# 2026 DEN833 / DCD833

**Florida GoldPlus Dental Network**

The following provides an all-inclusive list of dental services covered under this plan. All services must be received in-office from a participating in-network general dentist or dental specialist (e.g., oral surgeon, endodontist, periodontist, etc.). Limitations and exclusions may apply. Benefits are offered on a calendar year basis.

The dentist may suggest and help arrange for additional services not listed in this benefit schedule; however, any procedures received that are not listed or exceed the benefit limitations listed in this schedule are not covered by this benefit. The member may be responsible for the costs of these additional services and may be charged the dental provider's usual and customary fees, less any contracted discount. Submitted claims are subject to a review process, which may include a clinical review and dental history to approve coverage.

## Contact Information

**Members:** If you have questions, please call our Member Services Department at **800-794-5907**. If you use a TTY, call **711**. You can call us seven days a week, from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**. To view your Evidence of Coverage (EOC) for a full listing of dental limitations and exclusions, please sign in to MyCarePlus, your secure member portal, at **CarePlusHealthPlans.com/MyPlan**.

† **Providers:** For information about dental benefits or to determine if a patient is eligible for full Medicaid benefits (DCD) (QMB+, SLMB+ or FBDE), call Dental Provider Customer Service at **800-833-2223**, Monday – Friday, 8 a.m. to 8 p.m., Eastern time.

## Additional Plan Details

- In-network dental providers have agreed to provide covered services at contracted rates per the in-network fee schedules (INFS). If a member visits a participating network dental provider, the member cannot be billed for charges that exceed the negotiated fee schedule. To find a dentist or to check to see if a dentist is in our nationwide network, go to **CarePlusHealthPlans.com/DentalFinder**.
- No out-of-network coverage on this plan.
- Sponsored by CarePlus Health Plans, Inc. and the State of Florida, Agency for Health Care Administration. CarePlus is an HMO SNP plan with a Medicare contract and a contract with the Florida Medicaid Program. Enrollment in CarePlus depends on contract renewal.
- Dental benefits on this plan use a Preferred Provider Organization (PPO) dental network.

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|---|---|
| Deductible | $0 |
| Annual maximum | None |
| Waiting periods | None |

| ADA code | Description of benefit | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|---|---|---|
| **Exam** | | | | |
| D0120 | Periodic oral evaluation – established patient | Two procedure codes per calendar year | 100% | 0% |
| **Emergency diagnostic exam** | | | | |
| D0140 | Limited oral evaluation – problem focused | †Benefit frequency is unlimited if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| **Additional exam** | | | | |
| D0150 | Comprehensive oral evaluation – new or established patient | One procedure code every three calendar years | 100% | 0% |
| **Full mouth and panoramic X-rays** | | | | |
| D0210 | Intraoral – comprehensive series of radiographic images | One procedure code from this group every three calendar years | 100% | 0% |
| D0330 | Panoramic radiographic image | | 100% | 0% |
| **Intraoral X-rays – periapical** | | | | |
| D0220 | Intraoral – periapical first radiographic image | †Benefit frequency is one procedure code from this group every three calendar years if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| D0230 | Intraoral – periapical each additional radiographic image | | 100% | 0% |
| **Intraoral X-rays – occlusal** | | | | |
| D0240 | Intraoral – occlusal radiographic image | †Benefit frequency is one procedure code every three calendar years if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |

| ADA code | Description of benefit | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|---|---|---|
| Bitewing X-rays | | | | |
| D0270 | Bitewing – single radiographic image | One procedure code from this group per calendar year for all members<br><br>†Benefit frequency is two procedure codes from this group per calendar year if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| D0272 | Bitewings – two radiographic images | | 100% | 0% |
| D0273 | Bitewings – three radiographic images | | 100% | 0% |
| D0274 | Bitewings – four radiographic images | | 100% | 0% |
| Prophylaxis (cleaning) | | | | |
| D1110 | Prophylaxis adult (Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.) | Two procedure codes per calendar year | 100% | 0% |
| Restorations (fillings) | | | | |
| D2140 | Amalgam – one surface, primary or permanent | Four procedure codes from this group per calendar year | 100% | 0% |
| D2150 | Amalgam – two surfaces, primary or permanent | | 100% | 0% |
| D2160 | Amalgam – three surfaces, primary or permanent | | 100% | 0% |
| D2161 | Amalgam – four or more surfaces, primary or permanent | | 100% | 0% |
| D2330 | Resin-based composite – one surface, anterior (front) | | 100% | 0% |
| D2331 | Resin-based composite – two surfaces, anterior (front) | | 100% | 0% |
| D2332 | Resin-based composite – three surfaces, anterior (front) | | 100% | 0% |
| D2335 | Resin-based composite – four or more surfaces (anterior) | | 100% | 0% |
| D2391 | Resin-based composite – one surface, posterior (back) | | 100% | 0% |
| D2392 | Resin-based composite – two surfaces, posterior (back) | | 100% | 0% |
| D2393 | Resin-based composite – three surfaces, posterior (back) | | 100% | 0% |
| D2394 | Resin-based composite – four or more surfaces, posterior (back) | | 100% | 0% |

