CareFirst

Individual Select
Preferred Dental Plus
Maryland, District of Columbia and Northern Virginia
Did you know?

- People with periodontal disease are 2-4 times more likely to have a heart attack.¹
- Diabetic patients with periodontal disease have more difficulty controlling blood glucose levels.²
- Tooth decay (dental caries) is the most common chronic disease of childhood.³
- Women less than 35 weeks pregnant who receive treatment for gum disease have 84% fewer premature births.⁴
- Pregnancy can cause swelling, bleeding, redness, or tenderness in the gum tissue due to hormonal changes.

³ CDC, Oral Health. “Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers: At A Glance 2010”
Welcome

Your smile says a lot about you. It’s the first thing people see when they meet you. A healthy smile can make you more appealing, even more youthful. But did you know your smile also says a lot about your overall health?

That’s why it’s so important to protect your smile. Good dental care has been scientifically shown to reduce your risk of heart disease; it helps to control diabetes, and can even prevent premature births.

CareFirst BlueCross BlueShield (CareFirst) brings you Preferred Dental Plus which offers:

- **Freedom of choice**—you decide which dentist you want to use
- **Selection**—of more than 3,600 in-network dentists throughout Maryland, the District of Columbia and Northern Virginia and, access to a national network of 74,000 dentists and specialists
- **Coverage**—for numerous dental services — far more than a discount plan
- **Low deductibles**—to fit your budget

- **No referrals** – you visit the dentist/specialist you want to when you need to
- **No charge for oral exams, cleanings and X-rays**—when you visit an in-network provider
- **No claim forms**—when you stay in-network
- **Orthodontia benefit**—for children up to age 19
- **Guaranteed acceptance**—enjoy the benefits of good dental care today

Protect your smile, your health, and your budget from serious dental issues.
What Your Plan Covers

Preventive & Diagnostic Services

There is no deductible and no waiting period for the following services which are covered in full when visiting an in-network provider:

- Oral Examinations
- Cleanings
- X-rays
- Sealants
- Fluoride treatments for children

Basic Services

After a low deductible and no waiting period, your plan includes fillings, simple extractions, and periodontal scaling and root planing.

Major Services

After a low deductible and 12 month waiting period, you are covered for root canals, oral surgery, dentures, crowns, bridges and more!
Orthodontia

Preferred Dental Plus offers benefits for braces for children up to age 19 (after a 12 month waiting period).

Visiting Non-Participating Providers

You also have the option to seek treatment from Non-Participating Providers. If you visit a Non-Participating Provider, CareFirst will pay a percentage of the Allowed Benefit*, but you may be responsible for the difference in cost between the CareFirst Allowed Benefit and your Dental Provider’s full charge in addition to any applicable deductibles and coinsurance. You may also be required to pay all costs at the time of service and submit a claim form to be reimbursed for covered services.

*Allowed Benefit

The Allowed Benefit is typically a reduced rate rather than the dentist’s actual charge.

For example: You have just visited your dentist for a routine exam and cleaning. The total charge for the visit comes to $125. If the doctor is a participating provider, they may be required to accept $75 from CareFirst as payment in full for the visit—this is the Allowed Benefit. If, however, the dental provider you visit is non-participating, then you may be held responsible for the $50 difference between the CareFirst Allowed Benefit of $75 and the Dental Provider’s full charge of $125.
Meet the Johnsons

Anna and Jeff Johnson are an energetic couple with two children. They own a catering business, and have purchased a family health insurance plan. They didn’t think about dental coverage until their daughter needed braces and their son needed a filling. The costs quickly started to add up.

With no dental coverage, the Johnsons paid $6,495 for these services. With Preferred Dental Plus coverage, the Johnsons would have saved more than $4,100 for these services. The Johnsons decided to purchase the Preferred Dental Plus coverage to protect themselves against future dental costs.

