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 shown to significantly reduce your risk of heart disease. It helps control diabetes and some studies show it prevents premature births.

We’re pleased to introduce you to BlueDental Preferred.

As a member, you’ll enjoy:

- Two different deductible options to suit your budget
- More than 5,000 dentists throughout Maryland, Washington, D.C. and Northern Virginia, and access to a national network of 123,000 dentists and specialists
- Coverage for numerous dental services
- No referrals
- No charge for oral exams, cleanings and X-rays when you visit an in-network provider
- No claim forms to file in-network
- Medically necessary orthodontia benefit—for children up to age 19
- Guaranteed acceptance
- No charge for in-network covered services for members age 19 and under after they reach their $350 maximum out-of-pocket.

Read on to learn about BlueDental Preferred, offered by CareFirst BlueCross BlueShield (CareFirst). Or, contact our product consultants at 855-503-4862, Monday–Thursday, 8 a.m. to 5 p.m. and Friday, 10 a.m. to 5 p.m.

Did You Know...

- Some research suggests that heart disease, clogged arteries and stroke may be linked to the inflammation and infections that oral bacteria can cause.¹
- Diabetic patients with gum disease have a harder time controlling their blood sugar levels.¹
- Periodontal disease has been linked to premature birth and low birth weight.¹

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How Your Plan Works
Your Dental Plan Options

We offer two BlueDental Preferred options: **High Option** and **Low Option**. The High Option offers lower deductibles with preventive and diagnostic services covered in full without having to meet a deductible. The Low Option offers lower premiums with slightly higher deductibles. See pages 5 and 7 and decide which plan is best for your budget.

**BlueDental Preferred includes benefits for:**

**Preventive and diagnostic services (Class I)**

If you pick the High Option, there is no deductible for the following services, which are covered in full when visiting an in-network provider. If you pick the Low Option, these services are subject to the deductible.

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

**Basic and major services (Classes II, III, IV)**

After meeting a deductible, your plan includes fillings, simple extractions, periodontal scaling, root planing, root canals, oral surgery, dentures, crowns and more!

**Orthodontia (Class V)**

BlueDental Preferred offers benefits for braces when medically necessary for children up to age 19.

**BlueDental Preferred has a large network of providers**

As a member, you’ll enjoy access to more than 5,000 dentists throughout Maryland, Washington, D.C. and Northern Virginia, and access to a national network of 123,000 dentists and specialists. To locate a participating provider, go to carefirst.com/doctor, click on the Guest tab, select Dental and then Preferred Dental (PPO) & Pediatrics.

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.

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*Allowed benefit—the fee that providers in the CareFirst BlueCross BlueShield network have agreed to accept for a particular service. For example: Dr. Smith charges $100 to see a patient. To be included in a CareFirst network, he has agreed to accept $50 for the visit. After the member pays their copay or deductible, CareFirst will pay what’s left of the $50 charge. A participating provider cannot charge a member more than the allowed benefit (in this example $50) for any covered service.
BlueDental Preferred High Option

Meet the Smiths
High Option
Mary and Charles Smith are active retirees who recently took up golf. They have Medicare and have purchased a Supplement 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 a root canal and Charles needed a bridge.

<table>
<thead>
<tr>
<th>Common Dental Procedure</th>
<th>No Coverage1</th>
<th>BlueDental Preferred—High Option (In-Network)2</th>
<th>Savings on Services3</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month checkups, including routine exams, cleanings and X-rays (4 visits, 2 per person)</td>
<td>$784 ($196 per visit)</td>
<td>$0</td>
<td>$784</td>
</tr>
<tr>
<td>Root canal (bicuspoid)</td>
<td>$906</td>
<td>$97 (after $60 deductible)</td>
<td>$749</td>
</tr>
<tr>
<td>Bridge (3-unit)</td>
<td>$3,287</td>
<td>$985 (after $60 deductible)</td>
<td>$2,242</td>
</tr>
<tr>
<td>Total</td>
<td>$4,977</td>
<td>$1,202</td>
<td>$3,775</td>
</tr>
</tbody>
</table>

1 Based on National Dental Advisory Service Fee Report (2017).
2 Approximate amount. Pricing may vary depending upon dental provider’s negotiated rate with CareFirst.
3 Savings do not include premium costs.

With no dental coverage, the Smiths paid $4,977 for these services. They decided to purchase dental coverage to protect themselves against further unexpected dental costs. With BlueDental Preferred High Option, the Smiths would have spent only $1,202, a savings of more than $3,775 on these dental services. Now they’re covered and ready for whatever lies ahead!

