

# Traditional Dental

*Includes access to a national provider network*

CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice)<sup>1</sup> offer Traditional Dental coverage, which allows you the freedom to see any dentist you choose.

## Advantages of the plan

- **Freedom of choice, freedom to save**—With Traditional Dental coverage, you can see any dentist you choose. However, this plan also gives you the option to reduce your out-of-pocket expenses by visiting a dentist who participates in our Traditional Provider network. It's your choice!
- **Comprehensive coverage**—Benefits include regular preventive care, X-rays, dental surgery and more. A summary of your benefits is available on the following page. (Additional coverage for orthodontia may be included—ask your benefits manager for details).
- **Nationwide access to participating dentists**—You have access to one of the nation's largest dental networks, with more than 95,000 participating dentists throughout the United States. Traditional Dental gives you coverage for the dental services you need, whenever and wherever you need them.
- **Opportunity to reduce costs**—If you see a participating dentist, you will incur lower out-of-pocket costs for all dental services and you will have no claim forms to file. Participating dentists have agreed to accept CareFirst's allowed benefit as payment in full for covered services. Once you meet your deductible and coinsurance, you won't have any additional expenses. You will not be balance billed!
- **Out-of-network benefit**—You can receive care from a non-participating dentist and have the same level of coverage; however, you may be subject to higher out-of-pocket costs and balance billing.

## Frequently asked questions

### How do I find a traditional dentist?

You can access an online directory 24 hours a day at [carefirst.com/doctor](https://carefirst.com/doctor). Click on *Dental* and then select *Traditional Dental*.

### How much will I have to pay for dental services?

The chart on the following page gives you an overview of many of the covered services along with the percentage of what you will pay for each class of services, both in- and out-of-network.

### Is there a lot of paperwork?

There is no paperwork when you see a participating dentist, you are free from filing claims. However, if you use a non-participating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

### Who can I call with questions about my dental plan?

Call Dental Customer Service toll free at: 866-891-2802 between 8:30 a.m. and 5 p.m. ET, Monday–Friday.

<sup>1</sup> The CareFirst BlueChoice Dental Plan is offered in conjunction with Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield, which contracts with participating dentists and provides claims processing and administrative services under the Dental Plan.

## Summary of Benefits

Services	You Pay
<b>ANNUAL DEDUCTIBLE AND MAXIMUM</b>	See your benefits manager for specific deductibles and maximums. Deductible applies to specific classes based on your employer's dental plan.
<b>PREVENTIVE AND DIAGNOSTIC SERVICES</b>	
<ul style="list-style-type: none"> <li>■ Oral Exams (two per benefit period)</li> <li>■ Prophylaxis (two cleanings per benefit period)</li> <li>■ Bitewing X-rays</li> <li>■ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>■ Fluoride treatments (two per benefit period per member, until the end of the year the member reaches the age 19)</li> <li>■ Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year the member reaches the age 19)</li> <li>■ Space maintainers (once per 60 months)</li> <li>■ Palliative emergency treatment</li> </ul>
No charge from Participating Dentist <sup>1</sup>	
<b>BASIC SERVICES</b>	
<ul style="list-style-type: none"> <li>■ Direct placement fillings using approved materials (one filling per surface per 12 months)</li> </ul>	<ul style="list-style-type: none"> <li>■ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)</li> <li>■ Simple extractions</li> </ul>
20% of Allowed Benefit after deductible <sup>1</sup>	
<b>MAJOR SERVICES—SURGICAL</b>	
<ul style="list-style-type: none"> <li>■ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months)</li> <li>■ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy)</li> </ul>	<ul style="list-style-type: none"> <li>■ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section)</li> <li>■ General anesthesia rendered for a covered dental service</li> </ul>
20% of Allowed Benefit after deductible <sup>1</sup>	
<b>MAJOR SERVICES—RESTORATIVE</b>	
<ul style="list-style-type: none"> <li>■ Full and/or partial dentures (once per 60 months)</li> <li>■ Fixed bridges, crowns, inlays and onlays (once per 60 months)</li> <li>■ Denture adjustments and relining (limits apply for regular and immediate dentures)</li> </ul>	<ul style="list-style-type: none"> <li>■ Recementation of crowns, inlays and/or bridges (once per 12 months)</li> <li>■ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance)</li> <li>■ Dental implants, subject to medical necessity review (once per 60 months)</li> </ul>
50% of Allowed Benefit after deductible <sup>1</sup> (when applicable)	
<b>ORTHODONTIC SERVICES<sup>2</sup></b>	
<ul style="list-style-type: none"> <li>■ Benefits for orthodontic services may be available for covered members under age 19 who meet treatment criteria.</li> </ul>	
50% of Allowed Benefit <sup>1</sup>	

<sup>1</sup> NOTE: CareFirst and CareFirst BlueChoice payments are based on the CareFirst and CareFirst BlueChoice Allowed Benefit. Participating Dentists accept 100% of the Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

<sup>2</sup> Coverage for orthodontia may be included—ask your benefits manager for details, including lifetime maximum.

**Summary of Exclusions:** Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

**Benefits issued under policy form numbers:** Group Hospitalization and Medical Services, Inc.: VA/CF/GC (R. 10/11) • VA/CF/COC DEN (9/04) • VA/DN-DOCS (R. 10/11) • VA/CF/DO-SOB (R. 1/04) • VA/CF/ELIG (9/04) and any amendments; Group Hospitalization and Medical Services, Inc.: VA/CF/DN RDR (R. 6/09); CareFirst BlueChoice, Inc.: VA/BC/DN RDR (R. 6/09)



## Section 4—Limitations and Exclusions—Dental Contract

(in addition to those found in the Certificate)

### 4.1 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 or bridges, 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) (optional)
- 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

### 4.2 Exclusions. Benefits will not be provided for:

- A. Replacement of a denture, bridge, or crown as a result of loss or theft
- B. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable
- C. Replacement of dentures, bridges, 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 Contract
- D. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys
- E. Gold foil fillings
- 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 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 service in the Contract.
  - 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 service in the Contract.
- 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 fibrotomy or vestibuloplasty
- P. Orthognathic Surgery or other oral Surgery covered under the Member's medical benefit plan
- Q. The repair or replacement of any orthodontic appliance
- R. Any orthodontic services after the last day of the month in which covered services ended except as specifically described in the Certificate of Coverage
- S. Services or supplies that are not Medically Necessary.
- T. Services not specifically shown in the Contract as a Covered Dental Service, even if Medically Necessary
- U. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services)
- V. 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
- W. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services
- X. Services or supplies that are Experimental or Investigational in nature
- Y. Services, appliances, or supplies related to orthodontic treatment. (optional)