<table>
<thead>
<tr>
<th>Common Dental Procedure</th>
<th>No Coverage</th>
<th>Preferred Dental Plus (In-Network)</th>
<th>Savings on Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month check-ups, including routine exams, cleanings and x-rays (8 visits, 2 per person)</td>
<td>$1,320 (165 per visit)</td>
<td>$0</td>
<td>$1,320</td>
</tr>
<tr>
<td>Filling (1 filling)</td>
<td>$130</td>
<td>$10 (after $25 deductible)</td>
<td>$95</td>
</tr>
<tr>
<td>Orthodontic Services (1 Child to age 19)</td>
<td>$5,045</td>
<td>$2,300 (after 12 month waiting period)</td>
<td>$2,745</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,495</strong></td>
<td><strong>$2,335</strong></td>
<td><strong>$4,160</strong></td>
</tr>
</tbody>
</table>

1 Based on National Dental Advisory Service Fee Report (2012).
2 Approximate amount. Pricing may vary depending upon dental provider’s negotiated rate with CareFirst.
3 Savings do not include premium costs.
Meet the Smiths

Mary and Charles Smith are active retirees who recently took up golf. They have Medicare and have purchased a Supplemental Medicare plan and Medicare Prescription Drug Coverage to protect themselves against medical costs. They didn’t think about how their budget might be impacted by major dental expenses until Mary needed root canal therapy and Charles needed a bridge.

With no dental coverage, the Smiths paid $4,460 for these services. They decided to purchase dental coverage to protect themselves against further unexpected dental costs. With Preferred Dental Plus coverage, the Smiths would have spent only $1,035, a savings of over $3,400 on these dental services. Now they’re covered and ready for whatever lies ahead!

<table>
<thead>
<tr>
<th>Common Dental Procedures</th>
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<th>Preferred Dental Plus (In-Network)</th>
<th>Savings on Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month check-ups, including routine exams, cleanings and x-rays (4 visits, 2 per person)</td>
<td>$660 ($165 per visit)</td>
<td>$0</td>
<td>$660</td>
</tr>
<tr>
<td>Root Canal (bicuspident)</td>
<td>$800</td>
<td>$85 (after $25 deductible and 12 month waiting period)</td>
<td>$690</td>
</tr>
<tr>
<td>Bridge (3-unit)</td>
<td>$3,000</td>
<td>$900 (after $25 deductible and 12 month waiting period)</td>
<td>$2,075</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4,460</strong></td>
<td><strong>$1,035</strong></td>
<td><strong>$3,425</strong></td>
</tr>
</tbody>
</table>

1 Based on National Dental Advisory Service Fee Report (2012).
2 Approximate amount. Pricing may vary depending upon dental provider’s negotiated rate with CareFirst.
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Frequently Used Benefits

<table>
<thead>
<tr>
<th>Common Dental Procedures</th>
<th>Regular Cost¹</th>
<th>In-Network You Pay²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive check-ups, including routine exams, cleanings and x-rays</td>
<td>$165 per visit (2 visits per year)</td>
<td>$0</td>
</tr>
<tr>
<td>Fillings and simple extractions</td>
<td>$130 - $160</td>
<td>$10-$15 after deductible</td>
</tr>
<tr>
<td>Periodontal scaling and root planing (4 or more teeth per section of the mouth)</td>
<td>$240</td>
<td>$25 after deductible</td>
</tr>
<tr>
<td>Porcelain crown (high noble metal)</td>
<td>$1,050</td>
<td>$300 after deductible and 12 month waiting period</td>
</tr>
<tr>
<td>Root canal therapy (molar, excluding final restoration)</td>
<td>$965</td>
<td>$115 after deductible and 12 month waiting period</td>
</tr>
<tr>
<td>Complete upper dentures</td>
<td>$1,595</td>
<td>$350 after deductible and 12 month waiting period</td>
</tr>
<tr>
<td>Orthodontia (Child up to age 19)</td>
<td>$5,045</td>
<td>$2,300 after 12 month waiting period</td>
</tr>
</tbody>
</table>

¹ Based on National Dental Advisory Service Fee Report (2012)
² Approximate amount. Pricing may vary depending upon dental provider's negotiated rate with CareFirst.

This is a partial listing of services. For specific questions please contact CareFirst Dental Services toll-free at 866-891-2802.
Preferred Dental Plus Rates

You decide how to pay your premium—Make easy quarterly payments or pay just once annually.