Please note: all charges are subject to the $1,000 annual maximum.
# BlueDental Preferred High Option Summary of Benefits

<table>
<thead>
<tr>
<th>In-Network Member Pays</th>
<th>Out-of-Network Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLE APPLIES TO CLASSES II, III, IV</strong></td>
<td></td>
</tr>
<tr>
<td>- The family deductible amount is calculated in the aggregate. However, no family member will be charged more than the individual deductible amount.</td>
<td></td>
</tr>
<tr>
<td>- The in-network and out-of-network deductible will be a separate amount.</td>
<td></td>
</tr>
<tr>
<td>$60 Individual deductible; $180 Family deductible</td>
<td>$120 Individual deductible; $360 Family deductible</td>
</tr>
</tbody>
</table>

| **OUT-OF-POCKET MAXIMUM (CLASSES I–V) FOR MEMBERS UP TO AGE 19** |
| One member pays up to $350; Two or more members pay up to $700 | No limit |

| **ANNUAL MAXIMUM (CLASSES I–IV) FOR MEMBERS OVER AGE 19** |
| 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 (one per six months)
- Prophylaxis (one cleaning per six months)
- Bitewing X-rays (one per six months)
- Fluoride treatments until the end of the year in which member reaches age 19
- Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray
- Sealants on permanent molars until the end of the year in which member reaches age 19
- Space maintainers
- Palliative treatments
- Emergency oral exam

| **Basic Services (Class II)** |
| Direct placement fillings using approved materials |
| 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, and occlusal adjustments
- 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, vestibuloplasty and hemi-section)
- General anesthesia required for oral surgery

| **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 |
| Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance for members over age 19) |
| Dental implants, subject to medical necessity review (once per 60 months) |
| 50% of allowed benefit after deductible |
| 65% of allowed benefit after deductible |

## Orthodontic Services (Class V)

- Benefits for medically necessary orthodontic services are available for covered members until the end of the calendar year in which a member reaches the age of 19.

<table>
<thead>
<tr>
<th><strong>Summary of Exclusions:</strong> Not all services and procedures are covered by your benefits contract. The plan summary is for comparison purposes only and does not create rights not given through the benefit plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Frequency limitations may apply.</td>
</tr>
<tr>
<td><strong>2</strong> 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 members for the difference between the allowed benefit and their charges.</td>
</tr>
<tr>
<td><strong>3</strong> In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.</td>
</tr>
</tbody>
</table>
BlueDental Preferred Low Option

**Meet the Johnsons**

**Low Option**

Anna and Jeff Johnson are an energetic couple with two children. They own a catering business and have purchased a family health insurance plan that doesn’t include benefits for dental services. 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 Coverage¹</th>
<th>BlueDental Preferred—Low Option (In-Network)²</th>
<th>Savings on Services³</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month checkups, including routine exams, cleanings and X-rays (4 visits, 2 per person)</td>
<td>$1,568 ($190 per visit)</td>
<td>$0 (after $300 deductible)</td>
<td>$1,568</td>
</tr>
<tr>
<td>Root canal (bicuspid)</td>
<td>$906</td>
<td>$97 (deductible applies)</td>
<td>$809</td>
</tr>
<tr>
<td>Bridge (3-unit)</td>
<td>$3,287</td>
<td>$985 (deductible applies)</td>
<td>$2,302</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,761</strong></td>
<td><strong>$1,082</strong></td>
<td><strong>$4,679</strong></td>
</tr>
</tbody>
</table>

¹ Based on National Dental Advisory Service Fee Report (2017).
² Approximate amount. Pricing may vary depending upon dental provider’s negotiated rate with CareFirst.
³ Savings do not include premium costs.

With no dental coverage, the Johnsons paid $5,761 for these services. With BlueDental Preferred Low Option, the Johnsons would have saved more than $4,600 for these services. The Johnsons decided to purchase BlueDental Preferred Low Option coverage to protect themselves against future dental costs.

