CareFirst. Family of health care plans

Individual Select Dental HMO 2022

MARYLAND • WASHINGTON, D.C. • NORTHERN VIRGINIA
Welcome

Your smile says a lot about you. It’s the first thing people see when they meet you. 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 and help prevent some diseases and serious health conditions.

**Individual Select Dental HMO offers** comprehensive coverage for in-network and preventive diagnostic services. This plan provides access to over 600 dentists throughout Maryland, Washington, D.C. and Northern Virginia—all at a **low premium**.

As a member, you’ll enjoy:

- No deductible
- Predictable out-of-pocket costs
- Quick and easy enrollment
- No claim forms to file
- Guaranteed acceptance

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

For your convenience, our product consultants are available at 855-503-4862, Monday–Thursday from 8 a.m. to 5 p.m. and Friday from 10 a.m. to 5 p.m. ET.
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How Your Plan Works
Your Dental Plan

As a member, you’ll receive comprehensive coverage for in-network and preventive diagnostic services from a network of more than 600 participating dentists in Maryland, Washington, D.C. and Northern Virginia.

**Individual Select Dental HMO** offers reliable dental care with predictable copayments for routine and major dental services such as:
- Preventive and diagnostic dental care
- Surgical extractions
- Root canal therapy
- Comprehensive orthodontic treatment (adults and adolescents)

**Our network**

As a member of our Dental HMO plan, you’ll select a general dentist from a network of participating providers to coordinate all of your dental care. To find a participating dentist, visit carefirst.com/findadoc and select **DHMO—Individual (IND20)** from the Network drop-down menu. When specialized care is needed, your general dentist will refer you to a specialist within the Dental HMO network. This plan does not cover dental services outside of the provider network.

Note: Please review the Exclusions and Limitations for information on out-of-area emergency care.

### Common Dental Procedures

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Regular Cost</th>
<th>In-Network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive checkups</strong> <em>(includes routine exams, cleanings and X-rays)</em></td>
<td>$202 per visit (2 visits per year)</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td><strong>Basic dental services</strong> <em>(includes fillings, simple extractions and more)</em></td>
<td>$146-$198</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td><strong>Soft tissue management</strong> <em>(includes periodontal scaling, periodontal maintenance and more)</em></td>
<td>$280</td>
<td>$70 per office visit</td>
</tr>
<tr>
<td><strong>Porcelain crown</strong> <em>(high noble metal)</em></td>
<td>$1,220</td>
<td>$460</td>
</tr>
<tr>
<td><strong>Root canal therapy</strong> <em>(bicuspid, excludes final restoration)</em></td>
<td>$1,138</td>
<td>$375 primary dentist or $475 specialty care dentist</td>
</tr>
<tr>
<td><strong>Complete upper dentures</strong></td>
<td>$1,837</td>
<td>$495</td>
</tr>
</tbody>
</table>
| **Orthodontia (braces)**
  - Comprehensive—Adolescent                                                           | $5,480       | $2,500            |
  - Comprehensive—Adult                                                                | $5,495       | $2,700            |

1. Based on National Dental Advisory Service Fee Report (2020).
2. Approximate amount. Pricing may vary depending on dental provider’s negotiated rate with CareFirst.

This is a partial listing of services. If you have any questions, please call our product consultants at 855-503-4862, Monday–Thursday from 8 a.m. to 5 p.m. and Friday from 10 a.m. to 5 p.m. ET.
# 2022 Dental Rates

## Maryland

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Annual Rate</th>
<th>Quarterly Rate</th>
<th>1st Payment</th>
<th>2nd Payment</th>
<th>3rd Payment</th>
<th>4th Payment</th>
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<tbody>
<tr>
<td>Individual</td>
<td>$220.08</td>
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<td>$55.02</td>
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<tr>
<td>Individual &amp; Adult</td>
<td>$440.16</td>
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<td>$110.04</td>
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<tr>
<td>Individual &amp; Child(ren)</td>
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<td>$101.79</td>
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<tr>
<td>Family</td>
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<td>$154.05</td>
<td>$154.05</td>
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</table>

## Washington, D.C.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Annual Rate</th>
<th>Quarterly Rate</th>
<th>1st Payment</th>
<th>2nd Payment</th>
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<tr>
<td>Individual</td>
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<tr>
<td>Individual &amp; Adult</td>
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<tr>
<td>Individual &amp; Child(ren)</td>
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## Northern Virginia

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Annual Rate</th>
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<th>1st Payment</th>
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<tbody>
<tr>
<td>Individual</td>
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<td>$72.33</td>
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<td>$72.33</td>
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<tr>
<td>Individual &amp; Adult</td>
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<td>$144.66</td>
<td>$144.66</td>
<td>$144.66</td>
<td>$144.66</td>
</tr>
<tr>
<td>Individual &amp; Child(ren)</td>
<td>$535.20</td>
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<td>$133.80</td>
<td>$133.80</td>
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<tr>
<td>Family</td>
<td>$810.12</td>
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<td>$202.53</td>
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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.
Enroll Today
Enrolling in Your New Dental Plan

Applying is Easy!
Return the paper application in the enclosed, postage-paid envelope or mail your completed application to:
Mail Administrator
P.O. Box 14651
Lexington, KY 40512

You can also enroll through your broker.