Rates—Maryland and District of Columbia

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Annual Rate Full Annual Payment Due with Enrollment Application</th>
<th>Quarterly Rate First Quarterly Payment Due with Enrollment Application. Subsequent payments are due on the 1st of the month beginning the next quarter.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payment 1</td>
<td>Payment 2</td>
</tr>
<tr>
<td>Individual</td>
<td>$441.96</td>
<td>$115.47</td>
</tr>
<tr>
<td>Individual &amp; Child(ren)*</td>
<td>$817.68</td>
<td>$209.40</td>
</tr>
<tr>
<td>Individual &amp; Adult**</td>
<td>$1,016.52</td>
<td>$259.11</td>
</tr>
<tr>
<td>Family</td>
<td>$1,237.56</td>
<td>$314.37</td>
</tr>
</tbody>
</table>

Rates—Virginia

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Annual Rate Full Annual Payment Due with Enrollment Application</th>
<th>Quarterly Rate First Quarterly Payment Due with Enrollment Application. Subsequent payments are due on the 1st of the month beginning the next quarter.</th>
</tr>
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<td>$817.68</td>
<td>$209.40</td>
</tr>
<tr>
<td>Individual &amp; Adult**</td>
<td>$883.92</td>
<td>$225.96</td>
</tr>
<tr>
<td>Family</td>
<td>$1,237.44</td>
<td>$314.34</td>
</tr>
</tbody>
</table>

Please note that when selecting the quarterly payment, a $4.98 administration fee is already included into each payment. You pay an additional $19.92/year when you select the quarterly payment option.

* “Child” means your eligible child up to age 26. Eligibility requirements are defined in the contract.

**“Adult” means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in the contract.
### Summary of Benefits

#### Deductible Applies to Classes II, III & IV
- The family deductible amount is calculated in the aggregate. However, no family member will be charged more than the individual deductible amount.
- The in-network and out-of-network deductible will be a separate amount.

#### Annual Maximum (Classes I-IV)
- The in-network and out-of-network annual maximum is a combined amount.

#### Preventive & Diagnostic Services (Class I)
- Oral Exams (two per contract year)
- Prophylaxis (two cleanings per contract year)
- Bitewing X-Rays (two per contract year)
- Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months)
- Fluoride treatments (two per contract year per member, until the end of the year in which member reaches age 19)
- Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year in which member reaches age 19)
- Space maintainers (once per 60 months)
- Palliative treatments
- Emergency oral exam

#### Basic Services (Class II)
- Direct placement fillings using approved materials (one filling per surface per 12 months)
- Simple extractions
- Periodontal scaling and root planing (once per 24 months, one full mouth treatment)

#### Major Services – Surgical (Class III)
- Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months)
- Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy)
- Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section)
- General anesthesia rendered for a covered dental service

#### Major Services – Restorative (Class IV)
- Full and/or partial dentures (once per 60 months)
- Fixed bridges, crowns, inlays and onlays (once per 60 months)
- Denture adjustments and relining (limits apply for regular and immediate dentures)
- Recementation of crowns, inlays and/or bridges (once per 12 months)
- Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance)
- Dental implants, subject to medical necessity review (once per 60 months)

#### Orthodontic Services (Class V)
- Benefits for orthodontic services are available for covered members until the end of the month in which a member reaches the age of 19.
- The in-network and out-of-network lifetime maximum per child is a combined amount.

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*CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst 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.*
### Summary of Benefits

<table>
<thead>
<tr>
<th>In-Network Member Pays</th>
<th>Out-of-Network Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25 Individual Deductible / $75 Family Deductible</td>
<td>$50 Individual Deductible / $150 Family Deductible</td>
</tr>
</tbody>
</table>

Plan pays up to $1,000 per member

<table>
<thead>
<tr>
<th>No charge</th>
<th>20% of Allowed Benefit*</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>20% of Allowed Benefit* after deductible</th>
<th>40% of Allowed Benefit* after deductible</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>20% of Allowed Benefit* after deductible and 12 month waiting period</th>
<th>40% of Allowed Benefit* after deductible and 12 month waiting period</th>
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<tbody>
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<table>
<thead>
<tr>
<th>50% of Allowed Benefit* after deductible and 12 month waiting period</th>
<th>65% of Allowed Benefit* after deductible and 12 month waiting period</th>
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<tbody>
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<td></td>
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</tbody>
</table>

Plan pays up to $800 per child up to age 19

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*Percentages are based on the allowed benefit, after any applicable deductible has been met.*
Apply Today!