Please note: all charges are subject to the $1,000 annual maximum.
BlueDental Preferred Low Option Summary of Benefits

<table>
<thead>
<tr>
<th>DEDUCTIBLE APPLIES TO CLASSES I–IV</th>
<th>In-Network Member Pays</th>
<th>Out-of-Network Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>The family deductible amount is calculated in the aggregate. However, no family member will be charged more than the individual deductible amount.</td>
<td>$100 Individual deductible; $300 Family deductible</td>
<td>$200 Individual deductible; $600 Family deductible</td>
</tr>
<tr>
<td>OUT-OF-POCKET MAXIMUM (CLASSES I–V) FOR MEMBERS UP TO AGE 19</td>
<td>One member pays up to $350; Two or more members pay up to $700</td>
<td>No limit</td>
</tr>
</tbody>
</table>

ANNUAL MAXIMUM (CLASSES I–IV) FOR MEMBERS OVER AGE 19
- 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 (one per six months)
- Prophylaxis (one cleaning per six months)
- Bitewing X-rays (one per six months)
- Fluoride treatments\(^1\) until the end of the year in which member reaches age 19
- Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray\(^1\)
- Sealants on permanent molars\(^1\) until the end of the year in which member reaches age 19
- Space maintainers\(^1\)
- Palliative treatments
- Emergency oral exam
- No charge after deductible
- 20% of allowed benefit\(^2\) after deductible

BASIC SERVICES (CLASS II)
- Direct placement fillings using approved materials\(^1\)
- Simple extractions
- Periodontal scaling and root planing (once per 24 months, one full mouth treatment)
- 20% of allowed benefit\(^2\) after deductible
- 40% of allowed benefit\(^2\) after deductible

MAJOR SERVICES – SURGICAL (CLASS III)
- Surgical periodontic services including osseous surgery, and occlusal adjustments\(^1\)
- 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, vestibuloplasty and hemi-section)
- General anesthesia required for oral surgery
- 20% of allowed benefit\(^2\) after deductible
- 40% of allowed benefit\(^2\) after deductible

MAJOR SERVICES – RESTORATIVE (CLASS IV)
- Full and/or partial dentures (once per 60 months)
- Fixed bridges\(^1\), crowns, inlays and onlays (once per 60 months)
- Recementation of crowns, inlays and/or bridges (once per 12 months)
- Denture adjustments and relining\(^1\)
- Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance for members over age 19)
- Dental implants\(^2\), subject to medical necessity review (once per 60 months)
- 50% of allowed benefit\(^2\) after deductible
- 65% of allowed benefit\(^2\) after deductible

ORTHODONTIC SERVICES (CLASS V)
- Benefits for medically necessary orthodontic services are available for covered members until the end of the calendar year in which a member reaches the age of 19.
- 50% of allowed benefit\(^2\)
- 65% of allowed benefit\(^2\)

Summary of Exclusions: Not all services and procedures are covered by your benefits contract. The plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

1 Frequency limitations may apply.
2 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 members for the difference between the allowed benefit and their charges.
3 In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.
### Frequently Used Benefits

<table>
<thead>
<tr>
<th>Common Dental Procedures</th>
<th>Regular Cost</th>
<th>In-Network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive checkups, including routine exams, cleanings and X-rays</td>
<td>$190 per visit (2 visits per year)</td>
<td>$0 (after deductible for Low Option Plan)</td>
</tr>
<tr>
<td>Fillings and simple extractions</td>
<td>$146–$179</td>
<td>$10–$16 after deductible</td>
</tr>
<tr>
<td>Periodontal scaling and root planing (4 or more teeth per section of the mouth)</td>
<td>$261</td>
<td>$26 after deductible</td>
</tr>
<tr>
<td>Porcelain crown (high noble metal)</td>
<td>$1,156</td>
<td>$328 after deductible</td>
</tr>
<tr>
<td>Root canal therapy (molar, excluding final restoration)</td>
<td>$1,057</td>
<td>$126 after deductible</td>
</tr>
<tr>
<td>Complete upper dentures</td>
<td>$1,750</td>
<td>$355 after deductible</td>
</tr>
<tr>
<td>Medically necessary orthodontia (child up to age 19)</td>
<td>$5,355</td>
<td>$350</td>
</tr>
</tbody>
</table>

1 Based on National Dental Advisory Service Fee Report (2015)
2 Approximate amount. Pricing may vary depending upon dental provider’s negotiated rate with CareFirst.

This is a partial list of services. For specific questions, please contact our CareFirst Dental Business Operations team toll-free at 866-891-2802.
2018 Monthly Dental Rates

Figuring out the total monthly premium for the plans you’re considering is simple:

1. Based on where you live, find your rate on the chart below.
2. Circle the amount in the column that corresponds with your age when coverage will begin. If you’re buying an individual plan, that’s it!
3. For a family plan, repeat step 2 for each family member who will be covered by your new plan and add the numbers up.
4. If you want to pay quarterly, then multiply the monthly total by three. If you want to pay annually, multiply the monthly total by 12.

