Chapter 5 — Dental Plan

**Fast Facts**

- You have three options for dental coverage.
  - Two preferred provider organization (PPO) plans
  - A dental health maintenance organization (DHMO)

The university health coverage offers dental plan options covering a range of services and procedures including exams and cleanings, fillings, x-rays, oral surgery, dentures and orthodontics.

The three dental plans offered are:

- CareFirst BlueCross BlueShield (BCBS)
- CIGNA
- United Concordia ConcordiaPLUS®

Each plan offers a choice of network and, in some cases, non-network providers for dental services. The cost of your care depends on your choice of provider and the type of service rendered.

CareFirst BlueCross BlueShield and CIGNA dental plans operate as Preferred Provider Organization (PPO) plans. Network "preferred providers" under these plans have agreed to provide service at a lower cost to you than non-preferred providers. Preferred providers are considered to be “in-network” and non-preferred providers are “out-of-network.”

United Concordia ConcordiaPLUS operates similar to a Health Maintenance Organization (HMO). This plan has a network of participating dental offices. The cost of services provided is based on a negotiated fee with the plan provider. You must select a Primary Dental Office (PDO) for you and all your dependents. (Each family member may select a different PDO.) To find a PDO, visit the Concordia Web site at [www.unitedconcordia.com](http://www.unitedconcordia.com) or call customer service at 1-866-357-3304. You may change your PDO at any time by calling customer service; changes take effect the first day of the month after you notify customer service. Any service received outside of your approved Primary Dental Office (PDO) is not covered.

**What’s Covered**

Dental plan coverage under the JHU options is divided into four categories of service (called “Classes”). The cost of covered services varies for each class and for the type of dental provider you see (in-network or out-of-network). Refer to the next table for the coverage amounts for each option.
## Benefits At-A-Glance

The table below is an overview of covered services. Any limitations or exclusions for services are listed in the Limitations and Exclusions section of this chapter.

<table>
<thead>
<tr>
<th>Class</th>
<th>CAREFIRST BCBS DENTAL PLAN</th>
<th>CIGNA DENTAL PLAN</th>
<th>ConcordiaPLUS® DENTAL PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Calendar Year</td>
<td>$0</td>
<td>$50 individual $100 family</td>
<td>$0</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Class I</td>
<td>100% of allowable charges</td>
<td>100% of allowable charges</td>
<td>100% of allowable charges</td>
</tr>
<tr>
<td>Diagnostic &amp;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cleanings, x-rays,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>office visits (no</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>deductible applies)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class II</td>
<td>75% of allowable charges</td>
<td>75% of allowable charges, subject to deductible</td>
<td>75% of allowable charges, subject to deductible</td>
</tr>
<tr>
<td>Basic Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fillings, root</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>canals, periodontics,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class III</td>
<td>50% of allowable charges</td>
<td>50% of allowable charges, subject to deductible</td>
<td>50% of allowable charges, subject to deductible</td>
</tr>
<tr>
<td>Major services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dentures, crowns &amp;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bridges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class I, II, &amp; III</td>
<td>$1,500 combined</td>
<td>$1,500 combined</td>
<td>No maximum</td>
</tr>
<tr>
<td>Calendar Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class IV</td>
<td>50% of allowable charges</td>
<td>50% of allowable charges</td>
<td>50% of allowable charges</td>
</tr>
<tr>
<td>Orthodontics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>$1,500 total for in-network and out-of-network</td>
<td>$1,500 total for in-network and out-of-network</td>
<td>No maximum</td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(Class IV only)</td>
<td></td>
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</table>
Class I: Preventive & Diagnostic Services
Subject to the limitations and provisions of the Plan, the following preventive and diagnostic services are covered by the JHU dental options. Coverage amounts vary by option, dental provider and type of service. Refer to the Benefits-At-A-Glance chart in this chapter for coverage amounts. A summary of covered preventive and diagnostic services for each option is listed below.

