How Orthodontic Benefits are Paid

The standard CareFirst orthodontia benefit, if included in the dental plan, covers orthodontic service until the end of the month in which a member reaches age 19, regardless of any treatment that may be in progress. Some plans do not cover orthodontic treatment at all. Your orthodontist will work with you to determine what treatment works best for you and your family.

CareFirst does NOT reduce the lifetime maximum because of a previous dental carrier’s payment to the service.

On the following pages are examples of how orthodontic benefits are paid based on different circumstances. These scenarios assume a Traditional Dental product with a lifetime maximum benefit of $1,200 and a $3,000 allowed benefit for orthodontic treatment. If the member is receiving treatment from a participating orthodontist, the member and the plan will each pay 50 percent coinsurance of the allowed benefit, with the plan paying up to the orthodontic lifetime maximum benefit amount of $1,200. The member is responsible for the difference between the lifetime maximum and the allowed benefit.
Scenario 1—New orthodontia treatment

The benefit for orthodontic treatment is provided in quarterly installments, and is determined on the anticipated length of treatment, as specified by the orthodontist. Orthodontists will submit one claim for the entire orthodontic course of treatment. Twenty-five percent of the member’s lifetime maximum for orthodontic services will be paid upon the initial placement of the bands.

Payments of the remaining allowance will be divided into equal monthly amounts and paid quarterly. Members seeking treatment from a participating orthodontist are responsible for the coinsurance percentage associated with the treatment; the amount of member liability should not exceed the CareFirst allowed benefit. The allowance for the comprehensive treatment will be determined at the time the appliance (e.g. braces, retainer, headgear, etc.) is placed; any increase in allowances that may occur during the course of treatment will not apply to orthodontic cases in progress.

Example #1—Participating orthodontist

The orthodontic treatment plan costs $5,000 for 24 months.

<table>
<thead>
<tr>
<th>CareFirst’s initial payment</th>
<th>$300</th>
<th>25% of the member’s orthodontic lifetime maximum, $1,200.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareFirst is responsible for the remaining payment</td>
<td>$900</td>
<td>$900 ÷ 23 months x 3 = $117.39 plus final payment of $78.27 in the 8th quarter.</td>
</tr>
<tr>
<td>CareFirst allowed benefit</td>
<td>$3,000</td>
<td>$3,000 allowed benefit – $1,200 = $1,800</td>
</tr>
<tr>
<td>The member will be liable for</td>
<td>$1,800</td>
<td>$3,000 allowed benefit – $1,200 = $1,800</td>
</tr>
</tbody>
</table>

Example #2—Non-participating orthodontist

The orthodontic treatment plan costs $5,000 for 24 months.

<table>
<thead>
<tr>
<th>CareFirst’s initial payment</th>
<th>$300</th>
<th>25% of the member’s orthodontic lifetime maximum, $1,200.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareFirst is responsible for the remaining payment</td>
<td>$900</td>
<td>$900 ÷ 23 months x 3 = $117.39 plus final payment of $78.27 in the 8th quarter.</td>
</tr>
<tr>
<td>The member will be liable for any charges in excess of the CareFirst payment</td>
<td>$3,800</td>
<td>$5,000 – $1,200 = $3,800</td>
</tr>
</tbody>
</table>
Scenario 2—CareFirst coverage becomes effective after the start of an ongoing orthodontic treatment plan

Members enrolled after the placement of the appliance (e.g. braces, retainer, headgear, etc.) are eligible to receive orthodontia benefits for the treatment in progress. CareFirst will consider a benefit based on the cost of the remainder of the treatment plan. CareFirst will prorate an orthodontic claim if the banding date is before the members’ effective date. Providers will submit the total charges, banding date and number of treatment months for the treatment to be rendered. The prorated payments will be different dependent upon the length of treatment.

Example #1—36 month treatment plan, participating orthodontist

The orthodontic treatment plan costs $5,000 for 36 months and the member had 20 months in treatment prior to CareFirst coverage effective date.

<table>
<thead>
<tr>
<th>Monthly treatment plan cost</th>
<th>$138.89</th>
<th>$5,000 ÷ 36 months = $138.89</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total amount CareFirst will not cover for benefit</td>
<td>$2,777.80</td>
<td>$138.89 x 20 months = $2,777.80</td>
</tr>
<tr>
<td>New total charge for benefit and what CareFirst and the member will pay over the next 16 months</td>
<td>$2,222.20</td>
<td>$5,000 – 2,777.80 = $2,222.20</td>
</tr>
</tbody>
</table>

$2,222.20 is less than the allowed benefit of $3,000; therefore, CareFirst and the member share the total cost over the remaining 16 months of covered treatment (36 total months of treatment minus 20 months of coverage already received before CareFirst coverage effective date).

