BlueDental EPO

Includes access to a national provider network

CareFirst BlueCross BlueShield (CareFirst) offers low-cost BlueDental EPO coverage, which combines our large national network with a convenient, predictable copay schedule for comprehensive dental benefits.

Advantages of the plan

- **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 EPO gives you coverage for the dental services you need, whenever and wherever you need them.
- **Affordability through predictable copays**—Your dental plan offers in-network preventive care, x-rays, dental surgery and more for a set copay. A summary of your benefits is available on the following page. Most preventive services, like exams, cleanings and x-rays, are covered in full without a deductible.
- **Simplicity & flexibility**—BlueDental EPO coverage keeps dental insurance simple. Since you can only receive care from an in-network dentist in our national network, you have no claim forms to file and referrals are not required.

Using your plan

How do I find an in-network dentist?

Visit **carefirst.com/doctor** to access our online directory 24/7. Click on Dental and then select *BlueDental EPO*. You must visit an in-network dentists to take advantage of your dental plan.

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 corresponding copays for the services. Your deductible must be met prior to obtaining coverage for certain services.

Is there a lot of paperwork?

No—there is no paperwork. Just show your membership card when you arrive at your dentist's office. Depending on the procedure, you will be required to pay your deductible and the corresponding copay for that procedure.

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.

Summary of Benefits

MyEyeDr.

Service	You Pay
DEDUCTIBLE	
(does not apply to Preventive & Diagnostic Services)	$25 individual / $75 family
ANNUAL MAXIMUM	
(does not apply to Preventive & Diagnostic Services and Orthodontic Services)	Plan pays up to $2,000
PREVENTIVE & DIAGNOSTIC SERVICES SERVICES	
Examination	$0
Prophylaxis	$0
Bitewing X-rays	$0
Sealants (per tooth)	$18
Space maintainers	$89-$132
FILLINGS	
Amalgam restorations (one surface)	$34
SOFT TISSUE MANAGEMENT	
Periodontal scaling and root planing	$64–$93
Full mouth debridement	$63
Periodontal maintenance procedures following active therapy	$60
RESTORATIVE SERVICES	
Crown—porcelain fused to predominantly base metal	$417
Crown—porcelain fused to high noble metal	$460
ENDODONTICS—ROOT CANAL THERAPY	
Anterior (excluding final restoration)	$311
Molar (excluding final restoration)	$529
DENTURES AND RELATED PROCEDURES	
Complete denture—maxillary or mandibular	$535
Partial denture—cast metal framework with resin denture bases	$622
Reline complete maxillary or mandibular denture (in dentist's office)	$108
Pontic—porcelain fused to high noble metal	$514
SURGICAL SERVICES	
Osseous Surgery (including flap entry and closure) per quadrant	$333–$478
Surgical removal of erupted tooth	$108
Removal of impacted tooth—completely bony	$198
ORTHODONTIC LIFETIME MAXIMUM	
(applies to Orthodontic Services)	Plan pays up to $2,000
ORTHODONTIC SERVICES	
Comprehensive—adolescent or adult	$2,576
Pre-orthodontic treatment visit	$40
Orthodontic retention	$150

CareFirst payments are based on the CareFirst Allowed Benefit. Only services received from an in-network dentist are covered under the BlueDental Exclusive Provider Organization (EPO) program.

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 issues under policy form numbers: VA/CF/DENTAL/GC (1/19); VA/CF/BLUEDENTAL EPO EOC (1/19); VA/CF/BLUEDENTAL EPO DOCS (R. 4/19); VA/CF/BLUEDENTAL EPO DOCS LG (4/19); VA/CF/BLUEDENTAL EPO SOB I-V (R. 4/19); VA/CF/BLUEDENTAL EPO SOB 1-V LG (4/19); VA/CF/ELIG (R. 1/12) and any amendments.

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LIMITATIONS AND EXCLUSIONS (in addition to those found in the Evidence of Coverage)

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, bridges, and implants, 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 less expensive procedure, provided that the less expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the less 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.
F. Dental procedures not listed on the Schedule of Benefits and Copayments will be provided at the dentist's charges unless written approval is received from CareFirst.
G. The American Dental Association (ADA) may periodically change the Current Dental Terminology (CDT) Codes or definitions listed in the ADA publications. If such changes result in different CDT codes being used by Preferred Dentists or Participating Dentists to describe the Covered Dental Services listed in the Schedule of Benefits and Copayments, the Member Copayments will be determined by CareFirst. CareFirst will notify the Subscriber of such changes when applicable.
H. All services listed on the Schedule of Benefits and Copayments will be provided by a Participating Dentist or a Preferred Dentist.
I. Oral examination, routine teeth cleaning (prophylaxis), topical fluoride up to age 19, and pulp vitality tests not related to accidental injury or trauma or emergency limited to twice per Benefit Period.

Exclusions

Benefits will not be provided for:

A. Replacement of a denture, bridge, dental implant, or crown as a result of loss or theft.
B. Replacement of an existing denture, bridge, dental implant, or crown that is determined by CareFirst to be satisfactory or repairable.
C. Replacement of dentures, bridges, dental implants, 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. All Member Copayments listed on the Schedule of Benefits and Copayments are exclusive of gold.
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. Services not specifically listed in the Description of Covered Services as a Covered Dental Service, even if Medically Necessary.
R. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
S. 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.
T. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
U. Services or supplies that are Experimental or Investigational in nature.
V. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws.
W. Services which are provided without cost to the Member by any municipality, county or other political subdivision (with the exception of Medicaid).
X. Services which, in the opinion of the Dental Director, are not Medically Necessary for the Member's dental health.
Y. Cosmetic, elective, or aesthetic dentistry, which in the opinion of the Dental Director are not necessary for the Member's dental health;
Z. Oral surgery requiring the setting of fractures or dislocations.
AA. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations unless specifically listed as a Covered Dental Service in the Description of Covered Services.
AB. Hospitalization for any dental procedure.
AC. General anesthesia.
AD. Services which are obtained from a Non-Participating Dentist unless specifically listed as a Covered Dental Service in the Description of Covered Services.
AE. Additional fees charged for dental services which cannot be performed in the dental office of a Participating Dentist or Preferred Dentist due to the special needs or health related conditions of the Member. CareFirst shall provide the benefits for the Covered Dental Service as if the dental services were rendered in the Dentist's office during normal office hours. Any additional facility and professional fees charged shall be the Member's responsibility.
AF. Any service, supply or item that is not Medically Necessary for the Member's dental health. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary for the Member's dental health as determined by CareFirst.
AG. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
AH. The repair or replacement of any orthodontic appliance.
AI. 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 Evidence of Coverage.
AJ. Class III, Class IV, and Class V services incurred during a Member's Benefit Waiting Period (if applicable).

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