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.

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.

Need to find a dentist?
When you’re ready to review a list of providers, please visit carefirst.com/findadoc. From the Network drop-down menu, select DHMO—Individual (IND20). Remember to call your provider’s office to confirm that they are accepting new patients and your insurance.

Please note: 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.

If your address changes and you are no longer in our service area, please note that you will no longer be eligible for this plan.
Application for Maryland Residents

Please fill out the application on the following pages if you live in Maryland.
# 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

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

Date of Birth

Sex
- Female
- Male

Marital Status
- Single
- Married
- Partner/Other

Home Phone

Work/Cell Phone

Dental Office Code

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 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 (DENTAL HMO PLAN MUST HAVE A DENTAL OFFICE CODE. EACH PERSON MAY SELECT THEIR OWN DENTIST.)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Relationship</th>
<th>Social Security #</th>
<th>Date of Birth</th>
<th>Sex</th>
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Dental Office Code

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<tbody>
<tr>
<td>Domestic Partner</td>
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<tr>
<td>Dependent 1</td>
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<td>Dependent 2</td>
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<td>Dependent 3</td>
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<tr>
<td>Dependent 4</td>
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</table>
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:

- 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. Spouses, 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.

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.

<table>
<thead>
<tr>
<th>PRIMARY APPLICANT NAME</th>
<th>EMAIL ADDRESS</th>
<th>CELL PHONE NUMBER</th>
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<tr>
<th>ALTERNATE EMAIL ADDRESS</th>
<th>ALTERNATE CELL PHONE NUMBER</th>
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</table>

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 is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
■ This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment.
■ 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 The Dental Network policy.
■ If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at 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:

<table>
<thead>
<tr>
<th>Name:</th>
<th>NPN #:</th>
<th>Tax ID #:</th>
<th>CareFirst-Assigned ID #:</th>
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</thead>
<tbody>
<tr>
<td>Contracted Broker:</td>
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<tr>
<td>Sub-Agent/Sub-Agency:</td>
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<tr>
<td>Writing Agent:</td>
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</tbody>
</table>
Application for Washington, D.C. Residents

Please fill out the application on the following pages if you live in Washington, D.C.
INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Residence Address: (Number and Street, Apt #)</th>
<th>City</th>
<th>State</th>
<th>Zip Code (9-digit, if known)</th>
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<thead>
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<th>City</th>
<th>State</th>
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<th>Date of Birth</th>
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<th>Marital Status</th>
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<tr>
<th>Home Phone</th>
<th>Work/Cell Phone</th>
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<th>Payment Option</th>
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<table>
<thead>
<tr>
<th>Sex</th>
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<td></td>
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<td>F</td>
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</table>

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<th>Dentist Code</th>
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CareFirst BlueChoice, Inc. is an independent licensee 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. ELECTRONIC COMMUNICATION CONSENT

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- 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, legal or civil union 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.

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).

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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
- [x] 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 is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
- This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment.
- 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 BlueChoice policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at 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 DEFEATING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, CAREFIRST BLUECHOICE, INC. MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

<table>
<thead>
<tr>
<th>Signature of Applicant: X</th>
<th>Date:</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Parent or Legal Guardian Signature: X</th>
<th>Date:</th>
</tr>
</thead>
</table>

**FOR OFFICE USE ONLY:**

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

<table>
<thead>
<tr>
<th>Signature of Primary Applicant: X</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent or Legal Guardian's Signature: X</th>
<th>Date</th>
</tr>
</thead>
</table>

**FOR BROKER USE ONLY:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>NPN #</th>
<th>Tax ID #</th>
<th>CareFirst-Assigned ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracted Broker:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Agent/Sub-Agency:</td>
<td></td>
<td></td>
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<tr>
<td>Writing Agent:</td>
<td></td>
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</tbody>
</table>
Application for Northern Virginia Residents

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

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application, 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

