CareFirst

Individual Select Preferred Dental Plans

2025

MARYLAND ■ WASHINGTON, D.C. ■ NORTHERN VIRGINIA

Contents

The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or CareFirst.

Individual Select Preferred Dental

What your plan covers

In-network

As a member, you'll receive 100% coverage in-network for preventive and diagnostic services. Individual Select Preferred Dental combines the freedom to select any dentist from our large regional network.

The following are some of the services covered in full when visiting an in-network provider:

- Examinations
- Cleanings
- X-rays
- Sealants for children
- Fluoride treatments for children

Participating dentists accept 100% of the Allowed Benefit* from CareFirst as payment in full for covered services.

Out-of-network

You also have the option to seek routine preventive and diagnostic treatment from non-participating providers. If you visit a non-participating provider, CareFirst will still pay the Allowed Benefit,* but you will be responsible for the difference in cost between the CareFirst Allowed Benefit and your dental provider's full charge.

Is your dentist in the network? Search at **carefirst.com/findadoc** and select *Individual Select Preferred* from the *All Plans* drop-down menu.

***Allowed Benefit**—The Allowed Benefit is typically a reduced rate and not the actual charge. Example: you visited your dentist for a routine exam and cleaning. The total charge for the visit is $125. If the doctor is a participating provider, they may be required to accept $75 from CareFirst as payment in full for the visit—this is the Allowed Benefit. However, if you visit a non-participating provider, you may be responsible for the difference between the CareFirst Allowed Benefit and the dental provider's full charge. In this example, that means you would be responsible for an additional $50.

Individual Select Preferred Dental Summary of Benefits

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE	None	
ANNUAL MAXIMUM (CLASSES I-IV)	No maximum	
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)		
▪ Oral exams (two per contract year) ▪ Prophylaxis (two cleanings per contract year) ▪ Bitewing X-rays (two per contract year) ▪ Fluoride treatments (two per contract year, until the end of the year in which member reaches age 19) ▪ Palliative treatments ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) ▪ Sealants on permanent molars (once per tooth per 36 months until the end of the year in which member reaches age 19) ▪ Space maintainers (once per 60 months) ▪ Emergency oral exam	No charge	Member pays provider's full charge and submits claim to be reimbursed CareFirst's Allowed Benefit. (Member pays any difference between the CareFirst Allowed Benefit and the dentist's billed charge.)
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials (one filling per surface per 12 months) ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	Not covered	
MAJOR SERVICES – SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ 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, apicoectomy and hemi-section) ▪ General anesthesia required for oral surgery	Not covered	
MAJOR SERVICES – RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining (limits apply for regular and immediate dentures) ▪ Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance) ▪ Dental implants, subject to medical necessity review (once per 60 months)	Not covered	
ORTHODONTIC SERVICES (CLASS V)		
▪ Benefits for orthodontic services are available for covered members until the end of the month in which a member reaches the age of 19 ▪ The in-network and out-of-network lifetime maximum per child is a combined amount	Not covered	

Individual Select Preferred Dental Plus

What your plan covers

Preventive & Diagnostic Services (Class I)

There is no deductible and no waiting period for the following services, which are covered at 100% when visiting an Individual Select Preferred Dental Plus in-network provider:

- Oral examinations
- Cleanings
- X-rays
- Sealants for children
- Fluoride treatments for children

Basic Services (Class II)

After a low deductible and no waiting period, your plan includes fillings, simple extractions, and periodontal scaling and root planing.

Major Services (Class III, IV)

After a low deductible and 12-month waiting period, you are covered for root canals, oral surgery, dentures, crowns, bridges and more.

Orthodontia (Class V)

Select Preferred Dental Plus offers benefits for braces for children up to age 19, after a 12-month waiting period.

Visiting non-participating providers

You also have the option to seek treatment from non-participating providers. If you visit a non-participating provider, CareFirst will pay a percentage of the Allowed Benefit,* but you may be responsible for the difference in cost between the CareFirst Allowed Benefit and your dental provider's full charge—in addition to any applicable deductibles and coinsurance. You may also be required to pay all costs at the time of service and submit a claim form to be reimbursed for covered services.

***Allowed Benefit**—The Allowed Benefit is typically a reduced rate and not the actual charge. Example: you visited your dentist for a routine exam and cleaning. The total charge for the visit is $125. If the doctor is a participating provider, they may be required to accept $75 from CareFirst as payment in full for the visit—this is the Allowed Benefit. However, if you visit a non-participating provider, you may be responsible for the difference between the CareFirst Allowed Benefit and the dental provider's full charge. In this example, that means you would be responsible for an additional $50.

