% Coinsurance not Subject to Deductible	15% Coinsurance not Subject to Deductible	20% Coinsurance not Subject to Deductible	10% Coinsurance not Subject to Deductible	5% Coinsurance not Subject to Deductible	5% Coinsurance not Subject to Deductible	5% Coinsurance not Subject to Deductible
30% Coinsurance not Subject to Deductible	15% Coinsurance not Subject to Deductible	20% Coinsurance not Subject to Deductible	20% Coinsurance not Subject to Deductible	10% Coinsurance not Subject to Deductible	20% Coinsurance not Subject to Deductible	20% Coinsurance not Subject to Deductible	5% Coinsurance not Subject to Deductible
$2,000	$2,000	$2,500	$2,500	$2,000	$3,000	$3,000	$3,000
$3000 / $6000	$4800 / $9600	$950 / $1900	$700 / $1400	$950 / $1900	$325 / $650	$250 / $500	$600 / $1200

Zero Plans*	Bronze Zero	Federal Simple Choice Bronze Zero	Silver Zero	Federal Simple Choice Silver Zero	Low Premium Silver Zero	Gold Zero
Preventative / Diagnostic Cost Share	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Coinsurance	$0 Copay
Basic Restorative Cost Share	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Coinsurance	$0 Copay
Major Restorative Cost Share	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance
Orthodontic Cost Share	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance
Cosmetic Orthodontia Lifetime Limit	N/A	N/A	N/A	N/A	N/A	N/A
Individual / Family Deductible	$0	$0	$0	$0	$0	$0

** Zero and Limited plans are available for federally recognized tribes and ANCSA Corporation shareholders.*

Adult Dental Copays, Coinsurance and Deductibles

The following grids show 2018 adult dental copays, coinsurance and deductible amounts for each Marketplace plan type.

Gold , Limited and Bronze Plans	Gold and Limited*	Federal Simple Choice Bronze	Bronze	Bronze HSA
Preventative Copay	$35	$35	$20	No Plan Offering
Basic Restorative Copay	$35	$35	$20	
Major Restorative Copay	40%	40%	40%	
Medical Coinsurance*	40%	40%	40%	50%
Individual / Family Medical Deductible*	$1500 / $3000	$6650 / $13,300	$7250 / $14,500	$4000 / $8000

Silver Plans	Silver	Federal Simple Choice Silver	Low Premium Silver	Silver 1	Federal Simple Choice Silver 1	Low Premium Silver 1	Silver 2	Federal Simple Choice Silver 2	Low Premium Silver 2	Silver 3	Federal Simple Choice Silver 3	Low Premium Silver 3
Preventative Copay	$0	$30	$0	$0	$30	$0	$0	$10	$0	$0	$5	$0
Basic Restorative Copay	$0	$30	$0	$0	$30	$0	$0	$10	$0	$0	$5	$0
Major Restorative Copay	25%	25%	15%	20%	20%	15%	15%	20%	10%	5%	5%	5%
Medical Coinsurance*	25%	25%	15%	20%	20%	15%	15%	20%	10%	5%	5%	5%
Individual / Family Medical Deductible*	$3900 / $7800	$3500 / $7000	$6150 / $12,300	$3900 / $7800	$3000 / $6000	$4800 / $9600	$950 / $1900	$700 / $1400	$950 / $1900	$325 / $650	$250 / $500	$600 / $1200

All benefits are subject to the definitions, limitations and exclusions in the Evidence of Coverage (EOC) and are payable only when they are deemed medically necessary for the prevention, diagnosis, care or treatment of a covered service and meet generally accepted dental protocols.