| ADA code | Description of benefit | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|---|---|---|
| **Crowns** | | | | |
| D2740 | Crown – porcelain/ceramic | One procedure code from this group per calendar year | 100% | 0% |
| D2750 | Crown – porcelain fused to high noble metal | | 100% | 0% |
| **Endodontic services** | | | | |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | One procedure code from this group per calendar year | 100% | 0% |
| D3320 | Endodontic therapy, premolar tooth (excluding final restoration) | | 100% | 0% |
| D3330 | Endodontic therapy, molar tooth (excluding final restoration) | | 100% | 0% |
| **Periodontal scaling and root planing** | | | | |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant | One procedure code per quadrant from this group per calendar year | 100% | 0% |
| D4342 | Periodontal scaling and root planing – one to three teeth per quadrant | | 100% | 0% |
| **Scaling – moderate gingival inflammation** | | | | |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation | One procedure code per calendar year | 100% | 0% |
| **Complete dentures or removable partial dentures (including routine post-delivery care)** | | | | |
| D5110 | Complete denture – maxillary | One upper and one lower complete or partial denture every five calendar years | 100% | 0% |
| D5120 | Complete denture – mandibular | | 100% | 0% |
| D5130 | Immediate denture – maxillary | | 100% | 0% |
| D5140 | Immediate denture – mandibular | | 100% | 0% |
| D5211 | Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) | | 100% | 0% |
| D5212 | Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) | | 100% | 0% |
| D5213 | Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | 100% | 0% |
| D5214 | Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | 100% | 0% |

| ADA code | Description of benefit | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|---|---|---|
| Denture adjustments (not allowed on spare dentures or if within six months of initial placement) | | | | |
| D5410 | Adjust complete denture – maxillary | †Benefit frequency is one procedure code from this group per calendar year if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| D5411 | Adjust complete denture – mandibular | | 100% | 0% |
| D5421 | Adjust partial denture – maxillary | | 100% | 0% |
| D5422 | Adjust partial denture – mandibular | | 100% | 0% |
| Denture reline (not allowed on spare dentures or if within six months of initial placement) | | | | |
| D5730 | Reline complete maxillary denture (direct) | †Benefit frequency is one procedure code from this group per calendar year if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| D5731 | Reline complete mandibular denture (direct) | | 100% | 0% |
| D5740 | Reline maxillary partial denture (direct) | | 100% | 0% |
| D5741 | Reline mandibular partial denture (direct) | | 100% | 0% |
| D5750 | Reline complete maxillary denture (indirect) | | 100% | 0% |
| D5751 | Reline complete mandibular denture (indirect) | | 100% | 0% |
| D5760 | Reline maxillary partial denture (indirect) | | 100% | 0% |
| D5761 | Reline mandibular partial denture (indirect) | | 100% | 0% |
| Repairs to dentures (not covered if within six months of initial placement) | | | | |
| D5511 | Repair broken complete denture base, mandibular | †Benefit frequency is one procedure code from this group per calendar year if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| D5512 | Repair broken complete denture base, maxillary | | 100% | 0% |
| D5520 | Replace missing or broken teeth – complete denture – per tooth | | 100% | 0% |
| D5611 | Repair resin partial denture base, mandibular | | 100% | 0% |
| D5612 | Repair resin partial denture base, maxillary | | 100% | 0% |
| D5621 | Repair cast partial framework, mandibular | | 100% | 0% |
| D5622 | Repair cast partial framework, maxillary | | 100% | 0% |
| D5630 | Repair or replace broken retentive/clasping materials – per tooth | | 100% | 0% |
| D5640 | Replace missing or broken teeth – partial denture – per tooth | | 100% | 0% |
| D5650 | Add tooth to existing partial denture – per tooth | | 100% | 0% |
| D5660 | Add clasp to existing partial denture – per tooth | | 100% | 0% |