Individual Select Preferred Dental Plus Summary of Benefits

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE (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.	$25 Ind. deductible/ $75 Family deductible	$50 Ind. deductible/ $150 Family deductible
ANNUAL MAXIMUM (CLASSES I-IV)		
▪ 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 (two per contract year) ▪ Prophylaxis (two cleanings per contract year) ▪ Bitewing X-rays (two per contract year) ▪ Fluoride treatments (two per contract year, until the end of the year in which member reaches age 19) ▪ Palliative treatments ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) ▪ Sealants on permanent molars (once per tooth per 36 months until the end of the year in which member reaches age 19) ▪ Space maintainers (once per 60 months) ▪ Emergency oral exam	No charge	20% of Allowed Benefit*
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials (one filling per surface per 12 months) ▪ 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, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ 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, apicoectomy and hemi-section) ▪ General anesthesia required for oral surgery	20% of Allowed Benefit* after deductible and 12-month waiting period	40% of Allowed Benefit* after deductible and 12-month waiting period
MAJOR SERVICES – RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining (limits apply for regular and immediate dentures) ▪ Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance) ▪ Dental implants, subject to medical necessity review (once per 60 months)	50% of Allowed Benefit* after deductible and 12-month waiting period	65% of Allowed Benefit* after deductible and 12-month waiting period
ORTHODONTIC SERVICES (CLASS V)		
▪ Benefits for orthodontic services are available for covered members until the end of the month in which a member reaches the age of 19	50% of Allowed Benefit* after deductible and 12-month waiting period	65% of Allowed Benefit* after deductible and 12-month waiting period
▪ The in-network and out-of-network lifetime maximum per child is a combined amount	Plan pays up to $800 per child up to age 19	

*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 member for the difference between the Allowed Benefit and their charges.

Enrolling in Your New Dental Plan

To apply for Individual Select Preferred Dental (preventive dental only)

You have the option to use the paper application provided or enroll online.

- To enroll online, visit **carefirst.com/shopdental**
  - Get instant confirmation
  - Have access to real-time help via click-to-call or click-to-chat
- If you use the paper application, return it in the enclosed, postage-paid envelope or mail your completed application to:

  Mail Administrator
  P.O. Box 14651
  Lexington, KY 40512
- Enroll through your broker

To apply for Individual Select Preferred Dental Plus

- Use the paper application provided in this book. Return it in the enclosed, postage-paid envelope or mail your completed application to:

  Mail Administrator
  P.O. Box 14651
  Lexington, KY 40512
- Enroll through your broker

Please do not send payment. Once your application is received, we will send you a bill detailing your plan, selected payment option, premium information and payment due date. Payments can be made on an annual or quarterly basis.

When will my dental coverage start?

The effective date of coverage is based on the 20th of the month. If we receive your application before the 20th of the month and your premium is paid by the due date, your coverage will become effective on the first day of the following month.

Example: For coverage to begin on May 1, we must receive your application on/before April 20th. We will send your first bill confirming we received your application and indicating when payment is due for coverage to begin May 1.

Have questions?

Contact us at 855-503-4862, Monday–Thursday from 8 a.m. to 5 p.m. and Friday from 10 a.m. to 5 p.m.

2025 Dental Rates

Individual Select Preferred Dental

	Annually			Quarterly		
	MD	DC	VA	MD	DC	VA
Individual	$357.48	$339.72	$353.52	$89.37	$84.93	$88.38
Individual & Child(ren)*	$661.32	$628.44	$654.00	$165.33	$157.11	$163.50
Individual & Adult**	$714.96	$679.44	$707.04	$178.74	$169.89	$176.76
Family	$1,000.92	$951.24	$989.88	$250.23	$237.81	$424.80

Rates effective January 1, 2025

Individual Select Preferred Dental Plus

	Annually			Quarterly		
	MD	DC	VA	MD	DC	VA
Individual	$569.76	$519.72	$606.84	$142.44	$129.93	$151.71
Individual & Child(ren)*	$1,054.08	$961.44	$1,122.60	$263.52	$240.36	$280.65
Individual & Adult**	$1,139.52	$1,039.44	$1,213.68	$284.88	$259.86	$303.42
Family	$1,595.28	$1,455.24	$1,699.20	$398.82	$363.81	$424.80

Rates effective January 1, 2025

* "Child" means your eligible child up to age 26. Eligibility requirements are defined in the contract.

** "Adult" means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in the contract.

The rates shown reflect the current premium levels. Your actual premium rate may be higher than the rate shown based on the date of your signed application. All rates are subject to change.

Maryland Resident Application

Please fill out the Maryland Individual Select Preferred Dental application on the following pages if you live in Maryland.