CareFirst BlueCross BlueShield

Twice per calendar year
- Oral exam
- Bitewing x-rays (not occurring at same time as full mouth or panograph x-rays)
- Routine cleaning (except when diagnosed with periodontal disease, two (2) additional cleanings)
- Topical fluoride
- Pulp vitality tests

Once per 36 months
- One set of full mouth x-rays or one panograph x-ray and one additional set of bitewing x-rays
- One cephalometric x-ray or periapical and occlusal x-ray
- One sealant per tooth on permanent molars

Once per 60 months
- Space maintainers (prematurely lost cuspid to posterior deciduous teeth)

As required
- Palliative treatments
- Emergency oral exam
- Histopathology exams and other oral pathology procedures by report
- Periapical and occlusal x-rays
- Professional consultation rendered by a dentist, limited to one consultation per dentist per condition

CIGNA

Twice per calendar year
- Oral exam
- Bitewing x-rays
- Routine cleaning
One per calendar year

• Topical fluoride, excludes prophylaxis (until age 19)

One per three calendar years

• Complete series of x-rays, including panoramic
• Topical application of sealant per tooth (until age 14)

As required

• Periodontal maintenance procedures (following active therapy); periodontal prophylaxis
• Space maintainers, fixed unilateral (limited to nonorthodontic treatment)
• Emergency treatment of dental pain

**United Concordia ConcordiaPLUS**

Covered services

• Oral exam
• Routine x-rays
• Routine cleaning (one per six months)
• Topical fluoride
• Periodontal maintenance (two per year)
• Space maintainers (until age 18)
• Sealants are eligible for members to age 16 on permanent first and second molars
• Pulpal therapy (age 5 on 1 degree anterior teeth, age 11 on 1 degree posterior teeth)
• Emergency care (if within 50 miles of your home, an applicable copay may apply)

**Class II: Basic and Restorative Services**

Subject to the limitations and provisions of the Plan, the following basic and restorative services are covered by the JHU dental options. Coverage amounts vary by option, dental provider and type of service. Refer to the Benefits-At-A-Glance chart in this chapter for coverage amounts. A summary of covered basic and restorative services for each option is listed below.

**CareFirst BlueCross BlueShield**

Primary Maintenance Services

• Direct placement fillings, including direct pulp caps, limited to silver amalgam, silicate, plastic, composite, or equivalent material approved by CareFirst
• Services as required
  - Root tip removal
  - Pulpotomy for deciduous teeth
  - Root canal for permanent teeth
  - Root canal retreatment performed on permanent teeth limited to once per tooth per lifetime
  - Root resection
  - Other endodontics
  - Repair of removable dentures
  - Recementation of crowns, inlays, and or bridges
  - Stainless steel crowns
  - Visits by a dentist to the Member’s home when medically necessary to render a covered dental service

Primary Oral Surgical Services
• Services as required
  - Surgical extractions, including impactions
  - Oral surgery, including treatment for cysts, tumors and abscesses
  - Oral surgery performed for the preparation of the mouth for dentures
  - Biopsies of oral tissue if a biopsy report is submitted
  - General anesthesia and or intravenous sedation, if required for oral surgery and administered by a dentist who has a permit to administer conscious sedation or general anesthesia
  - Apicoectomy
  - Hemi-section

Primary Periodontic Services
• Services limited to once per 24 months, one full mouth treatment
  - Periodontal scaling and root planing
  - Gingival curettage
• Services limited to once per 60 months
  - One full mouth treatment
    - Osseous surgery, including flap entry and closure
    - Gingivectomy
• Limited or complete occlusal adjustments in connection with periodontal treatment
• Mucogingival surgery limited to grafts and plastic procedures; one treatment per site
**CIGNA**

As required

- Fillings
- Root canal
- Simple extractions
- Surgical extractions
- Osseous surgery
- Periodontal scaling and root planing
- Denture adjustments
- Recement bridges

**United Concordia ConcordiaPLUS**

Covered services

- Fillings
- Root canal (one per tooth, per lifetime)
- Simple extractions
- Periodontal scaling and root planing (one per 24 months)
- Other services - per schedule

**Class III: Major Services**

Subject to the limitations and provisions of the Plan, the following major services are covered by the JHU dental options. Coverage amounts vary by option, dental provider and type of service. Refer to the Benefits-At-A-Glance chart in this chapter for coverage amounts. A summary of covered major services for each option is listed below.

