



**CareSource West Virginia Co.**

Attn: Claims Department  
P.O. Box 804 Dayton,  
Ohio 45401

## **ADULT DENTAL, VISION AND FITNESS RIDER**

This Rider is a part of the Evidence of Coverage (EOC) to which it is attached. It is subject to all of the terms, conditions, exclusions and limitations of the EOC which are not in conflict with the terms, benefits, exclusions and limitations of this Rider.

CareSource Adult Dental, Vision, and Fitness Programs includes the Benefits and services described in this Rider. They are offered at an extra cost to you, as further described in the Schedule of Benefits and may be referred to as “Adult Dental”, “Adult Vision Benefits”, and “Adult Fitness Programs”. These Benefits are not Essential Health Benefits.

**NOTE:** Dental and Vision Benefits for pediatric members are not available under this Rider. Please reference Section 5 – *Your Covered Services* of your EOC for pediatric dental and vision Benefits.

### **Network of Providers**

CareSource utilizes a Network for the provision of covered Adult Dental and Vision Benefits, and Fitness Programs. We will only provide coverage for Adult Dental and Vision Benefits, and Fitness Programs when you use a dentist, optometrist, ophthalmologist, or other appropriate Provider within our Network. We do not cover dental, vision, and fitness program services provided by Non-Network Providers. For assistance locating a Network Provider, please visit our website at [CareSource.com/marketplace](http://CareSource.com/marketplace) and use our “Find A Doctor” tool. A printed directory may be provided to you free of charge. Find A Doctor is updated at least monthly.

### **1. ADULT DENTAL BENEFITS**

The Benefits available to you under this Section are administered by Dental Benefits Manager. The management and other services that they provide include, among others, maintaining and managing the Network Providers who will provide Covered Services to you under this Section. You must use a Network Provider for our Dental Benefits Manager in order to receive Benefits under this Section. If you do not use Dental Benefits Manager’s Network Provider to receive Health Care Services under this Section, then you will be responsible for all costs, and such Health Care Services will be considered Non-Covered Services. Please call 1-855-453-5281 for help locating a Dental Benefits Manager Network Provider and for additional information and details.

CareSource’s Adult Dental Benefits include the following listed services. Services outside of those listed are not Covered Services. All Adult Dental Benefits under this Section are subject to a combined \$1,000 limit per Benefit Year.

Dental (CDT codes) maintained by the American Dental Association, are listed in this section to help increase clarity to you and your Provider. There are times when delivery of new or modified dental procedures and the CDT Code maintenance process may result in changes following the finalization and publication of this Evidence of Coverage which may result in the replacement or removal of listed codes and or require the consideration of newly created codes. CareSource will evaluate these changes for administrative updates required to ensure our ability to continue to provide the coverage as intended by this section.

### **Class I – Preventive Services**

- Dental Prophylaxis (Cleanings) (D1110) - limited to two (2) per benefit year. We generally expect there to be a six (6) month separation between services, even when the services enter a new plan year.

### **Class I - Diagnostic Services & Other Services**

- Oral evaluations, including periodic, limited-problem focused, and comprehensive oral and periodontal (D0120, D0140, D0150, D0180) are combined and limited to two (2) times per benefit year. Comprehensive Oral evaluation (D0150, D0180) limited to one per 24 months per Provider or location.
- Complete set of Radiographic images including Bitewing or Panoramic radiographic image (D0210, D0330) limited to once per sixty (60) months.
- Intraoral X-rays and Bitewing images (D0220-D0240 & D0270-D0277) are limited to maximum daily amount and will be reimbursed up to the amount of a complete series for a single date of service.
  - Bitewings (D0270-D0274) are further limited to a total of four horizontal bitewing films in any combination or one set of vertical bitewings (D02777) per six (6) months.
  - Interpretation of diagnostic image including report (D0391) limited to one per image.
  - Diagnostic Casts (D0470) limited to one per case per provider or location.
  - Minor palliative treatment of pain (D9110) per day.

### **Class II – Minor Restorative**

- Amalgam & Resin restorations (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) limited to one per 12 month per tooth per surface. Composite resin restorations are limited to anterior (front) teeth only, if applied to posterior (rear) teeth we will reimburse for Amalgam.
- Re-cement or re-bond inlay, onlay, post and core, or crown (D2910, D2915, D2920). Not reimbursable within 6 months of initial placement.
- Protective Restoration (D2940) limited to one per benefit year per tooth.
- Pin retention (D2951) limited to a maximum of 3 pins per tooth.

