Welcome

Your smile says a lot about you. It’s the first thing people see when they meet you. A healthy smile can make you more appealing, even more youthful. But did you know your smile also says a lot about your overall health?

That’s why it’s so important to protect your smile. Good dental care has been significantly shown to reduce your risk of heart disease; it helps control diabetes, and even prevent premature births.

We’re pleased to introduce you to Individual Select Dental HMO – a plan offering comprehensive coverage for in-network and preventive diagnostic services for you and your family.

As a member of Individual Select Dental HMO you’ll enjoy:

- Lower premiums
- No deductibles
- Predictable out-of-pocket costs
- More than 580 dentists throughout Maryland, the District of Columbia and Northern Virginia
- Easy enrollment
- No claim forms to file
- Guaranteed acceptance

Protect your smile, your health, and your budget from serious dental issues.

Read on to learn about Individual Select Dental HMO, offered by The Dental Network and CareFirst BlueChoice, Inc. Or, contact our Product Consultants at 410-356-8000 or toll-free at 800-544-8703, Monday–Friday, 8 a.m. to 8 p.m.

Did You Know...

- People with periodontal disease are 2-4 times more likely to have a heart attack.¹
- Diabetic patients with periodontal disease have more difficulty controlling blood glucose levels.²
- Women less than 35 weeks pregnant who receive treatment for gum disease have 84% fewer premature births.³
- Pregnancy can cause swelling, bleeding, redness, or tenderness in the gum tissue due to hormonal changes.

How Your Plan Works
A Plan For You

Meet The Johnsons

Anna and Jeff Johnson are an energetic couple with two children. They own a catering business, and have purchased a family health insurance plan. They didn't think about dental coverage until their daughter needed braces and their son needed a filling. The costs quickly started to add up.

<table>
<thead>
<tr>
<th>Common Dental Procedure</th>
<th>No Coverage</th>
<th>Individual Select Dental HMO Plan</th>
<th>Savings on Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month check-ups, including routine exams, cleanings and x-rays (8 visits, 2 per person)</td>
<td>$1,320 ($165 per visit)</td>
<td>$160 ($20 copay per visit)</td>
<td>$1,160</td>
</tr>
<tr>
<td>Filling (1 filling)</td>
<td>$130</td>
<td>$20 copay per visit</td>
<td>$110</td>
</tr>
<tr>
<td>Orthodontic Services (1 Child to age 19)</td>
<td>$5,045</td>
<td>$2,500</td>
<td>$2,545</td>
</tr>
<tr>
<td>Total</td>
<td>$6,495</td>
<td>$2,680</td>
<td>$3,815</td>
</tr>
</tbody>
</table>

1 Based on National Dental Advisory Service Fee Report (2012).

With no dental coverage, the Johnsons paid $6,495 for these services. With Individual Select Dental HMO coverage, the Johnsons would have saved more than $3,800 for these services. The Johnsons decided to purchase the Individual Select Dental HMO coverage to protect themselves against future dental costs.
A Plan For You

Meet The Smiths
Mary and Charles Smith are active retirees who recently took up golf. They have Medicare and have purchased a Supplemental Medicare plan and Medicare Prescription Drug Coverage to protect themselves against medical costs. They didn’t think about how their budget might be impacted by major dental expenses until Mary needed root canal therapy and Charles needed a bridge.

<table>
<thead>
<tr>
<th>Common Dental Procedure</th>
<th>No Coverage1</th>
<th>Individual Select Dental HMO Plan</th>
<th>Savings on Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month check-ups, including routine exams, cleanings and x-rays (4 visits, 2 per person)</td>
<td>$660 ($165 per visit)</td>
<td>$80 ($20 copay per visit)</td>
<td>$580</td>
</tr>
<tr>
<td>Root Canal (bicuspids)</td>
<td>$800</td>
<td>$375</td>
<td>$425</td>
</tr>
<tr>
<td>Bridge (3-unit)</td>
<td>$3,000</td>
<td>$1,305</td>
<td>$1,695</td>
</tr>
<tr>
<td>Total</td>
<td>$4,460</td>
<td>$1,760</td>
<td>$2,700</td>
</tr>
</tbody>
</table>