<table>
<thead>
<tr>
<th></th>
<th>Montgomery and Prince George’s Counties</th>
<th>Baltimore City; Anne Arundel, Baltimore, Harford and Howard Counties</th>
<th>Allegany, Carroll, Frederick, Garrett and Washington Counties</th>
<th>Calvert, Caroline, Cecil, Charles, Dorchester, Kent, Queen Anne’s, St. Mary’s, Somerset, Talbot, Wicomico and Worcester Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueDental Preferred High Option</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 0-20</td>
<td>$44.31</td>
<td>$45.65</td>
<td>$42.07</td>
<td>$43.42</td>
</tr>
<tr>
<td>Ages 21+</td>
<td>$44.76</td>
<td>$46.11</td>
<td>$42.50</td>
<td>$43.85</td>
</tr>
<tr>
<td><strong>BlueDental Preferred Low Option</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 0-20</td>
<td>$31.27</td>
<td>$32.21</td>
<td>$29.69</td>
<td>$30.63</td>
</tr>
<tr>
<td>Ages 21+</td>
<td>$33.27</td>
<td>$34.28</td>
<td>$31.59</td>
<td>$32.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Washington, D.C.</th>
<th>Virginia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueDental Preferred High Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 0-20</td>
<td>$34.30</td>
<td>$41.75</td>
</tr>
<tr>
<td>Ages 21+</td>
<td>$44.33</td>
<td>$46.51</td>
</tr>
<tr>
<td><strong>BlueDental Preferred Low Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 0-20</td>
<td>$24.94</td>
<td>$32.12</td>
</tr>
<tr>
<td>Ages 21+</td>
<td>$35.46</td>
<td>$38.25</td>
</tr>
</tbody>
</table>
Enrolling in Your New Dental Plan

You have four options to enroll:

1. Enroll online at carefirst.com/shopdental. Get instant confirmation and have access to real-time help via:
   - Click-to-Call
   - Click-to-Chat

2. Fill out and sign the application that matches where you live—Maryland, Washington, D.C. or Northern Virginia. Be sure to choose the annual or quarterly payment option and check either the Low Option or High Option deductible plan on the application. Use the enclosed, postage-paid envelope or mail your application to:

   Mailroom Administrator
   P.O. Box 14651
   Lexington, KY 40512

3. Enroll online through your state’s Exchange.
   Maryland — marylandhealthconnection.com
   Virginia — healthcare.gov
   Washington, D.C. — dchealthlink.com

4. Enroll through your broker, if you have one. A broker is an independent agent who represents you (the buyer) and works to find you the best health insurance policy for your needs.

If you have any questions about the application contact a dental specialist at 855-503-4862, Monday – Thursday, 8 a.m. to 5 p.m. and Friday, 10 a.m. to 5 p.m.

Applications may be submitted at any time, but to guarantee your coverage will be effective the first of the following month, we must receive your application before the 20th of the month. For example: if CareFirst receives an application on March 18, that individual’s coverage starts April 1. If that same application did not reach our offices until March 25, coverage would not be in effect until May 1.

Once your application has been received, we will send you a bill for your first premium payment. We must receive your first premium payment before your coverage can begin. After CareFirst receives your payment, you will be mailed your member ID card(s) and your individual enrollment agreement. Then you can start enjoying the benefits of good dental care.

Please note: In order to purchase coverage, you must live in Maryland, Washington, D.C. 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.

When you’re ready to review a listing of providers, please visit carefirst.com/doctor. Click on the Guest link. Then, click on Dental and enter your zip code, select Preferred Dental (PPO) & Pediatrics. If you prefer a printed directory, please call our product consultants.
Maryland Resident Application

Please fill out the Maryland BlueDental Preferred application on the following pages, if you live in Maryland.
BlueDental Preferred Application
Maryland Residents

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type 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. If incomplete, the application will be returned and your coverage will be delayed.

1. APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
<th>Social Security #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

Residence County | Date of Birth | Sex | Marital Status |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Male ☐ Female</td>
<td>☐ Single ☐ Married ☐ Domestic Partner</td>
</tr>
</tbody>
</table>

Home Phone ( ) | Work/Cell Phone ( ) | Payment Option ☐ Annually ☐ Quarterly

2. DEDUCTIBLE SELECTION (Check One)

☐ Low Option ($100 Individual In-Network deductible) ☐ High Option ($60 Individual In-Network deductible)

3. ENROLLING FAMILY MEMBER(S) – Only list family members to be covered on this plan

<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</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td></td>
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<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
<tr>
<td>Dependent 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
<tr>
<td>Dependent 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
<tr>
<td>Dependent 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
<tr>
<td>Dependent 4</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
<tr>
<td>Dependent 5</td>
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<td></td>
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<td>☐M ☐F</td>
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<tr>
<td>Dependent 6</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
<tr>
<td>Dependent 7</td>
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<td></td>
<td></td>
<td></td>
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<td>☐M ☐F</td>
</tr>
<tr>
<td>Dependent 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐M ☐F</td>
</tr>
</tbody>
</table>

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. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc. If you reside in either Prince George’s or Montgomery county, then a Group Hospitalization and Medical Services, Inc. policy will be issued. For Baltimore City or any other county in the state of Maryland, a CareFirst of Maryland, Inc. policy will be issued.
## 4. 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:

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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](http://www.carefirst.com/myaccount). Members can also change email and consent information anytime by logging into [www.carefirst.com/myaccount](http://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.

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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.
### 5. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

**IT IS UNDERSTOOD AND AGREED THAT:**

- A copy of this application will be provided to the Primary Applicant or application filer.
- 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 or 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 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.

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Washington, D.C. Resident Application

Please fill out the Washington, D.C. BlueDental Preferred application on the following pages, if you live in the Washington, D.C.
INSTRUCTIONS
1. Please fill out all applicable spaces on this application. Print or type 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. If incomplete, the application will be returned and your coverage will be delayed.

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2. DEDUCTIBLE SELECTION (Check One)

☐ Low Option ($100 Individual In-Network deductible)  ☐ High Option ($60 Individual In-Network deductible)

3. ENROLLING FAMILY MEMBER(S) – Only list family members to be covered on this plan

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• 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 policy.
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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, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature of Applicant: X
Date

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Northern Virginia Resident Application

Please fill out the Virginia BlueDental Preferred 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 or type 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. *If incomplete, the application will be returned and your coverage will be delayed.*

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

☐ New coverage  ☐ Making changes
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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 (if applicable) certify that the applicant has read, or had read to him/her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

A coordination of benefits may apply as the result of the existence of other similar insurance providing coverage for the same dental services.

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's Signature: X  Date

Signature of Agent (if applicable): X  Date

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Signature of Primary Applicant: X  Date

Signature of Applicant 2: X (Spouse or Domestic Partner)  Date

Parent or Legal Guardian's Signature: X  Date

FOR BROKER USE ONLY:

Name:  NPN #:  Tax ID #:  CareFirst-Assigned ID #

Contracted Broker:  

Sub-Agent/Sub-Agency:  

Writing Agent:  

Exclusions and Limitations

For Maryland residents:

3.1 Limitations.

A. Covered dental services must be performed by or under the supervision of a dentist with an active and unrestricted license, 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, custom denture teeth and implant supported fixed or removable prostheses.

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 procedure.

3.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge, or crown as a result of loss or theft.

B. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable.

C. Replacement of dentures, bridges, metal and/or porcelain crowns, inlays, onlays and crown build-ups 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 Agreement and are judged by CareFirst to be adequate and functional.

D. Replacement of stainless steel crowns (until the end of the calendar year in which the member turns age 19) if judged by CareFirst to be adequate and functional.

E. Treatment or services for temporomandibular joint (TMJ) disorders including but not limited to radiographs and/or tomographic surveys, except for TMJ arthograms, including injection, and other TMJ films, by report, for members up to age 19.

F. Gold foil fillings.

G. Periodontal appliances.

H. Prescription drugs, including, but not limited to antibiotics administered by the member, inhalation of nitrous oxide (except for members under age 19), 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 Dental Service in this Agreement.

I. Nightguards for members over age 19, or other oral orthotic appliances, unless specifically listed as a Covered Dental Service in this Agreement.

J. 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 Agreement.

K. Intentional tooth reimplantation or transplantation for members over age 19.

L. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.

M. 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.

N. Transseptal fiberotomy.

O. Orthognathic surgery.

P. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service in this Agreement.