Zero Plans**	Bronze Zero	Federal Simple Choice Bronze Zero	Silver Zero	Federal Simple Choice Silver Zero	Low Premium Silver Zero	Gold Zero
Preventative Copay	$0	$0	$0	$0	$0	$0
Basic Restorative Copay	$0	$0	$0	$0	$0	$0
Major Restorative Copay	$0	$0	$0	$0	$0	$0
Medical Coinsurance*	$0	$0	$0	$0	$0	$0
Individual / Family Medical Deductible*	$0	$0	$0	$0	$0	$0

** The medical coinsurance and deductible apply to accidental dental benefits, which are part of the medical benefit.*

*** Zero plans are available to federally recognized tribes and ANCSA Corporation shareholders.*

DENTAL BENEFITS

Pediatric Dental Benefits

The following pediatric dental services require prior authorization:

- Implant services
- Medically necessary orthodontic services

CareSource Marketplace plans provide coverage for the following pediatric dental services.

All exams, oral evaluations and treatments such as fluorides and some images are combined under one limitation. Periodic oral exam (D0120), Oral evaluations (D0140) and Comprehensive oral exam (D0150, D0180) are combined and limited to one exam every 6 months from the date covered services were last rendered.

Dental Exam: Limited to 1 every 6 months from the date covered services were last rendered.

- Periodic oral evaluation
- Limited oral evaluation
- Comprehensive oral evaluation
- Comprehensive periodontal evaluation

Preventive Services: Preventive services are covered in full as part of your Essential Health Benefits.

- Prophylaxis – limited to 1 examination 2 times per benefit year
- Tropical Fluoride – limited to 2 every 12 months
- Sealant - per tooth – limited to 1 every 36 months
- Sealant Repair - per tooth - limited to 1 every 36 months
- Space Maintainer - fixed - unilateral
- Space Maintainer - fixed - bilateral
- Space Maintainer - removable - unilateral
- Space Maintainer - removable - bilateral
- Re-cementation or re-bond space maintainer

Diagnostic and Treatment Services: Minor palliative treatment of pain is included in these covered services.

- Palliative treatment of dental pain – minor procedure
- Intraoral complete set of images, including bitewings – limited to 1 every 60 months
- Intraoral periapical radiographic image(s) – limited to 1, 2 times per benefit year
- Bitewing(s) – limited to 1, 2 times per benefit year
- Vertical bitewings – 7 to 8 images – limited to 1, 2 times per benefit year
- Panoramic radiographic image – limited to 1 every 60 months
- Cephalometric radiographic image
- Oral/facial photographic images
- Interpretation of diagnostic image
- Diagnostic models

Minor Restorative Services: Covered services range from fillings to specific types of crowns.

- Amalgam(s) – primary or permanent
- Resin-based composite(s), anterior
- Prefabricated porcelain crown – primary tooth – limited to 1 every 60 months
- Prefabricated stainless steel crown – primary tooth – limited to 1 every 60 months
- Prefabricated stainless steel crown – permanent tooth – limited to 1 every 60 months

Major/Comprehensive Services: Covered services include root canals, oral surgery, dentures, bridges, endodontic services and periodontal therapy.

- Therapeutic pulpotomy
- Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
- Pulpal therapy – anterior tooth – once per lifetime
- Periodontal scaling and root planning – 4 or more teeth per quadrant – limited to 1 every 24 months
- Removal of impacted tooth – soft tissue
- Surgical removal of residual tooth roots (cutting procedure)
- Crown – porcelain/ceramic substrate – limited to 1 every 60 months
- Anterior root canal (excluding final restoration)
- Complete and immediate denture(s) – limited to 1 every 60 months
- Removable unilateral partial denture - limited to 1 every 60 months
- Gingivectomy or gingivoplasty – 4 or more teeth – limited to 1 every 36 months
- Complete denture – maxillary – limited to 1 every 60 months
- Inlay services
- Onlay services – limited to 1 per tooth every 60 months
- Veneer repair
- Anterior root canal
- Apexification/recalcification – initial visit through final visit
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy
- Osseous surgery – limited to 1 every 36 months
- Free soft tissue graft – 1st tooth and any additional teeth
- Eposteal implant – limited to 1 every 60 months

Cosmetic Orthodontic Services: There is a lifetime maximum for cosmetic orthodontic services.