| ADA code | Description of benefit | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|---|---|---|
| Implant repair | | | | |
| D6096 | Remove broken implant retaining screw | †Benefit frequency is unlimited if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| Simple or surgical extractions (unlimited extractions covered for the purpose of member receiving dentures, all other extractions limited to frequency below) | | | | |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | Six procedure codes from this group per calendar year | 100% | 0% |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | | 100% | 0% |
| D7220 | Removal of impacted tooth – soft tissue | | 100% | 0% |
| D7230 | Removal of impacted tooth – partially bony | | 100% | 0% |
| D7240 | Removal of impacted tooth – completely bony | | 100% | 0% |
| D7250 | Removal of residual tooth roots (cutting procedure) | | 100% | 0% |
| Simple or surgical extractions (unlimited extractions covered for the purpose of member receiving dentures, all other extractions limited to frequency below) | | | | |
| D7241 | Removal of impacted tooth – completely bony, with unusual surgical complications | †Benefit frequency is two procedure codes from this group per calendar year if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| D7260 | Oroantral fistula closure | | 100% | 0% |
| D7261 | Primary closure of a sinus perforation | | 100% | 0% |
| D7310 | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | | 100% | 0% |
| D7320 | Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | | 100% | 0% |
| D7472 | Removal of torus palatinus | | 100% | 0% |
| D7473 | Removal of torus mandibularis | | 100% | 0% |
| D7510 | Incision and drainage of abscess – intraoral soft tissue | | 100% | 0% |
| D7520 | Incision and drainage of abscess – extraoral soft tissue | | 100% | 0% |
| D7970 | Excision of hyperplastic tissue – per arch | | 100% | 0% |

| ADA code | Description of benefit | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|---|---|---|
| Anesthesia – general (in conjunction with extensive and/or complex procedures, subject to plan limitations and exclusions, subject to clinical review) | | | | |
| D9222 | Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof | As needed with covered codes for all members<br><br>†Benefit frequency is three procedure codes from this group per calendar year if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| D9223 | Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof | | 100% | 0% |
| D9239 | Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof | | 100% | 0% |
| D9243 | Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof | | 100% | 0% |
| D9246 | Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof | | 100% | 0% |
| D9247 | Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof | | 100% | 0% |
| Anesthesia – nitrous oxide/analgesia (in conjunction with covered services, subject to plan limitations and exclusions, subject to clinical review) | | | | |
| D9230 | Administration of nitrous oxide | As needed with covered codes for all members<br><br>†Benefit frequency is three procedure codes per calendar year if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |
| Adjunctive general services | | | | |
| D9420 | Hospital or ambulatory surgical center call | †Benefit frequency is one procedure code every three calendar years if the member is eligible for full Medicaid benefits (may vary month to month). | 100% | 0% |

**Dental Mandatory Supplemental Benefit Exclusions include, but not limited to, the following:**

- Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies).
- Services received from an out-of-network dentist are not covered benefits.
- Initial placement or replacement of a prior denture that is unserviceable and cannot be made serviceable. Spare dentures are not covered.
- Dental reline may not be covered within six months of initial denture placement or on spare dentures.
- Dental adjustments may not be covered within six months of initial denture placement or on spare dentures.
- Expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
    - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
    - Furnished by, or payable under, any plan or law through any government or any political subdivision – this does not include Medicare or Medicaid.
    - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- Any expense arising from the completion of forms.
- Your failure to keep an appointment with the dentist.
- Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures to include, but are not limited to:
    - Facings on crowns or pontics – the portion of a fixed bridge between the abutments – posterior to the second bicuspid;
    - Any service to correct congenital malformation;
    - Any service performed primarily to improve appearance;
    - Characterizations and personalization of prosthetic devices; or
    - Any procedure to change the spacing and/or shape of the teeth;
  - Charges for:
    - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
    - Precision or semi-precision attachments;
    - Other customized attachments;
    - Temporary or interim dental services;
    - Additional charges related to material or equipment used in the delivery of dental care;
    - The removal of any implants unless a covered service.
  - Any service related to:
    - Altering vertical dimension of teeth.
    - Restoration or maintenance of occlusion.
    - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
    - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction.
    - Bite registration or bite analysis.
- Infection control, including but not limited to sterilization techniques.

- Fees for treatment performed by someone other than a dentist, except for scaling, teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision of the dentist in accordance with generally accepted dental standards.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service not specifically listed in the Coverage Information.
- Any service that is not eligible for benefits based upon clinical review; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Orthodontic services.
- Retainer Crown services when bridge coverage is not included in the benefit.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the reimbursement limit for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Local anesthetics, irrigation, bases, pulp caps, temporary dental services, study models/diagnostic casts, treatment plans, occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
- Any test, intraoperative, x-rays, laboratory, removal of existing posts, filling material, Thermafill carriers, and any other follow-up care is considered integral to root canal therapy. A separate fee for these services is not considered a covered expense.
- Repair and replacement of orthodontic appliances.
- Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
- The oral surgery benefits under this plan do not include:
    - Any services for orthognathic surgery;
    - Any services for destruction of lesions by any method;
    - Any services for tooth transplantation;
    - Any services for removal of a foreign body from the oral tissue or bone;
    - Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
    - Any separate fees for pre and post-operative care.
- General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services.
- General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
    - Pain control unless a documented allergy to local anesthetic is provided;
    - Anxiety;
    - Fear of pain;
    - Pain management;
    - Emotional inability to undergo surgery.
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Separate fees for pre and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
- We do not cover services that generally are considered to be medical services except those specifically noted as covered in the Coverage Information.
- Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.