<table>
<thead>
<tr>
<th>Total member is responsible for</th>
<th>$1,111.10</th>
<th>Member is responsible for 50 percent coinsurance ($2,222.20 x 50% = $1,111.10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total amount CareFirst is responsible for</td>
<td>$1,111.10</td>
<td>Since the coinsurance is lower than the orthodontic lifetime maximum of $1,200, CareFirst will pay the remaining balance, after the member pays 50 percent coinsurance. CareFirst will make an initial payment of $69.44 ($1,111.10 ÷ 16 months = $69.44) and then 4 quarterly payments of $208.32, plus a final payment of $208.38.</td>
</tr>
</tbody>
</table>
Example #2—24 month treatment plan, participating orthodontist

The orthodontic treatment plan costs $5,000 for 24 months and the member had 20 months in treatment prior to CareFirst coverage effective date.

<table>
<thead>
<tr>
<th>Monthly treatment plan cost</th>
<th>$208.33</th>
<th>$5,000 ÷ 24 months = $208.33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total amount CareFirst will not cover for benefit</td>
<td>$4,166.60</td>
<td>$208.33 × 20 months = $4,166.60</td>
</tr>
</tbody>
</table>

**New total charge for benefit and what CareFirst and the member will pay over the next 16 months**

- **$833.40**
  - $5,000 – 4,166.60 = $833.40
  - $833.40 is less than the allowed benefit of $3,000; therefore, CareFirst and the member share the total cost over the next 4 months of covered treatment (24 total months of treatment minus 20 months of coverage already received before CareFirst coverage effective date).

**Total member is responsible for**

- **$416.70**
  - Member is responsible for 50 percent coinsurance ($833.40 × 50% = $416.70)

**Total amount CareFirst is responsible for**

- **$416.70**
  - Since the coinsurance is lower than the orthodontic lifetime maximum of $1,200, CareFirst will pay the remaining balance, after the member pays 50 percent coinsurance.
  - CareFirst will make an initial payment of $104.18 ($416.70 ÷ 4 months = $104.18) and then one quarterly payment of $312.52.

This information applies to most standard insured Traditional Dental plans. This information does not apply to Affordable Care Act (ACA) plans.
Virginia—Limitations and Exclusions
GHMSI Traditional Dental Group Contact
(in addition to those found in the Evidence of Coverage)

1.1 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) (optional).
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.

1.2 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 Contract.
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 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 service in the Contract.
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 service in the Contract.
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 Evidence of Coverage.
S. Services or supplies that are not Medically Necessary.
T. Services not specifically shown in the Contract 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.

Benefits issued under policy form numbers:

1) Dental Freestanding/Non-Rider contract policy form numbers—Group Regional Traditional Dental:
Group Hospitalization and Medical Services, Inc. (DC jurisdiction): DC/CF/GC (R. 1/13), DC/CF/EOCD-V (1/12), DC/CF/DO-DOCS (R. 10/11), DC/CF/DO-SOB (R. 1/04), DC/CF/ELIG (9/04) and any amendments.
CareFirst of Maryland, Inc. (MD Groups in CFMI Service Area): CFMI/51+/GC (R. 1/13) • CFMI/EOCD-V (R. 10/11) • CFMI/DENTAL DOCS (R. 9/11) • CFMI/DETO-DENTAL (7/09) • CFMI/ELIG/D-V (7/09) and any amendments.
Group Hospitalization and Medical Services, Inc. (MD Groups in GHMSI Service Area): MD/CF/DOCS (R. 1/13) • MD/CF/DO-DOCS (R. 10/11) • MD/CF/DENTAL DOCS (R. 9/11) • MD/CF/DO-SOB (7/03) • MD/CF/ELIG (R. 1/08) and any amendments.
Group Hospitalization and Medical Services, Inc. (VA/CF): VA/CF/DENTAL (R. 1/13) • VA/CF/EOCD-V (1/12) • VA/CF/DO-SOB (R. 10/11) • VA/CF/DO-DOCS (R. 9/11) • VA/CF/SOBD (R. 1/04) • VA/CF/ELIG (1/12); and any amendments.

2) Dental Rider policy form numbers—Group Regional Traditional Dental:
CareFirst of Maryland, Inc. Dental Rider (MD Groups in CFMI Service Area): CFMI/51+/DENTAL RIDER (4/09);
Group Hospitalization and Medical Services, Inc. Dental Riders: MD/CF/DENTAL RIDER (R. 4/08); DC/CF/DENTAL RIDER (R. 6/09); VA/CF/DO RDR (R. 6/09).