### **Class II – Other Services**

- Periodontal Maintenance (gum maintenance) (D4910) - limited to four (4) items per twelve (12) month period following active periodontal therapy within the last year. Dental cleanings (D1110) provided during the same period will reduce the number of periodontal maintenance available. Scaling & Root Planning (Deep Cleaning) (D4341, D4342) must be on file or documentation from patient record history of periodontal therapy with in the last six (6) months.
- Adjustments to dentures (D5410, D5411, D5421, D5422). Not covered within six (6) months of initial placement.

- Repairs to denture base and framework (D5511, D5512, D5611, D5612, D5621, D5622). Limited to repairs or adjustments performed more than 12 months after the initial insertion.
- Repair or replace broken clasp or tooth (D5520, D5630, D5640). Not covered within six (6) months of initial placement.
- Add tooth or clasp to existing partial denture (D5650, D5660).
- Relining and Rebasing Dentures (D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761)- limited to relining/rebasing performed more than six (6) months after initial insertion - Limited to one (1) time per thirty six (36) months per code.
- Tissue Conditioning (D5850, D5851).
- Extraction of erupted tooth or exposed root (D7140).
- Consultation with another dentist or physician (D9310, D9311) limited to one per day per code.

### **Class III - Major Restorative Dental Services**

- Inlays (D2510, D2520, D2530) limited to one per tooth per sixty (60) months per code. Covered only when a direct restoration will not adequately restore the tooth & limited to fully developed permanent teeth and primary teeth with no permanent successors.
- Onlays & Crowns (partial to full) (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) limited to one per tooth per sixty (60) months. Limited to fully developed permanent teeth and primary teeth with no permanent successors. Onlays limited to metallic and Crowns limited to porcelain and metallic.
- Core buildup including pins (D2950) limited to one per sixty (60) months per tooth.
- Post and core in addition to crown (D2952, D2954) limited to one per sixty (60) months per tooth.
- Additional prefabricated posts (D2953, D2957) limited to one per sixty (60) months per tooth per code.
- Crown, Inlay, Onlay, or Veneer Repair (D2980, D2981, D2982, D2983) limited to one per sixty (60) months per tooth per code.

### **Class III – Major Dental Services – Endodontics & Periodontics**

- Pulpotomy, therapeutic or partial (D3220, D3222).
- Pulpal Debridement, primary and permanent teeth (D3221).
- Root Canal (D3310, D3320, D3330) - limited to one (1) per tooth per lifetime per code.
- Retreatment of previous root canal (D3346, D3347, D3348) limited to one per tooth per lifetime per code.
- Apexification/recalcification and pulpal regeneration including all phases (D3351, D3352, D3353 & D3355, D3356, D3357) limited to one per lifetime per tooth per code.
- Apicoectomy/periradicular surgery including additional roots (D3410, D3421, D3425, D3426) limited to one per tooth/root per lifetime per code.
- Surgical repair of root resorption (D3471, D3472, D3473) limited to one (1) per lifetime per tooth per code.
- Surgical exposure of root surface without apicoectomy or repair of root resorption (D3501, D3502, D3503) limited to one (1) per lifetime per tooth per code.
- Root amputation & Hemisection (D3450, D3920).
- Gingivectomy or gingivoplasty (D4210, D4210) limited to one per thirty-six (36) months per quadrant and (D4212) limited to one per thirty-six (36) months per tooth.
- Gingival flap (D4240, D4241) limited to one per thirty-six (36) months per quadrant.
- Clinical crown lengthening (D4249) limited to one per thirty-six (36) months per tooth.

- Osseous surgery (D4260, D4261) limited to one per thirty-six (36) months per quadrant.
- Various graft procedures (D4270, D4273, D4277, D4278) limited to one per thirty-six (36) months per tooth per code.
- Scaling & Root Planning (Deep Cleanings) (D4341, D4342) - limited to one (1) time per quadrant per twenty-four (24) months.
- Full mouth debridement (D4355) limited to one per lifetime.