Individual Select Preferred Dental Application

Maryland

CareFirst of Maryland, Inc.
10455 Mill Run Circle, Owings Mills, MD 21117
Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065
A private, not-for-profit health service plan

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application, in the postage-paid return envelope if provided, or mail to:
   Mailroom Administrator
   P.O. Box 14651, Lexington, KY 40512

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Date of Birth / /	Sex ○ Male ○ Female	Marital Status ○ Single ○ Married ○ Partner
Home Phone ( )	Work/Cell Phone ( )	Payment Option ○ Annually ○ Quarterly

2. COVERAGE SELECTION—CHECK ONE

- ○ **Individual**—Provides coverage for one person
- ○ **Individual & Child(ren)**—Provides coverage for an individual and eligible dependent(s)
- ○ **Individual & Adult**—Provides coverage for two eligible adults
- ○ **Family**—Provides coverage for 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 of the Subscriber who satisfies the eligibility requirements defined in your contract.

3. ENROLLING FAMILY MEMBER(S)—COMPLETE ONLY IF YOU SELECT INDIVIDUAL & CHILD(REN), INDIVIDUAL & ADULT OR FAMILY COVERAGE

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							○ M ○ F
Partner							○ M ○ F
Dependent 1							○ M ○ F
Dependent 2							○ M ○ F
Dependent 3							○ M ○ F
Dependent 4							○ M ○ F
Dependent 5							○ M ○ F

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

4. PLAN SELECTION—CHECK ONE

◯ **Individual Select Preferred Dental** is a **Preferred Provider Organization (PPO)** plan underwritten by Group Hospitalization and Medical Services, Inc. *This is a preventive services only plan*.

◯ **Individual Select Preferred Dental Plus** is a **Preferred Provider Organization (PPO)** plan underwritten by:
*(Check the box on the left to choose this plan **and** check the box below based on where you live)*

For residents of Montgomery or Prince George's counties only, check here: ◯
Group Hospitalization and Medical Services, Inc.

For residents of Baltimore City or any other county in the state of Maryland excluding Montgomery and Prince George's counties, check here: ◯
CareFirst of Maryland, Inc.

All individuals listed on this application will be enrolled in the plan selected. Any individual who wants to enroll in a different plan must fill out a separate application.

5. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst health care coverage include, but are not limited to:

- Explanation of Benefits Alerts
- Notice of HIPAA Privacy Practices
- Reminders
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note: This consent for electronic communications applies to the primary applicant only. Spouse/Domestic Partners and dependents 18 years of age and older can consent to electronic communications through **www.carefirst.com/myaccount**. Members can also change email and consent information anytime by logging into **www.carefirst.com/myaccount** or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

I understand that to receive notices through text messaging,

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

PRIMARY APPLICANT NAME	EMAIL ADDRESS	CELL PHONE NUMBER
	ALTERNATE EMAIL ADDRESS	ALTERNATE CELL PHONE NUMBER

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery by:
◯ Email only ◯ Cell phone text messaging only ◯ Email and cell phone text messaging

Signature: X

CareFirst will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.

6. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Subscriber (or to a person authorized to act on his/her behalf).
- 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 quarterly basis.
- 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 BlueCross BlueShield 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 866-891-2802 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.

Parent or Legal Guardian Signature: X_____Date:_____

FOR OFFICE USE ONLY:

◯ Re-sign and re-date below only if box is checked.

Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:		[redacted]		
Sub-Agent/Sub-Agency:				[redacted]
Writing Agent:				

Washington, D.C. Resident Application

Please fill out the Washington, D.C. Individual Select Preferred Dental application on the following pages if you live in Washington, D.C.

Individual Select Preferred Dental Application

District of Columbia

Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application, in the postage-paid return envelope if provided, or mail to:
   Mailroom Administrator
   P.O. Box 14651, Lexington, KY 40512

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Date of Birth / /	Sex ○ Male ○ Female	Marital Status ○ Single ○ Married ○ Domestic Partnership/Other
Home Phone ( )	Work/Cell Phone ( )	Payment Option ○ Annually ○ Quarterly

2. COVERAGE SELECTION—CHECK ONE

- ○ **Individual**—Provides coverage for one person
- ○ **Individual & Child(ren)**—Provides coverage for an individual and eligible dependent(s)
- ○ **Individual & Adult**—Provides coverage for two eligible adults
- ○ **Family**—Provides coverage for 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, Domestic or Civil Union 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(REN), INDIVIDUAL & ADULT OR FAMILY COVERAGE

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							○ M ○ F
Domestic Partner; Legal Partner; or Civil Union Partner							○ M ○ F
Dependent 1							○ M ○ F
Dependent 2							○ M ○ F
Dependent 3							○ M ○ F
Dependent 4							○ M ○ F
Dependent 5							○ M ○ F

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4. PLAN SELECTION—CHECK ONE

◯ **Individual Select Preferred Dental** is a **Preferred Provider Organization (PPO)** plan underwritten by Group Hospitalization and Medical Services, Inc. *This is a preventive services only plan*.