- Limited orthodontic treatment of the primary dentition
- Limited orthodontic treatment of the transitional dentition
- Limited orthodontic treatment of the adolescent dentition
- Interceptive orthodontic treatment of the primary dentition
- Interceptive orthodontic treatment of the transitional dentition
- Comprehensive orthodontic treatment of the transitional dentition
- Comprehensive orthodontic treatment of the adolescent dentition
- Removable appliance therapy
- Fixed appliance therapy
- Pre-orthodontic treatment exam to monitor growth and development
- Periodic orthodontic treatment visit (as part of contract)
- Orthodontic retention (removal of appliances, construction and placement of retainer(s))

CareSource also provides benefits for medically necessary orthodontic services. Comprehensive medically necessary orthodontic services are covered services for covered persons who have a severe handicapping malocclusion related to a medical condition such as:

- Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
- Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services; or
- Skeletal anomaly involving maxillary and/or mandibular structures.

To be considered medically necessary (needed to treat, correct or ameliorate a medical defect or condition), orthodontic services must be an essential part of an overall treatment plan. Establishment of medical necessity requires documentation to support the severe handicapping malocclusion and medical condition status. Progress notes, photographs and other relevant supporting documentation may be included as appropriate.

Adult Dental Benefits

CareSource Marketplace plans with optional adult dental and vision coverage provide benefits for routine dental services such as the following. Some services require a copay or coinsurance.

- Dental exams
- Dental cleanings
- Dental X-rays
- Restorative services (fillings)
- Crowns
- Extractions
- Partial or complete dentures

Two preventive visits are allowed each year for cleanings and oral

examination. All dental benefits are subject to an $800 annual limit per benefit year.

Medically necessary dental services (rendered due to accidental injury or medical necessity) may be subject to an annual deductible and count towards annual plan out-of-pocket maximums.

Preventive and Diagnostic Dental Benefits

- D0140 Limited oral exam – problem focused (emergency dental exam)
- D0150 Comprehensive oral exam
- D0210 Intraoral – complete series (1 each 36 months)
- D0220 Intraoral – periapical first film
- D0230 Intraoral – periapical each additional film
- D0240 Intraoral – occlusal film
- D0270 Bitewing – single film (all bitewing X-rays – 1 series per year)
- D0272 Bitewings – two films
- D0273 Bitewings – three films
- D0274 Bitewings – four films
- D0330 Panoramic film (1 each 36 months)
- D1110 Prophylaxis – adult (1 each 6 months)