It takes just three simple steps, to start enjoying the benefits of Preferred Dental Plus

Applying for Preferred Dental Plus couldn’t be easier! Just follow these simple steps:

1. Fill out and sign the enclosed application. Choose the annual or quarterly payment option.

2. When you’re ready to review a listing of providers, please visit www.carefirst.com/doctor. Click the “Dental” tab and select “Preferred Dental PPO”.

3. Send in your application, with your premium payment, in the enclosed, postage-paid envelope and mail to:

   CareFirst BlueCross BlueShield
   Mailroom Administrator
   P.O. Box 14651
   Lexington, KY 40512

We will mail you your membership card and certificate of coverage. Then you can start enjoying all the benefits of good dental care.

Please note: You must live in Maryland, the District of Columbia or the following areas of Northern Virginia: city of Alexandria or Fairfax, the town of Vienna, Arlington County, or the areas of Fairfax and Prince William counties lying east of Route 123.
3.1 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).
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.

3.2 Exclusions. Benefits will not be provided for:
A. Any services, tests, procedures, or supplies which CareFirst determines are not necessary for the prevention, diagnosis, or treatment of the Member’s illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member’s particular case.
B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in CareFirst’s judgment, is Experimental/Investigational, or not in accordance with accepted dental practices and standards in effect at the time of treatment.
C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this Agreement or under any dental insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
D. Any service, supply, or procedure that is not specifically listed in this Description of Covered Dental Services and Schedule of Benefits as Covered Dental Services (even if Medically Necessary) or that do not meet all other conditions and criteria for coverage as determined by CareFirst.
E. Replacement of a denture, bridge, or crown as a result of loss or theft.
F. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable.
G. 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 this Description of Covered Dental Services and Schedule of Benefits.
H. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys.
I. Gold foil fillings.
J. 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 when the dental services are received after the Effective Date of coverage under the Agreement 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.

K. Periodontal appliances.
L. 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 this Description of Covered Dental Services and Schedule of Benefits.

M. Splinting.
N. Nightguards, occlusal guards, or other oral orthotic appliances.
O. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service in this Description of Covered Dental Services and Schedule of Benefits.

P. Intentional tooth reimplantation or transplantation.
Q. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning.
R. 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.

S. Transseptal fiberotomy or vestibuloplasty.
T. Orthognathic Surgery or other oral Surgery covered under the Member’s medical benefit plan.
U. The repair or replacement of any orthodontic appliance.
V. Any orthodontic services after the last day of the month in which Covered Dental Services ended except as specifically described in this Description of Covered Dental Services and Schedule of Benefits and the attached Agreement.
W. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be Covered Dental Services).
X. 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.
Y. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
Z. Services that are beyond the scope of the license of the provider performing the service.
AA. Services and supplies that are not Medically Necessary.
Policy Form Numbers:

MD GHMSI/DB/ISPP DOCS (10/11), MD GHMSI/DB/ISPP IEA (10/11), MD/GHMSI/DB/DENT/ES (10/11), MD/GHMSI/ISPP/AMEND (2/12)

CFMI/DB/ISPP DOCS (10/11), CFMI/DB/ISPP IEA (10/11), MD/CFMI/DB/DENT/ES (2/12), MD/CFMI/ISPP/AMEND (2/12)

VA/GHMSI/ISPP IEA (10/11), VA/GHMSI/ISPP/DOCS (10/11), VA/GHMSI/DB/DENT/ES (10/11);
VA/ISPD/MEMCOV (3/12)

DC/GHMSI/DB/ISPP IEA (10/11), DC/GHMSI/DB/ISPP/DOCS (10/11), DC/GHMSI/DB/DENT/ES (10/11); DC/GHMSI/ISPP/AMEND (2/12)

and any amendments