◯ **Individual Select Preferred Dental Plus** is a **Preferred Provider Organization (PPO)** underwritten by Group Hospitalization and Medical Services, Inc.

All individuals listed on this application will be enrolled in the plan selected. Any individual who wants to enroll in a different plan must fill out a separate application.

5. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst health care coverage include, but are not limited to:

- Explanation of Benefits Alerts
- Notice of HIPAA Privacy Practices
- Reminders
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note: This consent for electronic communications applies to the Primary Applicant only. Spouse, Domestic or Civil Union Partners and dependents 18 years of age and older can consent to electronic communications through **www.carefirst.com/myaccount**. Members can also change email and consent information anytime by logging into **www.carefirst.com/myaccount** or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

I understand that to receive notices through text messaging,

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

PRIMARY APPLICANT NAME	EMAIL ADDRESS	CELL PHONE NUMBER
	ALTERNATE EMAIL ADDRESS	ALTERNATE CELL PHONE NUMBER

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery by:
◯ Email only ◯ Cell phone text messaging only ◯ Email and cell phone text messaging

Signature: X

CareFirst will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.

6. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Subscriber (or to a person authorized to act on his/her behalf).
- 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 quarterly basis.
- 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 BlueCross BlueShield 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 866-891-2802 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 MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

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.

Parent or Legal Guardian Signature: X_____ Date:_____

FOR OFFICE USE ONLY:

◯ Re-sign and re-date below only if box is checked.

Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:		[redacted]		
Sub-Agent/Sub-Agency:				[redacted]
Writing Agent:				

FOR OFFICE USE ONLY:

◯ Re-sign and re-date below only if box is checked.

Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

Northern Virginia Resident Application

Please fill out the Virginia Individual Select Preferred Dental 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.

Individual Select Preferred Dental Application

Virginia

Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application, in the postage-paid return envelope if provided, or mail to:
   Mailroom Administrator
   P.O. Box 14651, Lexington, KY 40512

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

Are you applying for new coverage or are you making changes to a current policy? Check one box.
○ New coverage ○ Making changes

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Date of Birth	Sex	Marital Status
/ /	○ Male ○ Female	○ Single ○ Married ○ Domestic Partner
Home Phone	Work/Cell Phone	Payment Option
( )	( )	○ Annually ○ Quarterly

2. COVERAGE SELECTION—CHECK ONE

○ **Individual**—Provides coverage for one person
○ **Individual & Child(ren)**—Provides coverage for an individual and eligible dependent(s)
○ **Individual & Adult**—Provides coverage for two eligible adults
○ **Family**—Provides coverage for 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(REN), INDIVIDUAL & ADULT OR FAMILY COVERAGE

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							○ M ○ F
Domestic Partner							○ M ○ F
Dependent 1							○ M ○ F
Dependent 2							○ M ○ F
Dependent 3							○ M ○ F
Dependent 4							○ M ○ F
Dependent 5							○ M ○ F

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4. PLAN SELECTION—CHECK ONE

◯ **Individual Select Preferred Dental** is a **Preferred Provider Organization (PPO)** plan underwritten by Group Hospitalization and Medical Services, Inc. *This is a preventive services only plan*.

◯ **Individual Select Preferred Dental Plus** is a **Preferred Provider Organization (PPO)** underwritten by Group Hospitalization and Medical Services, Inc.

All individuals listed on this application will be enrolled in the plan selected. Any individual who wants to enroll in a different plan must fill out a separate application.

5. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst health care coverage include, but are not limited to:

- Explanation of Benefits Alerts
- Notice of HIPAA Privacy Practices
- Reminders
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note: This consent for electronic communications applies to the Primary Applicant only. Spouse/Domestic Partners and dependents 18 years of age and older can consent to electronic communications through **www.carefirst.com/myaccount**. Members can also change email and consent information anytime by logging into **www.carefirst.com/myaccount** or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

I understand that to receive notices through text messaging,

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

PRIMARY APPLICANT NAME	EMAIL ADDRESS	CELL PHONE NUMBER
	ALTERNATE EMAIL ADDRESS	ALTERNATE CELL PHONE NUMBER

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery by:
◯ Email only ◯ Cell phone text messaging only ◯ Email and cell phone text messaging

Signature: X

CareFirst will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.

6. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Subscriber (or to a person authorized to act on his/her behalf).
- 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 quarterly basis.
- 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 BlueCross BlueShield 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 866-891-2802 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:_____

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.