Basic Restorative Dental Benefits

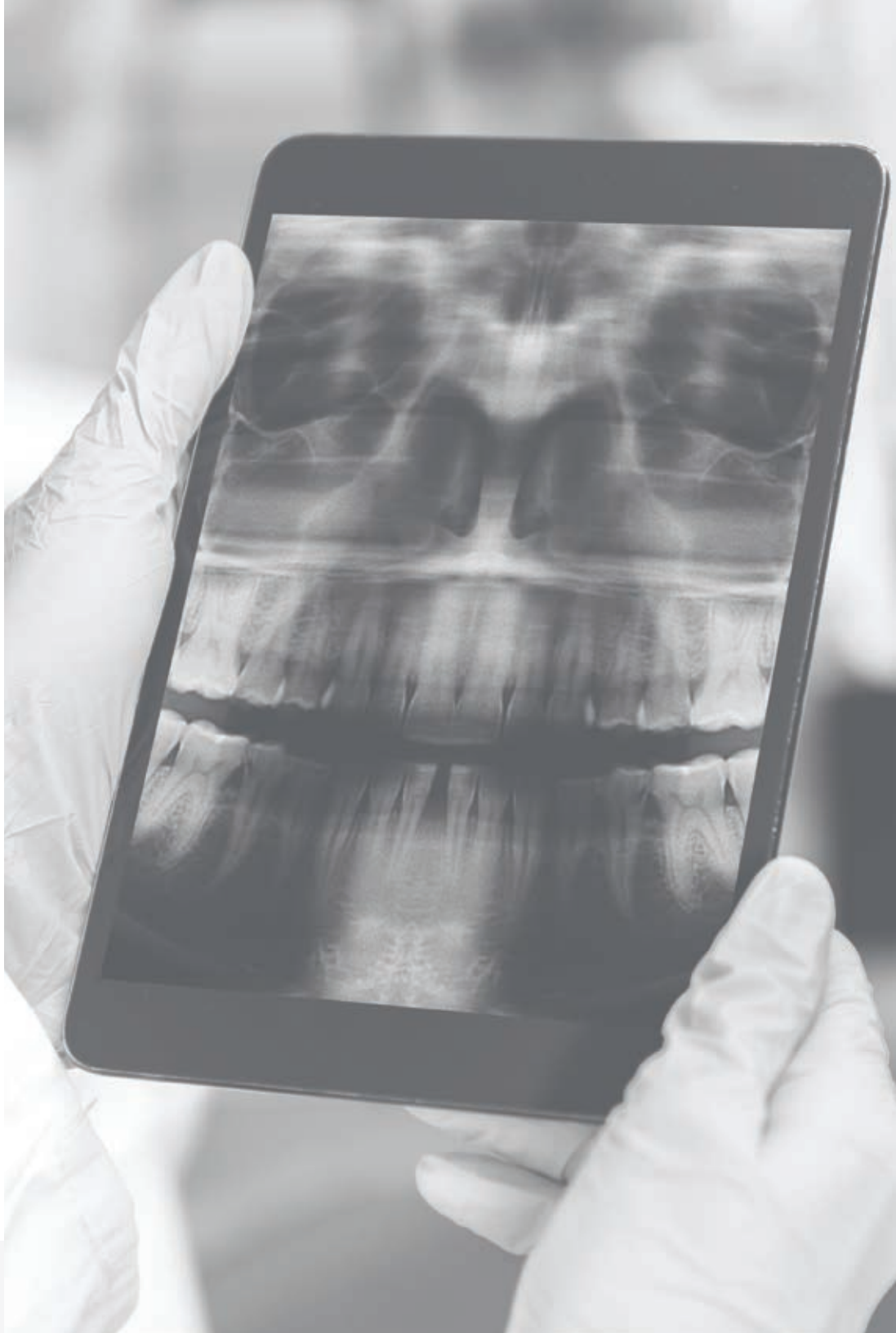
- D2140 Amalgam – one surface
- D2150 Amalgam – two surface
- D2160 Amalgam – three surface
- D2161 Amalgam – amalgam, four or more surfaces
- D2330 Resin-based composite – one surface, anterior
- D2331 Resin-based composite – two surface, anterior
- D2332 Resin-based composite – three surface, anterior
- D2335 Resin-based composite – four or more surfaces or involving incisal angle
- D2390 Resin-based composite crown – anterior, full resin-based composite coverage of tooth
- D2391 Resin-based composite – one surface, posterior
- D2392 Resin-based composite – two surface, posterior
- D2393 Resin-based composite – three surfaces, posterior
- D2394 Resin-based composite – Four or more surfaces, posterior
- D7140 Extraction – erupted tooth or exposed root

Major Restorative Dental Benefits

- D3310 Endodontic therapy, anterior tooth (excluding final restoration)
- D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)
- D3330 Endodontic therapy, molar tooth (excluding final restoration)
- D7220 Surgical removal of an erupted tooth removal of impacted tooth – soft tissue

