BlueDental Plus

Includes access to a national provider network

CareFirst BlueCross BlueShield (CareFirst) offers BlueDental Plus coverage, which allows you the freedom to see any dentist you choose.

Advantages of the plan

- **Freedom of choice, freedom to save**—With BlueDental Plus, 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 Preferred 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.
- **Nationwide access to participating dentists**—You have access to one of the nation's largest dental networks, with participating dentists throughout the United States. BlueDental Plus gives you coverage for the dental services you need, whenever and wherever you need them.

Three options for care

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you incur the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full, which means no balance billing for you. You are responsible for deductibles and coinsurance, and also have the convenience of your provider being reimbursed directly.
- **Option 2**—By choosing a dentist who participates with CareFirst, but not through the Preferred Provider Network, you incur slightly higher out-of-pocket costs. Similar to Option 1, there is no balance billing. You are responsible for deductibles and coinsurance, and also have the convenience of your provider being reimbursed directly.
- **Option 3**—You can receive out-of-network coverage from a dentist who has no relationship with CareFirst. With this option, you may experience higher out-of-pocket costs since you pay your provider directly. You can be balance billed and must pay your deductible and coinsurance as well.

Using your plan

How do I find a preferred dentist?

Visit **carefirst.com/doctor** to access our online directory 24 hours a day. Click on *Dental* and then select *BlueDental Plus*.

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 am and 5:00 pm ET, Monday–Friday.

Summary of Benefits

Washington Gas

	In-Network You Pay	Out-of-Network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$50 Individual/ $150 Family	$75 Individual/ $225 Family
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES* (standard would exclude Class I services)	Plan pays $1,000 combined 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, until the end of the year the member reaches the age 19) ▪ 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	20% of Allowed Benefit[1]
BASIC SERVICES		
▪ 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)	50% of Allowed Benefit after deductible[1]	40% of Allowed Benefit after deductible[1]
MAJOR SERVICES— SURGICAL AND RESTORATIVE		
▪ 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) ▪ 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) ▪ General anesthesia rendered for a covered dental service ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) ▪ 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)	50% of Allowed Benefit after deductible[1]	65% of Allowed Benefit after deductible[1]

[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.

* 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.

VA Benefits issued under policy form numbers: Group Hospitalization and Medical Services, Inc.: VA/GHMSI/BLUEDENTAL EOC (1/15); VA/GHMSI/BLUEDENTAL DOCS (1/15); VA/GHMSI/BLUEDENTAL SOB (1/15); VA/CF/GC (R.1/13); VA/CF/ELIG (R.1/12) and any amendments.

CareFirst

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.

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).