Parent or Legal Guardian Signature: X_____ Date:_____

Signature of Agent: X_____ Date:_____

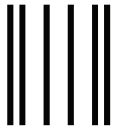
FOR OFFICE USE ONLY:

◯ Re-sign and re-date below only if box is checked.

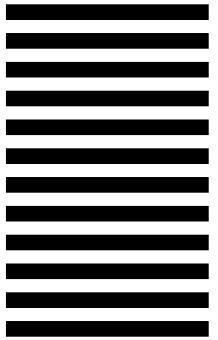
Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:		[redacted]		
Sub-Agent/Sub-Agency:				[redacted]
Writing Agent:				

Fold and Detach Along Perforation



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 11562 WASHINGTON DC

POSTAGE WILL BE PAID BY ADDRESSEE

CAREFIRST BLUECROSS BLUESHIELD
PO BOX 14651
LEXINGTON KY 40512-9876

Exclusions and Limitations

Individual Select Preferred Dental

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.

Exclusions. Benefits will not be provided for:

A. 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.
B. Services not specifically listed in the Subscriber's Agreement as a Covered Dental Service, even if Medically Necessary.
C. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
D. 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.
E. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
F. Services or supplies that are Experimental or Investigational in nature.
G. Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

Individual Select Preferred Dental Plus

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).
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.

Exclusions. Benefits will not be provided for:

A. Any services, tests, procedures or supplies which CareFirst determines are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
B. Any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in CareFirst's judgment, is Experimental/ Investigational, or not in accordance with accepted dental practices and standards in effect at the time of treatment.
C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this Agreement or under any dental insurance, or any charge or any portion of a charge which

by law the provider is not permitted to bill or collect from the Member directly.

D. Any service, supply or procedure that is not specifically listed in this Description of Covered Dental Services and Schedule of Benefits as Covered Dental Services (even if Medically Necessary) or that do not meet all other conditions and criteria for coverage as determined by CareFirst.
E. Replacement of a denture, bridge or crown as a result of loss or theft.
F. Replacement of an existing denture, bridge or crown that is determined by CareFirst to be satisfactory or repairable.
G. 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 this Description of Covered Dental Services and Schedule of Benefits.
H. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys.
I. Gold foil fillings.
J. 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 when the dental services are received after the Effective Date of coverage under the Agreement 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.
K. Periodontal appliances.
L. 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 this Description of Covered Dental Services and Schedule of Benefits.
M. Splinting.
N. Nightguards, occlusal guards or other oral orthotic appliances.
O. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs and other pathology procedures, unless specifically listed as a Covered Dental Service in this Description of Covered Dental Services and Schedule of Benefits.
P. Intentional tooth reimplantation or transplantation.
Q. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning.
R. 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.
S. Transseptal fiberotomy or vestibuloplasty.
T. Orthognathic Surgery or other oral Surgery covered under the Member's medical benefit plan.
U. The repair or replacement of any orthodontic appliance.
V. Any orthodontic services after the last day of the month in which Covered Dental Services ended, except as specifically described in this Description of Covered Dental Services and Schedule of Benefits and the attached Agreement.
W. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be Covered Dental Services).
X. 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.
Y. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
Z. Services that are beyond the scope of the license of the provider performing the service.
AA. Services and supplies that are not Medically Necessary.
BB. Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 4/15/2025)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 14858 Lexington, KY 40512
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The BLUE CROSS® and BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their identification card. All others may call 1-855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

ማሳሰቢያ (Amharic)፦ ይህ ማሳወቂያ ስለ ኢንሹራንስ ሽፋንዎ መረጃ ይዟል። ቁልፍ ቀኖችን ሊይዝ ይችላል እና በተወሰኑ የግዜ ገደቦች እርምጃ መውሰድ ሊኖርብዎ ይችላል። ይህን መረጃ እና እገዛ ያለ ምንም ወጪ በቋንቋዎ የማግኘት መብት አለዎት። አባላት በአባላት መታወቂያ ካርዳቸው ጀርባ ወዳለው ስልክ ቁጥር መደወል አለባቸው። ሌሎች በሙሉ ወደ 855-258-6518 በመደወል 0ን እንዲጫኑ እስኪጠየቁ ድረስ ምልልሱን መጠበቅ ይችላሉ። አንድ ወኪል ሲመልስ፣ የሚፈልጉትን ቋንቋ ይግለጹ እና ከአስተርጓሚ ጋር ይገናኛሉ።

انتبه (Arabic): يحتوي هذا الإشعار على معلومات حول تغطيتك التأمينية. قد يحتوي على تواريخ رئيسية وقد تحتاج إلى اتخاذ إجراء بحلول مواعيد نهائية معينة. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. يجب على الأعضاء الاتصال برقم الهاتف الموجود على ظهر بطاقة هوية العضوية الخاصة بهم. يمكن للآخرين الاتصال بالرقم 855-258-5618 والانتظار طوال الحوار حتى يُطلب منهم الضغط على الرقم 0. عندما يجيبك أحد الوكلاء، حدد اللغة التي تحتاجها وسيتم توصيلك بمترجم فوري.

