CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Membership and Product Information

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., and The Dental Network (collectively CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through **email** and ***BlueImpressions***, our online Dental provider newsletter.

Specific requirements of a member's Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels **CareFirst Direct** or **CareFirst on Call**. Through these channels, simple questions can be answered quickly.

Membership

Member's Rights and Responsibilities

Members have a right to:

- be treated with respect and recognition of their dignity and right to privacy
- receive information about the Health Plan, its services, its practitioners and providers, and members rights and responsibilities
- participate with practitioners in making decisions regarding their health care
- discuss appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- make recommendations regarding the organization's members' rights and responsibilities policies
- voice complaints or appeals about the their plan or the care provided
- provide, to the extent possible, information that the Health Plan and its practitioners and providers need in order to care for them
- understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- follow the plans and instructions for care that they have agreed on with their practitioners
- pay member copayments or coinsurance at the time of service
- be on time for appointments and to notify practitioners/providers when an appointment must be canceled

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Dental Products

CareFirst Traditional Dental

Traditional Dental members may seek treatment from any Participating Provider in the network. Reimbursement is based on 100 percent of the Traditional Allowed Benefit (AB) with applicable deductibles and co-insurance. Members seeking treatment from non-participating providers receive 100 percent of the AB for covered services, subject to deductibles, co-insurance and balance billing.

CareFirst Preferred Dental

Preferred Dental Members may seek treatment from any Preferred Dental Provider in the network. Reimbursement is based at 100 percent of the Preferred Allowed Benefit with applicable deductibles and coinsurance. Members seeking treatment from participating (not a preferred provider) may receive benefits at a reduced rate and are subject to billing up to the Traditional Allowed Benefit. Members seeking treatment from non-participating providers receive benefits at a reduced rate and are subject to deductibles, coinsurance and balance billing.

CareFirst BlueChoice and The Dental Network (DHMO)

DHMO members are required to select a general dentist who participates in their plan as their primary care dentist. If members do not select a primary care dentist, one will be assigned. If a member needs to see a specialist for dental procedures, they should obtain a referral from their primary care dentist to an in-network specialist.

CareFirst BlueChoice Discount Dental Program

Discount Dental is a free discount program offered to all CareFirst BlueChoice Medical HMO members at no additional cost. Members have access to any provider who participates in DHMO Discount Dental Program and can receive discounts on dental services through this program. Because it is a discount program and not a covered benefit, there are no claim forms, referrals or paperwork to complete. Members must show their CareFirst BlueChoice membership card and pay the discounted fee at the time of service to save.

CareFirst Individual Select Preferred (ISP)

The Individual Select Preferred (ISP) is designed to utilize the CareFirst Participating and Preferred Provider Networks. This product offers its enrollees full coverage for Preventive/Diagnostic (Class I) services provided the services are performed by an in-network dentist. Participating Providers are only required to file claims for Class I services. Services in the Class II, III, IV and V categories may be billed directly to the member at the time of service, at the provider's usual charge.

ACA embedded Pediatric Dental

Health Insurance Exchanges in Maryland, the District of Columbia, and Virginia established under the Affordable Care Act (ACA) enroll individuals and families who purchase health insurance plans offered by CareFirst and other carriers. CareFirst's medical plans offered in the individual and small group markets (both on and off of the Exchange) have the mandated 10 Essential Health Benefits (EHB), which include a pediatric dental benefit. They do not include an adult dental EHB; dental coverage for adults age 20 and older must be purchased through a separate dental plan.

FEP BlueDental

The Blue Cross Blue Shield Association (BCBSA) has partnered with the GRID Dental Corporation (GDC) to administer FEP BlueDental. FEP BlueDental members will be able to utilize the GRID+ network as an in-network provider source. By participating with CareFirst, providers will now have access to FEP BlueDental members. The member's card will be identified with FEP BlueDental, along with the claims submission address and customer service number to verify benefits. FEP members enrolled in both medical coverage and the FEP BlueDental plan should always consider their medical coverage primary. Claims for members who enroll in both the BCBS FEP Service Benefit medical plan and FEP BlueDental should always be sent to the BCBS FEP Service Benefit medical plan first, for primary consideration, and are automatically routed to FEP BlueDental for secondary coverage consideration.

FEHBP

The FEP Preferred Dental plan is offered to employees of the Federal Government. This coverage is included in the member's medical plan, and benefits are subject to negotiated, discounted amounts referred to Maximum Allowable Charges (MACs) as payment

in full for services listed on FEP's schedule of benefits. Services not listed under the FEP's schedule of benefits will be member liability, based on the provider's charge. Members can choose from the Standard Option plan or the Basic Option plan.

Identifying Product Type by Indicator

All membership ID cards have a dental indicator that tells what type of dental plan covers the member.

- Traditional Dental members are identified by the DT indicator on their ID card
- Preferred Dental members are identified by the DP indicator on their ID card
- Individual Select Preferred Dental members are identified by the DS indicator on their ID card
- DHMO Dental members are identified by the DH indicator on their ID card
- ACA Pediatric Dental members are identified by the PD indicator on their ID card
- GRID or GRID+ Dental members are identified by the GRID or GRID+ indicator on their ID card
- NCAS and CareFirst Administrators (CDA) Dental members are identified by the NCAS or CFA logo in the top left hand corner on their ID card