<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>

<table>
<thead>
<tr>
<th>Residence Address: (Number and Street, Apt #)</th>
<th>City</th>
<th>State</th>
<th>Zip Code (9-digit, if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing Address, if different: (Number and Street, Apt #)</th>
<th>City</th>
<th>State</th>
<th>Zip Code (9-digit, if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Single</th>
<th>Married</th>
<th>Domestic Partner</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work/Cell Phone</th>
<th>Dental Office Code</th>
<th>Payment Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
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</tr>
</tbody>
</table>

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 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 (DENTAL HMO PLAN MUST HAVE A DENTAL OFFICE CODE. EACH PERSON MAY SELECT THEIR OWN DENTIST.)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Relationship</th>
<th>Social Security #</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Dental Office Code</th>
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</thead>
<tbody>
<tr>
<td>Spouse</td>
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<td></td>
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<tr>
<td>Domestic Partner</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 1</td>
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<td></td>
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</tr>
<tr>
<td>Dependent 2</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 4</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
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:

- 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. Spouses, 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.

<table>
<thead>
<tr>
<th>PRIMARY APPLICANT NAME</th>
<th>EMAIL ADDRESS</th>
<th>CELL PHONE NUMBER</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>ALTERNATE EMAIL ADDRESS</th>
<th>ALTERNATE CELL PHONE NUMBER</th>
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</tbody>
</table>

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery by:

- [ ] Email only
- [ ] Cell phone text messaging only
- [x] 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 is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
■ This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment.
■ 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 BlueChoice policy.
■ If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at 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: __________________________

Sub-Agent/Sub-Agency: __________________________

Writing Agent: __________________________
Additional Information
Exclusions and Limitations

Maryland

PLAN LIMITATIONS In-Network. The following exclusions and limitations shall apply:

- Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;
- Services which are provided without cost to the Covered Individual and/or Dependent(s) by any municipality, county or other political subdivision (with the exception of Medicaid);
- Services which, in the opinion of the Participating DENTIST, are not necessary for the Covered Individual and/or Dependent(s) health;
- Payment of any claim or bill will not be made for prohibited referrals;
- Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient's dental health;
- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
- Dispensing of drugs, except those used as a local anesthetic;
- Hospitalization for any dental procedure;
- Loss or theft of bridgework or dentures previously supplied under the PLAN;
- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
- Any implantation;
- General anesthesia;
- Services that cannot be performed because of the general health of the patient;
- Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period.

Unlisted procedures will be provided at the dentist’s charge unless The Dental Network, Inc. determines the procedure is a covered benefit that has not yet been added to the Schedule of Benefits and Copayments. If so determined, the Covered Individual Copayments will be determined by The Dental Network, Inc. If a Covered Individual has questions about the Covered Individual Copayment for an unlisted CDT code, the Covered Individual should call the telephone number located on the Covered Individual’s Membership Identification Card;

- Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
- Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual and/or Dependent(s) General Participating DENTIST; all services listed on the Schedule of Benefits and Copayments will be provided by a general Participating DENTIST or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an Approved Specialist or recommend that the Covered Individual or Dependent contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care, and a referral to a non-participating general dentist or specialist;

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

- Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

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

ALL PRICES ARE EXCLUSIVE OF GOLD
WASHINGTON, D.C.

PLAN LIMITATIONS. The following in-network exclusions and limitations shall apply:

A. Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;
B. Unlisted procedures will be provided at the dentist’s charge unless CareFirst BlueChoice, Inc. determines the procedure is a covered benefit that has not yet been added to the Schedule of Benefits and Copayments. If so determined, the Covered Individual Copayments will be determined by CareFirst BlueChoice, Inc.;
C. Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Individual and/or Dependent(s) health;
D. Payment of any claim or bill will not be made for prohibited referrals;
E. Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient’s dental health;
F. Oral surgery requiring the setting of fractures or dislocations;
G. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
H. Dispensing of drugs, except those used as a local anesthetic;
I. Hospitalization for any dental procedure;
J. Loss or theft of bridgework or dentures previously supplied under the PLAN;
K. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
L. Any implantation;
M. General anesthesia;
O. Services that cannot be performed because of the general health of the patient;
P. Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;
Q. Unlisted procedures will be provided at the dentist’s charge unless CareFirst BlueChoice, Inc. determines the procedure is a covered benefit that has not yet been added to the Schedule of Benefits and Copayments. If so determined, the Covered Individual Copayments will be determined by CareFirst BlueChoice, Inc.;
R. Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
S. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual and/or Dependent(s) General Participating DENTIST;
T. All services listed on the Schedule of Benefits and Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an approved Specialist or recommend that the Covered Individual or Dependent contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care; and a referral to a non-participating general dentist or specialist;
U. Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).
V. Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

OUT-OF-AREA EMERGENCY CARE: Covered Individuals and/or Dependents are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest PLAN Dental Office. Limited to $50 per Covered Individual and/or Dependent(s) per emergency.