মনোযোগ দিন (Bengali): এই বিজ্ঞপ্তিতে আপনার বীমা কভারেজ সম্পর্কে তথ্য রয়েছে। এতে গুরুত্বপূর্ণ তারিখগুলি থাকতে পারে এবং আপনাকে হয়ত নির্দিষ্ট সময়সীমার মধ্যে পদক্ষেপ নিতে হতে পারে। আপনার ভাষায় বিনামূল্যে এই তথ্য এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদের তাদের সদস্য পরিচয়পত্রের পিছনে দেওয়া ফোন নম্বরে কল করা উচিত। অন্যরা 855-258-6518 নম্বরে কল করতে পারেন এবং 0 চাপ দেওয়ার জন্য অনুরোধ না করা পর্যন্ত সংলাপের জন্য অপেক্ষা করতে পারেন। যখন একজন এজেন্ট উত্তর দেবেন, তখন আপনার প্রয়োজনীয় ভাষাটি বলুন এবং আপনাকে একজন দোভাষীর সাথে সংযুক্ত করা হবে।

注意（Chinese）：此通知包含有關您的保險範圍的資訊。它可能包含關鍵日期，您可能需要在特定截止日期之前採取行動。您有權免費以您的語言獲取此資訊和協助。會員應撥打會員證背面的電話號碼。其他所有人可以撥打 855-258-6518 並等待對話框，直到提示按 0。當代理商接聽時，請說明您需要的語言，然後您将會與翻譯人員聯繫。

توجه (Farsi): این اطلاعیه حاوی اطلاعاتی درباره پوشش بیمه‌ای شما است. ممکن است شامل تاریخ‌های مهم باشد و لازم باشد تا مهلت‌های مشخصی اقدام کنید. شما حق دارید این اطلاعات و کمک را به زبان خود و به‌صورت رایگان دریافت کنید. اعضا باید با شماره تلفن درج‌شده در پشت کارت شناسایی عضویت خود تماس بگیرند. سایر افراد می‌توانند با شماره *855-258-6518* تماس بگیرند و منتظر بمانند تا دستور داده شود که عدد 0 را فشار دهند. هنگامی که یک نماینده پاسخ داد، زبان مورد نیاز خود را اعلام کنید تا به یک مترجم متصل شوید.

Attention (French): Le présent avis contient des informations essentielles relatives à votre couverture d’assurance. Il peut inclure des échéances importantes nécessitant une action de votre part dans un délai déterminé. Vous avez le droit d’obtenir ces informations ainsi qu’une assistance dans votre langue, et ce, sans frais. Les assurés sont invités à contacter le numéro figurant au verso de leur carte d’adhérent. Toute autre personne peut appeler le 855-258-6518 et patienter jusqu’à l’invitation à composer le 0. Lorsque votre appel sera pris en charge, indiquez la langue souhaitée afin d’être mis en relation avec un interprète.

Achtung (German): Dieser Hinweis enthält Informationen zu Ihrem Versicherungsschutz. Darin sind möglicherweise wichtige Termine aufgeführt und Sie müssen möglicherweise bis zu bestimmten Fristen Maßnahmen ergreifen. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Mitglieder sollten die Telefonnummer auf der Rückseite ihres Mitgliedsausweises anrufen. Alle anderen können 855-258-6518 anrufen und den Dialog abwarten, bis sie aufgefordert werden, die 0 zu drücken. Wenn ein Agent antwortet, geben Sie die gewünschte Sprache an und Sie werden mit einem Dolmetscher verbunden.

ध्यान दें (Hindi): इस नोटिस में आपके बीमा कवरेज के बारे में जानकारी है। इसमें महत्वपूर्ण तिथियां हो सकती हैं और आपको निश्चित समय सीमा तक कार्रवाई करनी पड़ सकती है। आपको यह जानकारी और सहायता अपनी भाषा में निःशुल्क प्राप्त करने का अधिकार है। सदस्यों को अपने सदस्य पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और 0 दबाने का संकेत मिलने तक संवाद की प्रतीक्षा कर सकते हैं। जब कोई एजेंट उत्तर दे, तो वह भाषा बताएं जिसकी आपको आवश्यकता है और आपको दुभाषिया से जोड़ा जाएगा।