**CareFirst BlueCross BlueShield**

Covered Services

- Services limited to 60 months
  - Dentures, full and/or partial
  - Fixed bridges, including crowns, inlays and onlays used as abutments for or as a unit of the bridge
  - Crowns, inlays, onlays
• Denture adjustments and relining Limited to
  - “Regular” dentures: once per 36 months, but not within six months of initial placement
  - “Immediate” dentures
    - Initial adjustment/relining after three months of placement
    - Second adjustment/relining within the first twelve months
    - Third adjustment/relining 36 months thereafter

• Repairs of fixed bridge

**CIGNA**

As required
• Bridges
• Crowns
• Full and partial dentures
• Prosthesis over implants - a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is a least 5 calendar years old, is not serviceable and cannot be repaired

**United Concordia ConcordiaPLUS**

One per five years
• Full and partial dentures
• Other services - per schedule

One per tooth per five years
• Bridges
• Crowns
• Inlays and onlays
• Buildups
• Posts
• Cores

**Class IV: Orthodontia**
Subject to the limitations and provisions of the Plan, the following orthodontic services are covered by the JHU dental options. Coverage amounts vary by option, dental provider, and type of service. Refer to the Benefits-At-A-Glance chart for coverage amounts. A summary of covered orthodontic services for each option is listed below.
**CareFirst BlueCross BlueShield**

Benefits for orthodontic services will be available to all Members.

**Covered benefits**

- The first and later installments of orthodontic services
- All orthodontic services treatments that reduce or eliminate an existing malocclusion and associated oral diseases

**Limitation**

The length of time for orthodontic services treatment shall be no more than 36 consecutive months of covered services

**CIGNA**

- The first month of active treatment including orthodontic work-up (x-rays, diagnostic casts, treatment plan and retention appliance)
- Continued active treatment after the first month
- One appliance (fixed or removable) for either tooth guidance or to control harmful habits

**United Concordia ConcordiaPLUS**

- Adults and children covered
- Limited orthodontic treatment
- Interceptive orthodontic treatment
- Comprehensive orthodontic treatment (two year treatment)
- All services - per schedule

**Limitations on Coverage**

The following limitations apply to services covered by the JHU dental options.

**CareFirst BlueCross BlueShield**

The following are the limitations on coverage by CareFirst BlueCross BlueShield:

- Services must be performed by or under the supervision of a dentist
- Standard procedures are covered, not personalized restorations or specialized techniques in the construction of dentures or bridges
- During the course of treatment, if a participant switches dentists or more than one dentist renders services for a dental procedure, coverage will be as if one dentist rendered the service
- Reimbursements will only occur after all dental procedures have been completed (exception for Orthodontic Services)
- If there are alternative dental procedures (but meet generally accepted standards of professional dental care) for a participant’s conditions, benefits will be based upon the lowest cost alternative (unless approved through CareFirst’s precertification process).
**CIGNA**

No payment will be made for expenses incurred for you or any of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers’ compensation or similar laws;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the Benefits-At-A-Glance chart;
- For charges for unnecessary care, treatment or surgery;
- For healthcare services determined to be furnished as a result of a referral prohibited by Maryland statues;
- To the extent that you or your dependents is any way paid or entitled to payment for those expenses by through a public program, other that Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

**United Concordia ConcordiaPLUS**

There is limited coverage for the services rendered in the following situations:

- Referrals to specialty care dentists are limited to orthodontics, oral surgery, periodontics, endodontics and pediatrics
- Coverage for referral to a pediatric specialty care dentist terminates on the 7th birthday. Exceptions are made for physical or mental handicaps or medically compromised children, when confirmed by a physician, and may be considered on an individual basis with prior approval
- Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts, frenectomy and crown lengthening
- If a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist, an alternate benefit provision (ABP) may be applied. The ABP does not, however, commit you to the less costly treatment. If you and the dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the ABP
- If an emergency occurs more than 50 miles from home, you are covered up to $50 per visit to see a non-PDO dentist
- Restorations, crowns, inlays, and onlays are covered only if necessary to treat diseased or accidentally fractured teeth, as determined by the dental director
Exclusions