ALL PRICES ARE EXCLUSIVE OF GOLD
Virginia

PLAN LIMITATIONS. The following limitations shall apply:

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

B. Unlisted procedures will be provided at the dentist's charge unless CareFirst BlueChoice, Inc. determines the procedure is a covered benefit that has not yet been added to the Schedule of Benefits and Copayments. If so determined, the Covered Individual Copayments will be determined by CareFirst BlueChoice, Inc.;

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

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

EXCLUSIONS. Benefits will not be provided for:

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

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

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

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

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

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

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

H. Hospitalization for any dental procedure;

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

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

K. Any implantation;

L. General anesthesia;

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

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

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

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

Q. Payment of any claim or bill will not be made for prohibited referrals.

R. 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 8/5/19)

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 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)

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.

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.
वर्ण (Bengali) नक्शा करें: ये नोटिस आपके बिमा कार्यालय में समर्पित अभियंता को खड़े होते हैं। इस नोटिस का उपयोग आपके बिमा कार्यालय में समर्पित अभियंता को खड़े होते हैं।

बास्तू-वूदु (Bassa) तो दुःखाल! यदि आपके बीमा कार्यालय में समर्पित अभियंता को खड़े होते हैं। इस नोटिस का उपयोग आपके बीमा कार्यालय में समर्पित अभियंता को खड़े होते हैं।

بمار (Urdu) توجه: ایان اعلان میں، اپنے بیماری اور مرض کے خصوصی حالت کے کامیابی ہے، اس کے لئے بہت سے معلومات پر مشتمل ہے۔ اس میں کئی خاص مواد ہیں جو اپنے کام کے لئے بہت مفید ہیں۔

فارسی (Persian) توجه: ایان اعلان میں مربوط بیماری کے حالت کے خصوصی حالت کے کامیابی ہے، اس کے لئے بہت سے معلومات پر مشتمل ہے۔ اس میں کئی خاص مواد ہیں جو اپنے کام کے لئے بہت مفید ہیں۔

لغة العربية (Arabic) تذكير: إذا كنت تختار معلومات بشأن تغطيات التأمين، فإنك تحتاج إلى مراجعة معلوماتكم. إذا كنت تختار معلومات بشأن تغطيات التأمين، فإنك تحتاج إلى مراجعة معلوماتكم. إذا كنت تختار معلومات بشأن تغطيات التأمين، فإنك تحتاج إلى مراجعة معلوماتكم.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打存入分識別卡背面的電話號碼。其他所有人可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出你需要使用的語言，這樣您就能與口譯人員連線。
Igbo (Igbo) Nrębama: Ọkwa a nwere ozi gbasara mkpuchi nchewa onwe gi. Ọ nwere ike ọnwe ụbọchị ndị mkpa, i nwere ike ime ihe tupu ufọdu ụbọchị njedebe. Ị nwere iike ịnweta ozi na onye ụdị aka ọzọ gi na akwụghị ugwọ ọ bula. Ndi ọtụ kwesịrị ikpo akara ekwenti ị n'azụ nke kaadị njiirimara ha. Ndi ọzọ niile nwere ike ikpo 855-258-6518 wee chere ụbọchị ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asusu i chọoro, a ga-ejiiko gi na onye ọkụwa okwu.


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 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge’: Díí bee i hane’ígií bií dahóóló bee éédahózin béeso ách’áah naanil ník’íst’ígií bá. Bi’i dahóólóq doo iiyisí yoolkááigíí dóó t’áádoo le’ é ádadoolyííigíí da yókeedgo t’áá doo bee e’e’aaah ájíl’ííh. Bee ná ahóót’í’ dií bee i hane’ dóó níká’ádoowól t’áá nínizaad bee t’áá jiik’été. Atah daniliníígí béésh bee hane’é bee wróta’ígií nit’izgo bee nee hódolziníígí bìkéédéég’ bikáá’ bich’í’ hodoonihjí’. Aadóó nánána’ ẹí kojí dahoóoolnìh 855-258-6518 dóó yìi diïlts’íjí yait’íígíí t’áá nilééjí áádóó ẹí bìkéé’dóó nànsbqàs bìl addidiilchít. Aká’ándaalwó’ígií neiidiitáágo, saad bee yániit’íígií yìi diïkít dóó ata’ halne’ ẹ lá níká’ádoolwól.
Policy Form Numbers

Individual Select Dental HMO Maryland
The Dental Network, Inc.
FORM DN001C (R. 1/10),
FORM DN4001 (R. 1/10),
and any amendments

Individual Select Dental HMO Washington, D.C.
CareFirst BlueChoice, Inc.
DN001DC (R. 1/10),
FORM DN4001DC (R. 1/10),
and any amendments

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