Leruoanya (Igbo): ọ́kwà a nwere ozi bànyéré mkpuchi megide ihe mberede gị. Ọ nwere ike inwe ụbọchị ndi dị óké ḿkpà ma o nwekwara ike idị mkpa ka imee ihe tupu oge ụfọdụ agafee. Inwere ikike inweta ozi a ya na enyemaka na asụsụ gị n'akwụghị ụgwọ ọbụla. Ndi òtù ga akpọ ọnụọgụgụ ekwenti dị na àzụ́ ḱáàdị njirimara ndi òtù ha. Ndi ọ̀zọ́ nile nwere íke ịkpọ 855-258-6518 ma chere geruo mkparịta ụka ruo mgbe asi ha pịa 0. Mgbe onye ozi zara,kwuo asụsụ ichọrọ, a ga ejikota gi na onye ntughari asụsụ.

Attenzione (Italian): Questa informativa contiene informazioni sulla copertura assicurativa. Potrebbe contenere date importanti e potrebbe essere necessario intraprendere azioni entro determinate scadenze. È possibile ottenere queste informazioni e assistenza nella propria lingua gratuitamente. I membri sono pregati di chiamare il numero di telefono riportato sul retro del proprio tesserino di riconoscimento. Tutti gli altri possono chiamare il numero 855-258-6518 e rimanere in linea fino a quando non viene richiesto di premere 0. Quando un operatore risponde, è necessario indicare la lingua desiderata per essere messi in contatto con un interprete.

주의 (Korean): 이 고지에는 귀하의 보험 적용 범위에 대한 정보가 포함되어 있습니다. 여기에는 주요 날짜가 포함되어 있을 수 있으며, 특정 마감일까지 조치를 취해야 할 수도 있습니다. 귀하는 비용 없이 귀하의 언어로 이러한 정보와 지원을 받을 권리가 있습니다. 회원은 회원증 뒷면에 있는 전화번호로 전화하시기 바랍니다. 회원이 아닌 모든 분들은 855-258-6518 로 전화하여 안내 메시지가 끝날 때까지 기다렸다가 0 을 눌러주세요. 상담원이 통화에 응답했을 때, 필요한 언어를 말씀하시면 통역사와 연결됩니다.

Baa'ákonínízin (Navajo): Díí bee ił hane'í béeso nich'ą́ąh naa'nil bee nik'é'asti'í bódahólníihgo bee baa dahane'í biyi'. Dayoołkáłí dóó bee ida'ii'aahí háídíí shį́į́ t'áá bich'į'jį' ha'át'íishį́į́ ádadiiliiłígíí biyi'. Díí bee baa dahane'í dóó t'áá jiik'eh nizaad bee nika'e'eyeedgo bee ná'ahoot'i'. Bił hada'dít'éhí binaaltsoos nitł'izhí bee béédahóziní bąąh béésh bee hane'í námboo biká'ígíí yee dahalne' dooleeł. Nááná ła' 855-258-6518 yee dahalne' dóó yáłti'í biba' asdáago niléí ó bił adílchíid hodoo'niidjį'. Naalnishí haadzį́į'go, saad nínízinígíí bee bił hodíilnih dóó ata' yáłti'í bich'į' ni'doolnih.

ध्यान दिनुहोस् (Nepali): यस सूचनामा तपाईंको बीमा कभरेजका बारेमा जानकारी समावेश छ। यसमा प्रमुख मितिहरू हुन सक्छन् र तपाईंले निश्चित समयसीमा भित्र कारबाही गर्नुपर्ने हुन सक्छ। तपाईंलाई यो जानकारी र सहयोग तपाईंको भाषामा निःशुल्क प्राप्त गर्ने अधिकार छ। सदस्यहरूले आफ्नो सदस्य परिचयपत्रको पछाडि रहेको फोन नम्बरमा कल गर्नुपर्छ। अरू सबैले 855-258-6518 मा कल गर्न सक्छन् र ० पुश गर्न प्रेरित नभएसम्म संवादको प्रतीक्षा गर्न सक्छन्। एजेन्टले जवाफ दिँदा, तपाईंलाई चाहिने भाषा बताउनुहोस् र तपाईंलाई दोभाषेसँग जोडिने छ।

Atenção (Portuguese): Este aviso contém informações sobre a cobertura do seu seguro. Ele pode conter datas importantes e você pode precisar tomar medidas dentro de determinados prazos. Você tem o direito de obter essas informações e assistência em seu idioma, sem nenhum custo. Os associados deverão ligar para o número de telefone indicado no verso do seu cartão de identificação de associado. Todos os outros podem ligar para 855-258-6518 e aguardar a mensagem até que seja solicitado a pressionar 0. Quando um agente atender, indique o idioma que você precisa e você será conectado a um intérprete.