1 Based on National Dental Advisory Service Fee Report (2012).

With no dental coverage, the Smiths paid $4,460 for these services. They decided to purchase dental coverage to protect themselves against further unexpected dental costs. With Individual Select Dental HMO coverage, the Smiths would have spent only $1,760, a savings of over $2,700 on these dental services. Now they’re covered and ready for whatever lies ahead!
# Frequently Used Benefits

<table>
<thead>
<tr>
<th>Common Dental Procedures</th>
<th>Regular Cost¹</th>
<th>In-Network You Pay²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive check-ups (includes routine exams, cleanings and X-rays)</td>
<td>$165 per visit (2 visits per year)</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td>Basic Dental Services (includes fillings, simple extractions and more)</td>
<td>$130 – $320</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td>Soft Tissue Management (includes periodontal scaling, periodontal maintenance and more)</td>
<td>$240</td>
<td>$70 per office visit</td>
</tr>
<tr>
<td>Porcelain crown (high noble metal)</td>
<td>$1,050</td>
<td>$460</td>
</tr>
<tr>
<td>Root canal therapy (bicuspids, excludes final restoration)</td>
<td>$800</td>
<td>$375 Primary Dentist or $475 Specialty Care Dentist</td>
</tr>
<tr>
<td>Complete upper dentures</td>
<td>$1,595</td>
<td>$495</td>
</tr>
<tr>
<td>Orthodontia (Braces)</td>
<td>$5,045</td>
<td>$2,500</td>
</tr>
<tr>
<td>Comprehensive – Adolescent</td>
<td>$5,020</td>
<td>$2,700</td>
</tr>
</tbody>
</table>

¹ Based on National Dental Advisory Service Fee Report (2012)
² Approximate amount. Pricing may vary depending upon dental provider’s negotiated rate with CareFirst.

This is a partial listing of services. If you have any questions, please call our Customer Service Associates at (410) 847-9060 or toll free at (888) 833-8464, Monday–Friday, 8:30 a.m.–5:00 p.m.
Rates

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Annual Rate Full Annual Payment Due with Enrollment Application</th>
<th>Semi-Annual Rate Second Payment Due by the 1st of the seventh month from the effective date of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Payment</td>
<td>2nd Payment</td>
</tr>
<tr>
<td>Individual</td>
<td>$120</td>
<td>$65</td>
</tr>
<tr>
<td>Individual &amp; Child</td>
<td>$204</td>
<td>$107</td>
</tr>
<tr>
<td>Individual &amp; Adult</td>
<td>$240</td>
<td>$125</td>
</tr>
<tr>
<td>Family</td>
<td>$360</td>
<td>$185</td>
</tr>
</tbody>
</table>

Please note that when selecting the semi-annual payment, a $5 administration fee is already included into each payment. You pay an additional $10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application.

The second payment is due by the 1st of the seventh month from the effective date of coverage. For example, if coverage is effective January 1, the second payment is due July 1.
Apply Today
Apply Today for Individual Select Dental HMO

Three steps to apply!

1) Fill out and sign the application that matches where you live – Maryland, the District of Columbia or Northern Virginia.

   Choose the annual or semi-annual payment option.

2) When you’re ready to review a listing of providers, please visit www.carefirst.com/findadoc. Click on Dental, and select Individual Select Dental HMO. Or, if you’d like to request a printed directory, please call our Product Consultants at 410-356-8000 or toll-free at 800-544-8703, Monday–Friday, 8 a.m.–8 p.m.

3) Send in your application, with your premium payment, in the enclosed, postage-paid envelope or mail to:

   The Dental Network and CareFirst BlueChoice, Inc.
   P.O. Box 79810
   Baltimore, MD 21279-0810

Payments must be deposited on or before the last business day of each month to ensure coverage will be effective on the first of the next month.

We will mail your membership cards and certificate of coverage to you. Then you can start enjoying all the benefits of good dental care.

