BlueDental Plus Summary of Benefits

Gates Hudson — High Option

Includes access to a national provider network

	In-Network You Pay	Out-of-Network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$50 Individual $150 Family	$50 Individual $150 Family
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES*	Plan pays $1,500 maximum	
PREVENTIVE & DIAGNOSTIC SERVICES		
▪ Oral Exams (two per benefit period) ▪ Prophylaxis (two cleanings per benefit period) ▪ Bitewing X-rays ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) ▪ Palliative emergency treatment ▪ Fluoride treatments (two per benefit period per member) ▪ Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year the member reaches the age 19) ▪ Space maintainers (once per 60 months)	No charge[1]	No charge[1]
BASIC SERVICES AND MAJOR SERVICES—SURGICAL[2]		
▪ 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) ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ Periodontal maintenance cleanings (two per benefit period) ▪ General anesthesia rendered for a covered dental service ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section)	10% of Allowed Benefit after deductible[1]	20% of Allowed Benefit after deductible[1]
MAJOR SERVICES—RESTORATIVE[2]		
▪ 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 (once per tooth per 60 months)	40% of Allowed Benefit after deductible[1]	50% of Allowed Benefit after deductible[1]
ORTHODONTIC SERVICES[2]		
Benefits for orthodontic services are available for covered members who meet treatment criteria.	50% of Allowed Benefit[1]	50% of Allowed Benefit[1]
ORTHODONTIC LIFETIME MAXIMUM	Plan pays $1,000 combined maximum	

[1] 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.

[2] For Voluntary products without proof of prior coverage, benefits for Major Services and Orthodontic Services may not be available until 12 months after your Effective Date.

***** Deductible and Annual Maximum Combined In-network/Out-of-network.

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.

Group Hospitalization and Medical Services, Inc.: VA/CF/GC (R. 1/13); VA/CF/LG/2021 GC AMEND (1/21); VA/CF/EOC/D-V (1/12); VA/GHMSI/DOL APPEAL (R. 1/20); VA/GHMSI/BLUEDENTAL DOCS (R. 7/21); VA/GHMSI/BLUEDENTAL SOB (R. 7/21); VA/GHMSI/HEALTH GUARANTY 7/18; VA/CF/PARTNER (R. 10/11); VA/CF/ELIG (R. 1/12) and any amendments.

BlueDental Plus Summary of Benefits

Our plusses

- Most plans cover 100% of preventive and diagnostic services
- No claim forms or paperwork to fill out when a member sees a participating dentist
- We coordinate benefits for members with dental coverage from another carrier
- More than 123,000 participating dentists and specialists across the United States.

Our plans

With BlueDental Plus, you'll save the most money by seeing a participating provider.

What's a participating provider?
It's a dentist or specialist who is in our network and accepts our reduced negotiated fees as payment in full. This means no balance for you to pay, keeping your out-of-pocket costs low.

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you pay the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full. You're only responsible for deductibles and coinsurance. And for your convenience, your provider is reimbursed directly.
- **Option 2**—By choosing a dentist who participates with CareFirst, but not through the Preferred Provider Network, you'll pay slightly higher out-of-pocket costs. Similar to Option 1, there is no balance to pay. You're still responsible for deductibles and coinsurance, and have the convenience of your provider being reimbursed directly.

Can I see a non-participating provider?
Of course. But your out-of-pocket expenses will be highest with providers outside our network. You may have to pay the difference between the dentist's fee and what your plan allows for those services.

Where can I find a dentist?
Visit **carefirst.com/doctor** and select *BlueDental* to view in-network providers.

When do I get my ID card?
Member ID cards are mailed to your home after enrollment. You can also access your ID card—along with other claims and benefit information—at *My Account* or on the CareFirst mobile app. Visit **carefirst.com/myaccount** to register.

Who can I call with questions about my dental plan?
Call Dental Customer Service toll free at 866-891-2802 between 8 a.m. and 6 p.m. ET, Monday–Friday.

Common dental insurance terms

Deductible: The amount you are responsible for before CareFirst pays for dental services.

Family deductible: A deductible that is satisfied by the combined expenses of all covered family members. For example, a plan with a $25 deductible may be limited to a maximum of three deductibles ($75 per family) regardless of the number of family members.

Coinsurance: Your share of the dentist's fee after CareFirst has paid its share.

Annual maximum: The yearly reimbursement level for an individual/family set by your CareFirst dental plan.

Section 3—Limitations and Exclusions

(in addition to those found in the Evidence of Coverage)

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. CareFirst benefits will cover treatment based upon the CareFirst allowance for the least expensive procedure, provided that the least expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the least expensive procedure. However, if the Subscriber and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

3.2 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 Evidence of Coverage.
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 when the dental services are received after the Effective Date of coverage under the Evidence of Coverage 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 Dental Service in the Description of Covered Services.
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 Dental Service in the Description of Covered Services.
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 fiberotomy 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 Description of Covered Services and the Evidence of Coverage.
S. Services or supplies that are not Medically Necessary.
T. Services not specifically listed in the Description of Covered Services 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).
Z. Class III, Class IV and Class V services incurred during a Member's Benefit Waiting Period (optional).