General Exclusions
The university’s dental options do not provide coverage for the following services:

• Any services not listed in the coverage descriptions under each class of service
• Dental services performed for cosmetic reasons
• Surgical implant, including any prosthetic device attached to it
• Replacement of a lost, missing, or stolen appliance (such as an orthodontic retainer, headgear or removable partial or full denture)
• Replacement of dentures, bridges, or crowns that are serviceable, usable or repairable by common dental standards
• Services or appliances that alter the vertical dimension
• Treatment or services for temporal mandibular joint (TMJ)
• Splinting
• Any experimental procedures or treatment methods
• Dental care that does not meet accepted standards of dental treatment
• Services not deemed necessary by the caregiver

Other services not covered by dental options are plan specific. See below for detailed descriptions.

CareFirst BlueCross BlueShield
In addition to the general exclusions, the following services are not covered under this dental option:

• Replacement of dentures, bridges, or crowns within five years from the date of replacement or replacement for which benefits were paid in whole or part under the terms of Class III coverage
• The repair or replacement of any orthodontic appliance
• Any orthodontic service after the last day of the month in which covered services end
• Orthognathic surgery
• Gold foil fillings
• Periodontal appliances
• Nightguards
• Services received from a provider who is a relative of the patient or is not a health care practitioner
• Prescription drugs
• Orthognathic surgery or other oral surgery covered under the medical plan
• Nightguards, occlusal guards, or other oral orthotic appliances
• Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed elsewhere in this document as a covered dental service
• Intentional tooth reimplantation or transplantation
• 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
• Transseptal fiberotomy or vestibuloplasty
• Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be a covered dental service)

**CIGNA**

In addition to the general exclusions, the following services are not covered under this dental option:
• Replacement of a bridge, crown or denture within five years after the date it was originally installed unless:
  - Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth
  - The bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered under the plan
• Procedures, appliances or restorations (except full dentures) whose main purpose is to stabilize periodontally involved teeth or restore occlusion
• Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars
• Bite registrations
• Precision or semiprecision attachments
• Instruction for plaque control, oral hygiene and diet
• Services that do not meet common dental standards or are deemed to be medical services
• Services and supplies received from a hospital

**United Concordia ConcordiaPLUS**

In addition to the general exclusions, the following services are not covered under this dental option:
• Services, supplies or charges provided by out-of-network dentists unless preauthorized, except when immediate dental treatment is required as a result of a dental emergency occurring more than 50 miles from your home
• Dental services necessary due to patient neglect, lack of cooperation with the Primary Dental Office or failure to comply with a professionally prescribed treatment plan
• Dental services that began prior to your coverage under the option or started after the termination date of coverage
• Services received in and associated with a hospital
• Services determined to be the responsibility of workers' compensation, a health care plan or payable under any federal government or state program
• Administration of oral sedation, nitrous oxide, general anesthesia or intravenous sedation not specifically provided under the option
• For congenital mouth malformations or skeletal imbalances
• Repair of an orthodontic appliance
• Prosthetic reconstruction or other services which require a prosthodontist
• Active orthodontic treatment that began prior to your coverage under the option
• Broken appointments
• Services as the result of voluntary self-inflicted injury or illness whether the patient is sane or insane
• House calls
• Prescription or nonprescription drugs, vitamins or dietary supplements
• Any dental or medical services performed by a physician and/or services which are otherwise provided under a health care plan
• Training and/or appliance to correct or control harmful habits
• Duplicate dentures, prosthetic devices or any other duplicate appliance
• Services required because of, or in connection with, acts of war, declared or undeclared
• Elective procedures, including prophylactic extraction of third molars
• Retreatment of orthodontic cases and changes in orthodontic treatment necessitated by patient neglect
• An assistant dental surgeon

**Predetermination of Benefits**
CareFirst and CIGNA suggest you obtain predetermination of benefits prior to extensive proposed and/or planned work (e.g., work that could exceed $300). Predetermination lets you know whether the service is covered and if the amount is paid by the plan.

