

# Dental Plan Comparison

Benefit	Individual Select DHMO	Individual Select Preferred Dental		BlueDental Preferred			
	In-Network Only Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays		Out-of-Network Member Pays	
				High Option	Low Option	High Option	Low Option
Preventive & Diagnostic Services (Class I)	\$20 copay per office visit	No charge	Member pays provider's full charge and submits claim to be reimbursed CareFirst's Allowed Benefit. (Member is responsible for any difference between the CareFirst Allowed Benefit and the Dentist's billed charge.)	No charge	No charge after deductible	20% of Allowed Benefit <sup>2</sup>	20% of Allowed Benefit <sup>2</sup> after deductible
Basic Services (Class II) <i>Fillings, non-surgical periodontics, simple extractions</i>	\$20-\$70 copay per office visit	Not covered <sup>1</sup>		20% of Allowed Benefit <sup>2</sup> after deductible	20% of Allowed Benefit <sup>2</sup> after deductible	40% of Allowed Benefit <sup>2</sup> after deductible	40% of Allowed Benefit <sup>2</sup> after deductible
Major Services—Surgical (Class III) <i>Surgical periodontics, endodontics, oral surgery</i>	<u>Copays per service</u>	Not covered <sup>1</sup>		20% of Allowed Benefit <sup>2</sup> after deductible	20% of Allowed Benefit <sup>2</sup> after deductible	40% of Allowed Benefit <sup>2</sup> after deductible	40% of Allowed Benefit <sup>2</sup> after deductible
Major Services—Restorative (Class IV) <i>Inlays, onlays, dentures, bridges, crowns</i>	<u>Copays per service</u>	Not covered <sup>1</sup>		50% of Allowed Benefit <sup>2</sup> after deductible	50% of Allowed Benefit <sup>2</sup> after deductible	65% of Allowed Benefit <sup>2</sup> after deductible	65% of Allowed Benefit <sup>2</sup> after deductible
Orthodontic Services (Class V)	Child: \$2,500 per member Adult: \$2,700 per member	Not covered <sup>1</sup>		50% of Allowed Benefit <sup>2</sup>	50% of Allowed Benefit <sup>2</sup>	65% of Allowed Benefit <sup>2</sup>	65% of Allowed Benefit <sup>2</sup>
Orthodontic Services Maximum (Class V)	No Maximum	Not applicable		No plan maximum, medically necessary orthodontia only for members age 19 and under			
Annual Maximum (Classes I-IV)	No Maximum	No Maximum		Members up to age 19: No Maximum. Members age 19 and over: Plan pays \$1,000 combined maximum for in- and out-of-network covered services per calendar year per member, then member pays balance.			
Maximum Out-of-Pocket	No Maximum	No Maximum		One member pays up to \$350; Two or more members pay up to \$700 (for members up to age 19)	One member pays up to \$350; Two or more members pay up to \$700 (for members up to age 19)	No Maximum	No Maximum
Deductible	None	None		\$60 Individual/ \$180 Family <sup>3</sup> Applies to Classes II, III & IV	\$100 Individual/ \$300 Family <sup>3</sup> Applies to Classes I-IV	\$120 Individual/ \$360 Family <sup>3</sup> Applies to Classes II, III & IV	\$200 Individual/ \$600 Family <sup>3</sup> Applies to Classes I-IV

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	In-Network Only Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays		Out-of-Network Member Pays	
				High Option	Low Option	High Option	Low Option
Benefit Waiting Periods	None	None		None			
Network	Over 600 providers in MD, DC, and Northern VA. <a href="#">Find a Dental Provider</a> , click on <i>Dental HMO</i> then <i>DHMO-IND20</i>	Over 5,000 providers in MD, DC, and Northern VA. <a href="#">Find a Dental Provider</a> , click on <i>Individual Select Preferred</i>		Over 5,000 providers in MD, DC, and Northern VA. 123,000 dentists nationally. <a href="#">Find a Dental Provider</a> , click on <i>Preferred Dental (PPO)</i>			
Claim Forms	No	Out-of-network only		None		Yes	
Out-of-Area Emergency Care	Limited to \$50 per member per emergency	Out-of-network benefit applies		When visiting a dentist in the national network, benefits are paid based on the In-Network coinsurance.			
Select a Primary Care Dentist	Yes	No		No			
Referrals Required	Yes	No		No			
Guaranteed Acceptance	Yes	Yes		Yes			
Key Advantages	<ul style="list-style-type: none"> <li>■ Predictable out-of-pocket costs with set copays</li> <li>■ One copay per office visit for preventive, diagnostic and basic dental services, including exams, cleanings, X-rays, sealants, and simple extractions</li> <li>■ One copay per office visit for soft tissue management services (periodontics)</li> <li>■ No deductibles</li> <li>■ No claim forms</li> <li>■ No annual maximums</li> <li>■ Orthodontia for children and adults</li> </ul>	<ul style="list-style-type: none"> <li>■ Freedom of provider choice</li> <li>■ No requirement to pre-select a Primary Care Dentist</li> <li>■ Large provider network across MD, DC and Northern VA</li> <li>■ No deductibles</li> <li>■ No annual maximum</li> <li>■ No referrals required</li> <li>■ No claim forms when using a participating provider</li> </ul>		<ul style="list-style-type: none"> <li>■ Freedom of provider choice</li> <li>■ No requirement to pre-select a Primary Care Dentist</li> <li>■ Large national provider network</li> <li>■ No referrals required</li> <li>■ No claim forms when using a participating provider</li> <li>■ Coverage for many services in all Dental Classes</li> <li>■ High Option: No deductible for Preventive/Diagnostic and Orthodontic Services</li> <li>■ Low Option: Low premiums</li> </ul>			

"Child" is an eligible child up to age 26.

- <sup>1</sup> Providers are not required to accept CareFirst's Allowed Benefit on non-covered services. This means you may have to pay your dentist's entire billed amount for these non-covered services. At your dentist's discretion, they may choose to accept the CareFirst Allowed Benefit, but are not required to do so. Please talk with your dentist about your cost for any dental services.
- <sup>2</sup> CareFirst payments are based upon the CareFirst Allowed Benefit. Participating dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for any amount over the Allowed Benefit.
- <sup>3</sup> The family deductible amount is calculated in the aggregate—no member charged more than individual deductible amount. In-network and out-of-network deductibles will be separate amounts.

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. Additional benefit information and plan policy form numbers are available upon request.

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