Q. Any orthodontic services after the last day of the month in which Covered Dental Services ended except as specifically described in this Agreement.
R. Services or supplies that are not medically necessary as determined by CareFirst.
S. Services not specifically listed in this Agreement as a Covered Dental Service, even if medically necessary.
T. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
U. 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.
V. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
W. Services or supplies that are experimental or investigational in nature.
X. Orthodontic or any other services for cosmetic purposes.
Y. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
Z. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.

For Washington, D.C. residents:

3.1 Limitations.
A. Covered dental services must be performed by or under the supervision of a dentist with an active and unrestricted license, 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 procedure.

3.2 Exclusions. Benefits will not be provided for:
A. Replacement of a denture, bridge, or crown as a result of loss or theft.
B. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable.
C. Replacement of dentures, bridges, implants, metal and/or porcelain crowns, inlays, onlays and crown build-ups 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 Agreement and are judged by CareFirst to be adequate and functional.
D. Treatment or services for temporomandibular joint (TMJ) disorders including but not limited to radiographs and/or tomographic surveys.
E. Gold foil fillings.
F. Periodontal appliances.
G. 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 Dental Service in this Agreement.
H. Nightguards for members over age 19, or other oral orthotic appliances, unless specifically listed as a Covered Dental Service in this Agreement.
I. 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 Agreement.
J. Intentional tooth reimplantation or transplantation.
K. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.
L. 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.

M. Transseptal fiberotomy.

N. Orthognathic surgery.

O. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service in this Agreement.

P. Any orthodontic services after the last day of the month in which Covered Dental Services ended.

Q. Services or supplies that are not medically necessary as determined by CareFirst.

R. Services not specifically listed in this Agreement as a Covered Dental Service, even if medically necessary.

S. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).

T. 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.

U. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.

V. Services or supplies that are experimental or investigational in nature.

W. Orthodontic or any other services for cosmetic purposes.

X. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

Y. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.

Z. Provision splinting, intracoronal and extracoronal.

AA. Endodontic implant.

BB. Fabrication of athletic mouthguard.

CC. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

DD. Adjustments to maxillofacial prosthetic appliance.

EE. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral).

FF. Any orthodontic services after the last day of the calendar year in which the member turned age 19.

For Virginia residents:

3.1 Limitations.

A. Covered dental services must be performed by or under the supervision of a dentist with an active and unrestricted license, 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, custom denture teeth and implant supported fixed or removable prostheses.

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 procedure.

3.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge, or crown as a result of loss or theft.

B. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable.

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C. Replacement of dentures, bridges, metal and/or porcelain crowns, inlays, onlays and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the dental benefits Agreement and are judged by CareFirst to be adequate and functional.
D. Treatment or services for temporomandibular joint (TMJ) disorders including but not limited to radiographs and/or tomographic surveys.
E. Gold foil fillings.
F. Periodontal appliances.
G. Prescription drugs, including, but not limited to antibiotics administered by the member, inhalation of nitrous oxide (except for members under age 19), 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 Dental Service in the dental benefits Agreement.
H. Nightguards for members over age 19, or other oral orthotic appliances, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
I. 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 the dental benefits Agreement.
J. Intentional tooth reimplantation or transplantation for members over age 19.
K. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.
L. 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.
M. Transseptal fiberotomy.
N. Orthognathic surgery.
O. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
P. Any orthodontic services after the last day of the month in which Covered Dental Services ended.
Q. Services or supplies that are not medically necessary as determined by CareFirst.
R. Services not specifically listed in the dental benefits Agreement as a Covered Dental Service, even if medically necessary, except as required to be covered under state or federal laws and regulations.
S. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
T. 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.
U. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
V. Services or supplies that are experimental or investigational in nature.
W. Orthodontic or any other services for cosmetic purposes.
X. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
Y. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.
Z. Local anesthesia services are included in the benefit for restorative services and surgical services and are not separately reimbursed.
Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. 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 8894
Baltimore, Maryland 21224

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)


NOLDA (12/17)

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. of Maryland (used in VA by: First Care, Inc.).

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Foreign Language Assistance

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 member identification card. All others may call 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.

Amharic (Amharic)

Foreign Language Assistance

Edê Yorùbá (Yoruba) litéléko: Àkiyé is ìíú win ìpì ìsì èdáì iṣòwò fún ìbíjìì. Ìbíjìì ni ìbíjìì tàìpò o si le ni ìbíjìì gbé igbésé ni ìbíjìì ojo ìbíjìì èkàn. O ni ètì látì gba ìiwùn yí àti ìránlò wù ni èdè re íwé. Ìwùn omo-ègbé ìwùn pe námá fún wí wá léyín káádi idánmò wín. Ìwùn miràn le pé 855-258-6518 kí o sí dùró nípa ìjíòró títì a ò fi so fun ìbíjìì tó jẹ. Njikòati asọjú kàbá dähin, sì èdè ti o fẹ a ò si so ò pò mó ìgbúfọ kán.


Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Russian (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут позвонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.
हिन्दी (Hindi) भाषा: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मूल्य तिथियाँ का उल्लेख है और आपके लिए किसी नियम समय-सीमा के भीतर काम करना जरूरी हो। आपकी यह जानकारी और संबंधित सहायता अपनी भाषा में निश्चल पाने का अधिकार है। सदस्यों को अपने पहले पत्र के पीछे दिया गए फोन नंबर पर कॉल करना चाहिए। अन्य सम्मिलित नंबर 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद करना चाहिए। जब कोई एजेंट उत्तरदायी तो उसे अपनी भाषा बताएं और आपको व्याख्याकार से कॉनेक्ट कर दिया जाएगा।

BàŚkā-wūḍū (Bassa) Tà Dùù Càol! Bò ni nà bìi bå nì kó bó à ni fùù-fùù-tĩn nycè jè dyi. Bò ni nà bìi bérè wà jè bì mì kó dë wa mó mì kó nyuèc nycè hwè bérè wà bérè kù. O nì mì kó bérè mì kó bì mì ni bì kó bì kó bì kó bì bì bì kó bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì bì
Igbo (Igbo) Nwụbma: Ọkwa ọ dịERE ọzi gbasara mkpuchị nchekwa onwe gi. Ọ nwere ike ịnwọ mkpa, i nwere ike ime ihe tupu ufohụ ubochi njedebe. I nwere ikike inweta ọzi na enyemaka a n‘asụsu gi na akwụghị ugwọ ọ bua. Ndị otu kwesiri ịkpọ akara ekwenị di n‘azu nke kaadi njirimara ha. Ndị ọzọ nịile ọnwere ịke ịkpọ 855-258-6518 wee chere ụbọchọ ahụ ruo mgbe amanyere iji 0. Mgbe onye nnọchite anya zara, kwo asusu i chọrọ, a ga-eji ọgị ga onye ọkwa ọkwu.


Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu’un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보 및 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 진화번호로 연락해 주십시오. 회원이 아닐 경우 855-258-6518 번으로 전화하여 0을 누르는 데서가 끝날 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하신 후 등록 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge': Díí bee il hane’ígíi bii dahóló bee éé dahózin béeso ách’aáh naaníl ník’ist’íígíi bá. Bii dahólóqoo doo ńiisíi yoolkákálígíi dór t’áádoó le’é ádádooyílíígíi da yökeedgo t’àá doo bee e’e’aaah ájíil’íih. Bee ná ahóót’íí díí bee il hane’ dóó niká’ádoowol t’áá níńízaad bee t’áá jíik’ée. Atah danlinígíi béesh bee hane’ée bee wólta’ígíi nit’ízgo bee nee hödolzinígíi bikéédéq’ bikáá’ bích’í’ hödooñííjí’í. Aadóo náánála’ el kojíí dahódooñííh 855-258-6518 dóó yi diíts’íí yalt’íígíi t’àá nílíjíí áádoó éi bikéédóó naasbaq béí addilíihít. Aká’ánídaawol’ígíi neidítáa’go, saad bee yáíñít’íígíi yíi diíkí dóó ata’ halné’é lá niká’ádoowol. 
### Policy Form Numbers

#### Maryland

CFMI—MD Individual Dental—On Exchange 2017
- BlueDental Preferred HIGH Option: CFMI/EXC/DEN/IEA (1/14); CFMI/DB/PREF DENT DOCS-SOB (R. 1/15); CFMI/EXC/2018 DENTAL AMEND (1/18); CFMI/DOL APPEAL (R. 9/11); and any amendments
- BlueDental Preferred LOW Option: CFMI/EXC/DEN/IEA (1/14); CFMI/DB/PREF DENT DOCS-SOB LOW (1/15); CFMI/EXC/2018 DENTAL AMEND LOW (1/18); CFMI/DOL APPEAL (R. 9/11); and any amendments