### **Class III – Comprehensive Dental Services – Removable Prosthodontics**

- Complete or immediate denture (D5110, D5120, D5130, D5140) limited to one per sixty (60) Months per maxillary or mandibular. Includes all adjustments within six (6) months of initial placement.
- Partial denture including immediate, resin base, or cast metal framework (D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) limited to one per sixty (60) months per maxillary or mandibular. Includes all adjustments within six (6) months of initial placement.
- Removable unilateral partial denture (D5282, D5283) limited to one per sixty (60) months per code.

### **Class III – Comprehensive Dental Services – Implants and Fixed Prosthodontics**

- Pontics – metal, porcelain, or ceramic (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) limited to one per sixty (60) months per tooth.
- Retainer for fixed prosthesis (D6545, D6548, D6549) limited to one per sixty (60) months per tooth.
- Fixed partial denture retainer inlays and onlays (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) limited to one per sixty (60) months per tooth.
- Fixed partial denture crowns ( D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) limited to one per sixty (60) months per tooth.
- Recement fixed partial denture (D6930).
- Fix partial denture repair, by report (D6980).

### **Class III – Comprehensive Dental Services – Oral & Maxillofacial Surgery**

- Surgical removal of erupted tooth (D7210).
- Removal of impacted tooth, soft tissue and various levels of bony (D7220, D7230, D7240, D7241).
- Surgical removal of residual tooth roots (D7250).
- Coronectomy (D7251), Tooth reimplantation (D7270), & Surgical access to unerupted tooth (D7280).
- Placement of device to facilitate eruption (D7283) limited to one per lifetime per tooth.
- Alveoloplasty in conjunction with extraction or not (D7310, D7311, D7320, D7321) limited to one per lifetime per quadrant per code. Minimum of four extractions and must be associated to the construction of a prosthodontic appliance.
- Removal of exostosis (D7471).
- Incision and drainage of abscess (D7510, D7520).
- Suture of small wound (D7910).
- Excision of pericoronal gingiva (D7971).

### **Class III – Other Services**

- Deep sedation/anesthesia (D9222, D9223). First 15 minutes limited to one per day, while each subsequent 15 minute is limited to 4 per day. Maximum of a combined 10 units or 150 total minutes per benefit period.
- Intravenous sedation/anesthesia (D9239, D9243). First 15 minutes limited to one per day, while each subsequent 15 minute is limited to 4 per day. Maximum of a combined 10 units or 150 total minutes per benefit period.
- Therapeutic parenteral drug (D9610) limited to one per day.
- Treatment of complications (post-surgical), by report (D9930).
- Occlusal guard (D9944) limited to one per 12 months for age 13 and older.

### **Class IV –Orthodontics**

- No coverage for Orthodontics.

### **Exclusions.**

The Plan does not cover the following:

- Services provided by Providers not within the Dental Benefit Manager’s Network of Providers.
- Adult Dental Services and treatments not listed within this Rider.
- Services and treatment not prescribed by or under the direct supervision of a dentist, except for eligible Covered Services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are not Medically Necessary or which do not meet generally accepted standards of dental practice;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- State or territorial taxes on Dental Services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same Covered Person by another dentist;
- Those performed by a dentist who is compensated by a Facility for similar Covered Services performed for Covered Persons;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (Inpatient or Outpatient);
- Charges by the Provider for completing dental forms;

- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for permanent teeth;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Intravenous sedation;
- Topical medicament center;
- Orthodontic care for a Covered Person or spouse;
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
- Except for Emergency Health Care Services, Dental Care Services received from a Non- Network Provider unless authorized by us.

## 2. VISION BENEFITS

### *Network of Providers*

The Benefits available to you under this Section are administered by EyeMed®. The management and other services that EyeMed® provides include, among others, maintaining and managing the Network Providers who will provided Covered Services to you under this Section. You must use an EyeMed® Network Provider in order to receive Benefits under this Section. If you do not use an EyeMed® Network Provider to receive Health Care Services under this Section, then you will be responsible for all costs, and such Health Care Services will be considered Non-Covered Services. Please call 1-833-337-3129 for help locating an EyeMed® Network Provider and for additional information and details.

**IMPORTANT:** IF YOU OPT TO RECEIVE VISION CARE SERVICES OR VISION MATERIALS THAT ARE NOT COVERED SERVICES UNDER THIS PLAN, A PARTICIPATING NETWORK PROVIDER MAY CHARGE YOU HIS OR HER NORMAL FEE FOR SUCH SERVICES OR MATERIALS. PRIOR TO PROVIDING YOU WITH VISION CARE SERVICES OR VISION CARE MATERIALS THAT ARE NOT COVERED BENEFITS, THE VISION CARE PROVIDER WILL PROVIDE YOU WITH AN ESTIMATED COST FOR EACH SERVICE OR MATERIAL UPON REQUEST.