Please note: you must live in Maryland, the District of Columbia or one of the following areas of Northern Virginia: City of Alexandria and Fairfax, the town of Vienna, Arlington county and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.
Application for Maryland Residents

Please fill out the Maryland Individual Select Dental HMO application on the following pages, if you live in the state of Maryland.
**INSTRUCTIONS**

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application, with exact payment amount, in the postage-paid return envelope or, to **P.O. Box 79810**
   **Baltimore MD 21279-0810**

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. **If payment amount is incorrect, the application with refund will be returned.**

---

**1. APPLICANT INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Social Security #</th>
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<th>Zip Code (9-digit, if known)</th>
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<tr>
<td></td>
<td>□ Female</td>
<td>□ Married</td>
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<tr>
<td></td>
<td>□ Partner</td>
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<th>Work/Cell Phone</th>
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<th>Payment Option</th>
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<tr>
<td>( )</td>
<td>( )</td>
<td></td>
<td>□ Annual □ Semi-annual</td>
</tr>
</tbody>
</table>

**2. COVERAGE SELECTION: (Check one)**

- □ Individual - Provides coverage for one person
- □ Individual & Child - Provides coverage for an individual and eligible dependent (if you have more than one child, you must select Family coverage)
- □ Individual & Adult - Provides coverage for two eligible adults
- □ Family - Provides coverage for up to two eligible adults and eligible dependent(s)

A “Child” means your eligible child up to age 26. Eligibility requirements are defined in your contract.

An "Adult" means the Spouse or Partner who satisfies the eligibility requirements defined in your contract.

**3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child, Individual & Adult or Family Coverage**

(Dental HMO Plan must have a dental office code. Each person may select their own dentist.)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M. I.</th>
<th>Relationship</th>
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The Dental Network is an independent licensee of the Blue Cross and Blue Shield Association.®

© Registered trademark of the Blue Cross and Blue Shield Association.
4. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

**IT IS UNDERSTOOD AND AGREED THAT:**

- A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
- This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.
- Premium payment options are available on an annual and a semi-annual basis. Those members who elect the semi-annual payment option will be subject to an additional five dollar ($5) surcharge per payment, which equals ten dollars ($10) annually.
- To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for The Dental Network policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (888) 833-8464 before signing this application.

**WARNING:** ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**Signature of Applicant:** X  
**Date:**

**NOTE:** Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

**Signature of Legal Guardian:** X  
**Date:**

**Please make checks payable to:**

THE DENTAL NETWORK, INC.  
and mail to:  
Dental Processing Center  
P.O. Box 79810  
Baltimore, MD 21279-0810

**AGENTS MUST COMPLETE THIS SECTION**

<table>
<thead>
<tr>
<th>Agency Name</th>
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<tr>
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<th>Annual or Semi-annual Premium</th>
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Application for District of Columbia Residents

Please fill out the District of Columbia Individual Select Dental HMO application on the following pages, if you live in the District of Columbia.
INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application, with exact payment amount, in the postage-paid return envelope or, to P.O. Box 79810 Baltimore MD 21298-8159

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. If payment amount is incorrect, the application will be returned.

1. APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
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<th>Middle Initial</th>
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Residence Address: Number and Street, Apt. #

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Date of Birth / / Sex Male Female

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Home Phone ( )

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2. COVERAGE SELECTION: (Check one)

- Individual - Provides coverage for one person
- Individual & Child - Provides coverage for an individual and eligible dependent (if you have more than one child, you must select Family coverage)
- Individual & Adult - Provides coverage for two eligible adults
- Family - Provides coverage for up to two eligible adults and eligible dependent(s)

A “Child” means your eligible child up to age 26. Eligibility requirements are defined in your contract.
An “Adult” means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in your contract.

3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child, Individual & Adult or Family Coverage

(You must have a dental code. Each person may select their own dentist.)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M. I.</th>
<th>Relationship</th>
<th>Social Security #</th>
<th>Date of Birth (Mo/Day/Yr)</th>
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<tbody>
<tr>
<td>Spouse/Domestic Partner</td>
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</table>

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4. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
- This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.
- Premium payment options are available on an annual and a semi-annual basis. Those members who elect the semi-annual payment option will be subject to an additional five dollar ($5) surcharge per payment, which equals ten dollars ($10) annually.
- To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst BlueChoice policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll free at (888) 833-8464 before signing this application.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, CAREFIRST BLUECHOICE, INC. MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature of Applicant: X ______________________________________ Date: _______________

Signature of Dependent: X ______________________________________ Date: _______________