- D7230 Removal of impacted tooth – partial bony
- D7240 Removal of impacted tooth – completely bony
- D7241 Removal of impacted tooth – completely bony with complications
- D7250 Surgical removal of residual roots
- D5110 Complete upper denture
- D5120 Complete lower denture
- D5211 Maxillary partial denture – resin base
- D5212 Mandibular partial denture – resin base
- D5410/D5411/D5421/D5422 – Denture adjustment (1 every 36 months, but if occurring within 6 months of placement of dentures, must be provided by the dentist without charge)
- D2710 Crown – resin-based composite (indirect)
- D2712 Crown – 3/4 resin-based composite (indirect); does not include facial veneers
- D2720 Crown – resin with high noble metal
- D2721 Crown – resin with predominantly base metal
- D2722 Crown – resin with noble metal
- D2740 Crown – porcelain/ceramic substrate
- D2750 Crown – porcelain fused to high noble metal
- D2751 Crown – porcelain fused to predominantly base metal
- D2752 Crown – porcelain fused to noble metal
- D2780 Crown – 3/4 cast high noble metal
- D2781 Crown – 3/4 cast predominantly base metal
- D2782 Crown – 3/4 cast noble metal
- D2783 Crown – 3/4 porcelain/ceramic; does not include facial veneers
- D2790 Crown – full cast high noble metal
- D2791 Crown – full cast predominantly base metal
- D2792 Crown – full cast noble metal
- D2910 Recement inlay, onlay or partial coverage restoration
- D2915 Recement cast or prefabricated post and core
- D2920 Recement crown
- D2932 Prefabricated resin crown
- D2940 Protective restoration; direct placement of a restorative material to protect tooth and/or tissue form
- This procedure may be used to relieve pain, promote healing or prevent further deterioration. Not to be used for endodontic access closure or as a base or liner under a restoration.
- D2950 Core buildup, including any pins
- Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form or concave irregularity in the preparation.

- D2951 Pin retention – per tooth, in addition to restoration
- D2952 Post and core in addition to crown, indirectly fabricated; post and core are custom fabricated as a single unit
- D2953 Each additional indirectly fabricated post – same tooth; to be used only with code D2952
- D2954 Prefabricated post and core in addition to crown; core is built around a prefabricated post
- This procedure includes the core material.
- D2955 Post removal
- D2957 Each additional prefabricated post – same tooth; to be used only with code D2954
- D2980 Crown repair necessitated by restorative material failure



PROVIDER WEB PORTALS

CareSource has partnered with national benefit organizations to administer our dental benefit programs. This makes it easier for you to verify our members' eligibility, obtain authorizations and process claims.

In Indiana and Ohio, access the Scion Dental Provider Web Portal: **https://pwp.sciondental.com/PWP/Landing**

West Virginia providers should use the CareSource Provider Portal: **https://providerportal.caresource.com/WV**

CLAIMS

Online

Indiana and Ohio: **https://pwp.sciondental.com/PWP/Landing**

West Virginia: **https://providerportal.caresource.com/WV**

Paper

Indiana	Ohio	West Virginia
CareSource	CareSource	CareSource
Attn: Claims	Attn: Claims	Attn: Claims
P.O. Box 3607	P.O. Box 8730	P.O. Box 804
Dayton, OH 45401-3607	Dayton, OH 45401-8730	Dayton, OH 45401-0804

PRIOR AUTHORIZATION

Online

Indiana and Ohio: **https://pwp.sciondental.com/PWP/Landing**

West Virginia: **https://providerportal.caresource.com/WV**

Paper

Indiana	Ohio	West Virginia
CareSource	CareSource	CareSource
Attn: Prior Authorization	Attn: Prior Authorization	Attn: Prior Authorization
P.O. Box 745	P.O. Box 314	P.O. Box 1307
Milwaukee, WI 53201	Milwaukee, WI 53201	Dayton, OH 45401-1307

For questions about Scion web portal access, contact the Scion web portal team at **ProviderPortal@scion.com** or call **1-855-434-9239**.

Contact CareSource Provider Services for questions regarding paper submissions:

Indiana: **1-866-286-9949**

Ohio: **1-800-488-0134**

West Virginia: **1-855-202-1091**

ELECTRONIC FUNDS TRANSFER

We encourage our dental providers to enroll in Electronic Funds Transfer (EFT) to enjoy efficient and reliable claim payments. Visit the applicable provider portal to enroll.

Indiana and Ohio: **https://pwp.sciondental.com/PWP/Landing**

West Virginia: **https://providerportal.caresource.com/WV**

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AM-EXCP-0186a