### **Covered Services:**

1. **Comprehensive Eye Exam with Dilation, if Medically Necessary.** Limited to one per Benefit Year. Cost share applies.

2. **Eyewear:** Covered in Full up to a \$250 allowance per benefit year, limited to one pair of glasses or contacts per Benefit Year.
  - a. Eyeglasses (includes materials only)
    - i. Frames, lens & options: 20% discount on balance after \$250 allowance.
  - b. Contact lenses (includes materials only)
    - i. Conventional - 15% discount balance after \$250 allowance.
    - ii. Disposable - No discount after \$250 allowance.
3. **Low-Vision:** Low vision is a significant loss of vision but not total blindness.
  - a. **Supplemental Testing:** Diagnostic evaluation beyond a comprehensive eye examination including, but not limited to, an ocular function assessment, measurements, visual field evaluations. Limited to one per Benefit Year.
    - o **Low Vision Aids:** Includes, but is not limited to spectacle-mounted magnifiers, hand-held or spectacle-mounted telescopes, hand-held and stand magnifiers, and video magnification. Limited to one per Benefit Year.
4. **Retinal Imaging Benefit:** Covered at no member cost share. Limited to one per Benefit Year.
5. **Medically Necessary Contact Lenses:** In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, niriidia, corneal disorders, post-traumatic disorders, irregular astigmatism. Medically Necessary contact lenses are dispensed in lieu of other eyewear.

In the event that contact lenses are determined to be Medically Necessary, the contact lenses and associated services, including fit and follow-ups, will be Covered In Full with no limitation on the number of follow-ups required.

## Limitations

The Plan will only provide Benefits for one pair of glasses or contact lenses. You may purchase additional eyewear at your own cost, and you may receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses upon exhaustion of the Benefits above.

## Exclusions

The Plan does not cover the following:

- Services and materials not meeting accepted standards of optometric practice;
- State or territorial taxes on vision services performed;
- Visual therapy;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals; or
- Insurance of contact lenses.

### 3. THE ACTIVE&FIT® FITNESS PROGRAM

The Plan provides covered adults age 18 and older with the ability to enroll in select fitness centers for the Benefit Year while enrolled in the Plan. Using the Active&Fit® fitness program is voluntary, and is provided at no cost to you. Enrollment may give you access to cardiovascular equipment, strength training equipment, certain fitness classes, and other amenities, such as saunas, locker rooms, and pools, where available.

Active&Fit® also offers digital fitness choices with home fitness tools, including:

- Home fitness kits: You are eligible to receive one home fitness kit per benefit year from a variety of fitness categories, with some kits including a wearable device (e.g. Fitbit or Garmin).
- Digital Workouts: Choose from over 8,000 workout videos for all fitness levels.
- Live Lifestyle Coaching: Focuses on exercise, nutrition, and more.

For more information on this program, how to enroll, available services in your area, and exclusions and limitations, please call Active&Fit® member services at the number found on the back of your ID card, or at [ActiveandFit.com](http://ActiveandFit.com).

Limitations:

- Fees paid under this program, if required, do not count towards your Annual Out-of-Pocket Maximum, are non-refundable, are not prorated, and may be required to be paid to a third party and not CareSource.
- Available fitness or exercise centers \ may vary and change at any time. Enrolled adults may not have access to all services offered by the fitness center and some services may require the purchase of upgraded memberships.
- Prior to enrollment, please verify with the fitness center what services are included as part of this program and what services (if any) would require additional fees.
- Not all Covered Persons may be eligible to participate in this program. Available fitness centers may have certain restrictions for enrollment, such as age requirements.
- Enrollment in this program is limited to the current Benefit Year and while Covered Persons are enrolled in the Plan. If you disenroll or are terminated from the Plan during the Benefit Year, then you will no longer be able to access fitness centers.

This Rider amends and is incorporated into the EOC between you and CareSource. This Rider takes the place of any other issued to you by CareSource on a prior date. All coverage under this Rider shall begin at 12:00 midnight and shall end at 11:59:59 Eastern Standard Time.



Erhardt H. Preitauer  
President and Chief Executive  
Officer CareSource