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Signature of Legal Guardian: X ______________________________________ Date: _______________

Please make checks payable to:

CAREFIRST BLUECHOICE, INC.
and mail to:
Dental Processing Center
P.O. Box 79810
Baltimore, MD 21298-8159

AGENTS MUST COMPLETE THIS SECTION

Agency Name

Agency Address: Number and Street, Apt.# City and State Zip Code (9-digit, if known)

Telephone Number ( ) Fax Number ( ) E-mail Address

Annual or Semi-annual Premium
Application for Northern Virginia Residents

Please fill out the Virginia Individual Select Dental HMO application on the following pages, if you live in the cities of Alexandria and Fairfax, the town of Vienna, Arlington county and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.
INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.

2. Sign and return this application, with exact payment amount, in the postage-paid return envelope or, to P.O. Box 79810 Baltimore MD 21298-8159

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. If payment amount is incorrect, the application will be returned.

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<tr>
<th>Last Name</th>
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<tr>
<th>Residence Address: Number and Street, Apt. #</th>
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CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

© Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.
4. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
- This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.
- Premium payment options are available on an annual and a semi-annual basis. Those members who elect the semi-annual payment option will be subject to an additional five dollar ($5) surcharge per payment, which equals ten dollars ($10) annually.
- To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst BlueChoice policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (888) 833-8464 before signing this application.

WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED VIRGINIA STATE LAW.

The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Signature of Applicant: X ___________________________ Date: ______________

Signature of Dependent: X ___________________________ Date: ______________

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Signature of Legal Guardian: X ___________________________ Date: ______________

Signature of Agent: X ___________________________ Date: ______________

Please make checks payable to:

CAREFIRST BLUECHOICE, INC.
and mail to:
Dental Processing Center
P.O. Box 79810
Baltimore, MD 21298-8159

AGENTS MUST COMPLETE THIS SECTION

Agency Name

Agency Address: Number and Street, Apt.# City and State Zip Code (9-digit, if known)

Telephone Number ( ) Fax Number ( ) E-mail Address

Annual or Semi-annual Premium
Compensation and Premium Disclosure Statement

Our compensation to providers who offer health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your health care provider, please call our Member Services Department at the number listed on your identification card, or write to:

The Dental Network, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117
Attention: Member Services

A. Methods of Paying Physicians

The following definitions explain how insurance carriers may pay physicians (or other providers) for your health care services.

The examples show how Dr. Jones, an obstetrician/gynecologist, would be compensated under each method of payment.

Salary: A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services.

Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing pre-natal care to Mrs. Smith, who is a member of the HMO, Dr. Jones’ salary is unchanged. Although Mrs. Smith’s baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones’ salary.

Capitation: A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.

Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.

Fee-for-Service: A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.

Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith’s baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones’ bill.

Discounted Fee-for-Service: Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.

Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones’ usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.

Bonus: A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.

An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.
**Case Rate:** The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care. This type of arrangement stipulates how much an insurer or HMO will pay for a patient’s obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

**B. Provider Payment Methods**
TDN utilizes the following methods of paying physicians (dentists) who render health care (dental) services to our enrollees: capitation, fee-for-service, and discounted fee-for-service.

**C. Distribution of Premium Dollars**
The bar graph below illustrates the proportion of every $100 in premium used by The Dental Network, Inc. to pay providers (dentists) for medical care (dental care) expenses, and the proportion used to pay for plan administration. The provider payment method percentages for TDN are approximately 47% discounted fee-for-service and approximately 53% capitated.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Claims</th>
<th>Plan Administration</th>
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<tbody>
<tr>
<td>79%</td>
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<tr>
<td>21%</td>
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CDS1079-1P (12/13)
Exclusions and Limitations

MARYLAND

PLAN LIMITATIONS. The following exclusions and limitations shall apply:

- Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;
- Services which are provided without cost to the Covered Individual and/or Dependent(s) by any municipality, county or other political subdivision (with the exception of Medicaid);
- Services which, in the opinion of the Participating DENTIST, are not necessary for the Covered Individual and/or Dependent(s) health;
- Payment of any claim or bill will not be made for prohibited referrals;
- Cosmetic, elective, or aesthetic dentistry, which in the opinion of the Participating DENTIST are not necessary for the patient’s dental health;
- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
- Dispensing of drugs, except those used as a local anesthetic;
- Hospitalization for any dental procedure;
- Loss or theft of bridgework or dentures previously supplied under the PLAN;
- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
- Any implantation;
- General anesthesia;
- Services that cannot be performed because of the general health of the patient;
- Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;
- Unlisted procedures will be provided at the dentist’s charge;
- Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
- Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual and/or Dependent(s) Personal Participating DENTIST; all services listed on the Schedule of Benefits and Copayments will be provided by a general Participating DENTIST or an Approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an Approved Specialist or recommend that the Covered Individual or Dependent contact an Approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an Approved Specialist, with an exception for out-of-area emergency care, and a referral to a non-participating general dentist or specialist;
- Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

OUT-OF-AREA EMERGENCY CARE: Covered Individuals and/or Dependents are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than fifty (50) miles from their “Personal Participating DENTIST.” Limited to $50 per Covered Individual or Dependent per emergency, minus member’s copay.

ALL PRICES ARE EXCLUSIVE OF GOLD
PLAN LIMITATIONS. The following in-network exclusions and limitations shall apply:

A. Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;
B. Services which are provided without cost to the Covered Individual by any municipality, county or other political subdivision (with the exception of Medicaid);
C. Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Individual’s health;
D. Payment of any claim or bill will not be made for prohibited referrals;
E. Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient’s dental health;
F. Oral surgery requiring the setting of fractures or dislocations;
G. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
H. Dispensing of drugs, except those used as a local anesthetic;
I. Hospitalization for any dental procedure;
J. Loss or theft of bridgework or dentures previously supplied under the PLAN;
K. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
L. Any implantation;
M. General anesthesia;
O. Services that cannot be performed because of the general health of the patient;
P. Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;
Q. Unlisted procedures will be provided at the dentist’s charge;
R. Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
S. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual’s General Participating DENTIST.
T. All services listed on the Schedule of Benefits and Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an approved Specialist or recommend that the Covered Individual or Dependent contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care.
U. Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

OUT-OF-AREA EMERGENCY CARE: Members are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest PLAN Dental Office. Limited to $50 per member per emergency, minus member’s copay.

ALL PRICES ARE EXCLUSIVE OF GOLD
**PLAN LIMITATIONS.** The following limitations shall apply:

A. All services listed on the Schedule of Benefits and Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an approved Specialist or recommend that the Covered Individual or Dependent contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care;

B. Unlisted procedures will be provided at the dentist’s charges;

C. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual’s General Participating DENTIST

D. OUT-OF-AREA EMERGENCY CARE: Members are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest PLAN Dental Office. Limited to $50 per member per emergency, minus member’s copay.

**EXCLUSIONS.** Benefits will not be provided for:

A. Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;

B. Services which are provided without cost to the Covered Individual by any municipality, county or other political subdivision (with the exception of Medicaid);

C. Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Individual's health;

D. Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient's dental health;

E. Oral surgery requiring the setting of fractures or dislocations;

F. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;

G. Dispensing of drugs, except those used as a local anesthetic;

H. Hospitalization for any dental procedure;

I. Loss or theft of bridgework or dentures previously supplied under the PLAN;

J. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;

K. Any implantation;

L. General anesthesia;

M. Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;

N. Services which are obtained outside the dental office in which enrolled and which are not preauthorized by the PLAN. This does not apply to out-of-area emergency dental services;

O. Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

P. All Member Copayments listed on the Schedule of Benefits and Copayments are exclusive of gold;

Q. Payment of any claim or bill will not be made for prohibited referrals.
Individual Select Dental HMO Maryland
The Dental Network, Inc.
FORM DN001C (R. 1/10),
FORM DN4001 (R. 1/10),
and any amendments

Individual Select Dental HMO Virginia
CareFirst BlueChoice, Inc.
VA/BC/DB/COC (R. 1/10),
VA/BC/DB/SOB (R. 1/10),
and any amendments

Individual Select Dental HMO District of Columbia
CareFirst BlueChoice, Inc.
DN001DC (R. 1/10),
FORM DN4001DC (R. 1/10),
and any amendments