**CareFirst BlueCross BlueShield**

**Estimate of Eligible Benefits**
A dentist may propose a planned dental treatment or series of dental procedures. You may choose to obtain a written estimate of the benefits available for such procedure(s).

You are encouraged to obtain a written Estimate of Eligible Benefits for major dental procedures before service is rendered. You will then be alerted about out-of-pocket expenses that may be associated with the treatment plan and/or procedures considered non-covered services. Based on an Estimate of Eligible Benefits, you can decide whether or not to incur any expense associated with your dental treatment.

Failure to obtain an Estimate of Eligible Benefits has no effect on the benefits you are entitled to under this contract. You may choose to forgo the Estimate of Eligible Benefits and proceed with treatment.

After services are rendered, the claim will be reviewed by CareFirst. If the review determines that service(s) rendered met the criteria for benefits, coverage will be provided. However, if the review of the claim determines that treatment or procedure(s) do not meet the criteria for benefits, coverage will not be provided.

To request an Estimate of Eligible Benefits prior to receiving dental treatment or dental procedures, contact your dentist who will then coordinate the request on your behalf.

If your dentist has any questions about the process, he or she may contact the CareFirst Provider Services
Department. The Estimate of Eligible Benefits is merely an estimate, and cannot be considered a guarantee of your benefits or enrollment under this contract.

**CIGNA**

Predetermination of Benefits
Following a submission of a dentist’s description of planned treatment and expected charges, CIGNA will advise you of the covered services and your out-of-pocket costs. CIGNA will advise you if an Alternate Benefit Provision (ABP) is applicable. An ABP applies when more than one dental service can provide treatment based on common dental standards. If you and your dentist choose a more costly treatment, you are responsible for additional charges beyond those allowed for the ABP.

**United Concordia ConcordiaPLUS**

Pre-treatment review
If extensive dental work is proposed or planned, it is recommended that you find out in advance what the dental option will pay before you undergo costly dental treatment. This is called pre-treatment review. Generally, pre-treatment review is recommended when your dentist proposes dental treatment that will cost $300 or more (or otherwise specified by the dental option), or coverage for the proposed procedure(s) is in question.

**Services In-progress When Coverage Ends**

**CareFirst BlueCross BlueShield**
Services are covered for at least 90 days after the termination date if either of the following is true:

- The service begins before the date the participant's coverage terminates and
- Two or more visits are required on separate days to a dentist's office to complete the service (not applicable to orthodontic services).

Orthodontic services will be covered for 60 days after the termination date if the orthodontist agrees to receive payment either monthly or quarterly.

**CIGNA**

Dental Benefit Extension
An expense incurred in connection with a dental service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases;
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases; or
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and a treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any dental services except as set forth above.

5.13
Dental Plan
United Concordia ConcordiaPLUS
Orthodontic services will continue for 60 days after date of termination if the following is true:
• Either paid monthly, or
• At the end of the quarter in progress if paid quarterly.

Dental Services Covered Under the Medical Plan
Services which are covered under JHU medical plan options are not eligible for dental coverage.

Filing Dental Claims
You must file claims for both out-of-network care under the CIGNA and CareFirst BlueCross BlueShield dental options. For in-network care, your dental provider will complete and submit the claim forms. No claim forms are required for covered services under the United Concordia ConcordiaPLUS® option.

For Other Information, Go To...

<table>
<thead>
<tr>
<th>The Big Picture</th>
<th>For general information about the university’s overall benefits program and how the myChoices Program works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to Your Benefits</td>
<td>For information on how changes in family or work situations may affect your coverage</td>
</tr>
<tr>
<td>Administrative Information</td>
<td>For important facts about health care plan administration, and your rights under ERISA</td>
</tr>
</tbody>
</table>