CFMI—MD Individual Dental—OFF Exch 2017
- BlueDental Preferred HIGH Option: CFMI/DEN/IEA (1/14); CFMI/DB/PREF DENT DOCS-SOB (R. 1/15); CFMI/DB/2018 DENTAL AMEND (1/18); CFMI/DOL APPEAL (R. 9/11); and any amendments
- BlueDental Preferred LOW Option: CFMI/DEN/IEA (1/14); CFMI/DB/PREF DENT DOCS-SOB LOW (1/15); CFMI/DB/2018 DENTAL AMEND LOW (1/18); CFMI/DOL APPEAL (R. 9/11); and any amendments

GHMSI—MD Individual Dental—ON Exch 2017
- BlueDental Preferred HIGH Option: MD/CF/EXC/DEN/IEA (1/14); MD/CF/DB/PREF DENT DOCS-SOB (R. 1/15); MD/CF/EXC/2018 DENTAL AMEND (1/18); MD/GHMSI/DOL APPEAL (R. 9/11); and any amendments
- BlueDental Preferred LOW Option: MD/CF/EXC/DEN/IEA (1/14); MD/CF/DB/PREF DENT DOCS-SOB LOW (1/15); MD/CF/EXC/2018 DENTAL AMEND LOW (1/18); MD/GHMSI/DOL APPEAL (R. 9/11); and any amendments

GHMSI—MD Individual Dental—OFF Exch 2017
- BlueDental Preferred HIGH Option: MD/CF/DB/DENTAL/IEA (1/14); MD/CF/DB/PREF DENT DOCS-SOB (R. 1/15); MD/CF/DB/2015 DENTAL AMEND (REV 1/15); MD/CF/DB/2018 DENTAL AMEND (1/18); MD/GHMSI/DOL APPEAL (R. 9/11); and any amendments
- BlueDental Preferred LOW Option: MD/CF/DB/DENTAL/IEA (1/14); MD/CF/DB/PREF DENT DOCS-SOB LOW (1/15); MD/CF/DB/2015 DENTAL AMEND (REV 1/15); MD/CF/DB/2018 DENTAL AMEND LOW (1/18); MD/GHMSI/DOL APPEAL (R. 9/11); and any amendments

#### Washington, D.C.

DC GHMSI CD ON Exchange:
- BlueDental Preferred HIGH Option: DC/CF/DB/EXC/DENTAL/IEA (1/14); DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15); DC/CF/EXC/2015 DENTAL AMEND (REV 1/15); DC/CF/EXC/2018 DENTAL AMEND (1/18); DC/GHMSI/DOL APPEAL (R. 11/11); and any amendments
- BlueDental Preferred LOW Option: DC/CF/DB/EXC/DENTAL/IEA (1/14); DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15); DC/CF/EXC/2015 DENTAL AMEND (REV 1/15); DC/CF/EXC/2018 DENTAL AMEND (1/18); DC/GHMSI/DOL APPEAL (R. 11/11); and any amendments

DC GHMSI CD OFF Exchange:
- BlueDental Preferred HIGH Option: DC/CF/DB/DENTAL/IEA (1/14); DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15); DC/CF/DB/2015 DENTAL AMEND (REV 1/15); DC/CF/DB/2018 DENTAL AMEND (1/18); DC/GHMSI/DOL APPEAL (R. 11/11); and any amendments
- BlueDental Preferred LOW Option: DC/CF/DB/DENTAL/IEA (1/14); DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15); DC/CF/DB/2015 DENTAL AMEND (REV 1/15); DC/CF/DB/2018 DENTAL AMEND LOW (1/18); DC/GHMSI/DOL APPEAL (R. 11/11); and any amendments

#### Virginia

Virginia GHMSI CD ON EXCH:
- BlueDental Preferred HIGH Option: VA/CF/DB/PREF DENT (R. 1/15)-HIX; VA/CF/DB/2017 DENTAL AMD HIGH (1/17)-HIX; and any amendments
- BlueDental Preferred LOW Option: VA/CF/DB/PREF DENT LOW (1/15)-HIX; VA/CF/DB/2017 DENTAL AMD LOW (1/17)-HIX; and any amendments

Virginia GHMSI CD OFF EXCH:
- BlueDental Preferred HIGH Option: VA/CF/DB/PREF DENT (R. 1/15); VA/CF/DB/2017 DENTAL AMD HIGH (1/17)
- BlueDental Preferred LOW Option: VA/CF/DB/PREF DENT LOW (1/15); VA/CF/DB/2017 DENTAL AMD LOW (1/17)