Внимание (Russian): В настоящем уведомлении содержится информация о вашем страховом покрытии. Оно может содержать ключевые даты, и вам может потребоваться предпринять действия к определенным срокам. Вы имеете право получить эту информацию и помощь на своем языке бесплатно. Членам профсоюза следует звонить по номеру телефону, указанному на обратной стороне их удостоверения личности. Все остальные могут звонить по номеру 855-258-6518 и дождаться диалога, пока не появится предложение нажать 0. Когда агент ответит, назовите нужный вам язык, и вас соединят с переводчиком.

Fa'alogo (Samoan): O lenei fa'aaliga o lo'o iai fa'amatalaga i vaega e kava e lau inisiua. E ono aofia ai aso taua ma atonu e te manaʻomia ai le faia o se gaioiga i nisi taimi faʻagata. E iai lau aia tatau e maua ai nei fa'amatalaga ma fesoasoani i lau gagana e aunoa ma se totogi. E tatau i sui auai ona vili le numera o le telefoni i tua o le latou pepa faamaonia. O isi uma e mafai ona vala'au i le 855-258-6518 ma fa'atali i le talanoaga se'ia fa'atonuina e oomi le 0. A tali mai se so'o upu, fa'ailoa atu le gagana e te mana'omia ona fa'afeso'ota'i lea o oe i se tagata fa'aliliu.

Pažnja (Serbian): Ovo obaveštenje sadrži informacije o vašem osiguranju. Može sadržati ključne datume i možda ćete morati da preduzmete akciju do određenih rokova. Imate prava da dobijete ove informacije i pomoć na vašem jeziku besplatno. Trebalo bi da članovi nazovu telefonski broj na poleđini svoje članske legitimacije. Svi ostali mogu pozvati 855-258-6518 i sačekati automat dok ne dobiju obaveštenje da pritisnu taster "0". Kada se agent javi, navedite jezik koji vam je potreban i bićete povezani s prevodiocem

Atención (Spanish): Este aviso contiene información sobre su cobertura de seguro. Puede contener fechas clave y es posible que deba tomar medidas antes de determinadas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin coste alguno. Los afiliados deben llamar al número de teléfono que figura en el reverso de su tarjeta de identificación del afiliado. Todos los demás pueden llamar al 855-258-6518 y esperar el diálogo hasta que se les solicite presionar 0. Cuando un agente responda, indique el idioma que necesita y se conectará con un intérprete.

Atensyon (Tagalog): Ang abisong ito ay naglalaman ng impormasyon tungkol sa saklaw ng iyong insurance. Maaaring naglalaman ito ng mga mahahalagang petsa at maaaring kailanganin mong kumilos ayon sa ilang partikular na mga deadline. May karapatan kang makuha ang impormasyong ito at tulong sa iyong wika nang walang bayad. Ang mga miyembro ay dapat tumawag sa numero ng telepono sa likod ng kanilang member identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa masabihan na pindutin ang 0. Kapag sumagot ang isang ahente, sabihin ang wikang kailangan mo at ikaw ay ikokonek sa isang tagapagsalin.

توجہ (Urdu): اس نوٹس میں آپ کی انشورنس کوریج کے بارے میں معلومات شامل ہیں۔ اس میں کلیدی تاریخیں شامل ہو سکتی ہیں اور آپ کو کچھ آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑ سکتی ہے۔ آپ کو یہ معلومات اور مدد اپنی زبان میں، بغیر کسی قیمت کے حاصل کرنے کا حق ہے۔ ممبران کو اپنے رکنیتی کارڈ کی پشت پر دئے گئے فون نمبر پر کال کرنی چاہیے۔ باقی تمام لوگ *855-258-6518* پر کال کر سکتے ہیں اور 0 دبانے کا اشارہ ملنے تک ڈائیلاگ پر انتظار کرنا چاہئیے۔ جب کوئی ایجنٹ جواب دیتا ہے تو اپنی مطلوبہ زبان بتائیں اور آپ کا رابطہ ایک مترجم سے کر دیا جائے گا۔

Lưu ý (Vietnamese): Thông báo này có chứa thông tin về phạm vi bảo hiểm của bạn. Nó có thể chứa các ngày quan trọng và bạn có thể cần phải hành động theo thời hạn nhất định. Bạn có quyền nhận thông tin và hỗ trợ này bằng ngôn ngữ của mình mà không mất phí. Các thành viên nên gọi đến số điện thoại ở mặt sau thẻ thành viên của mình. Những người khác có thể gọi đến số 855-258-6518 và chờ qua hội thoại cho đến khi được nhắc nhấn số 0. Khi có nhân viên trả lời, hãy nêu ngôn ngữ bạn cần và bạn sẽ được kết nối với phiên dịch viên.

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