BlueDental Preferred—High Option

Summary of Benefits	In-Network Member Pays	Out-of-Network Member Pays
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.	$60 Individual Deductible $180 Family Deductible	$120 Individual Deductible $360 Family Deductible
OUT-OF-POCKET MAXIMUM (CLASSES I–V) FOR MEMBERS UP TO AGE 19	One member pays up to $350; Two or more members pay up to $700	No limit
ANNUAL MAXIMUM (CLASSES I-IV) FOR MEMBERS OVER AGE 19		
▪ The in-network and out-of-network annual maximum is a combined amount.	Plan pays up to $1,000 per member	
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)		
▪ Oral Exams (twice per year) ▪ Prophylaxis (cleanings, twice per year) ▪ Bitewing X-Rays (twice per year) ▪ Fluoride treatments* until the end of the year in which member reaches age 19 ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray* ▪ Sealants on permanent molars* until the end of the year in which member reaches age 19 ▪ Space maintainers* ▪ Palliative treatments ▪ Emergency oral exam	No charge	20% of Allowed Benefit**
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials* ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of Allowed Benefit** after deductible	40% of Allowed Benefit** after deductible
MAJOR SERVICES – SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments* ▪ 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, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	20% of Allowed Benefit** after deductible	40% of Allowed Benefit** after deductible
MAJOR SERVICES – RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining* ▪ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance for members over age 19) ▪ Dental implants, fixed bridges (once per 60 months for members age 19 and over) ▪ Athletic mouthguard (once per 12 months for members under age 19)	50% of Allowed Benefit** after deductible	65% of Allowed Benefit** after deductible
ORTHODONTIC SERVICES (CLASS V)		
▪ Benefits for medically necessary orthodontic services are available for covered members until the end of the calendar year in which a member reaches the age of 19.	50% of Allowed Benefit**	65% of Allowed Benefit**

Not all services and procedures are covered by the BlueDental Preferred contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan contract.
*Frequency limitations may apply.
**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 members for the difference between the Allowed Benefit and their charges.

These benefits are issued under policy form numbers:

CareFirst of Maryland, Inc.:CFMI/EXC/DEN/IEA (1/14), CFMI/DB/PREF DENT DOCS-SOB (R. 1/15), CFMI/EXC/2015 DENTAL AMEND (1/15), and any amendments.

Group Hospitalization and Medical Services, Inc.: MD/CF/EXC/DEN/IEA (1/14), MD/CF/DB/PREF DENT DOCS-SOB (R. 1/15), MD/CF/EXCH/2015 DENTAL AMEND (1/15), and any amendments.

CareFirst