Welcome

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

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

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

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

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

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

Read on to learn about Individual Select Dental HMO, offered by The Dental Network and CareFirst BlueChoice, Inc. Or, contact our dental 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...

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

How This Plan Works
Get maximum savings on major dental services and access to a network of 580+ participating dentists.

**Individual Select Dental HMO** offers you 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)

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 needs. Visit [www.carefirst.com/doctor](http://www.carefirst.com/doctor) to find a dentist. When specialized care is needed, your general dentist will refer you to a specialist within the Dental HMO network.
A Plan For You

Meet The Johnsons

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

<table>
<thead>
<tr>
<th>Common Dental Procedure</th>
<th>No Coverage¹</th>
<th>Individual Select Dental HMO Plan²</th>
<th>Savings on Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-month Checkups (8 visits, 2 per person)</td>
<td>$1,520 ($190 per visit)</td>
<td>$160 ($20 copay per visit)</td>
<td>$1,360</td>
</tr>
<tr>
<td>Filling (1 filling)</td>
<td>$146</td>
<td>$20 copay per visit</td>
<td>$126</td>
</tr>
<tr>
<td>Orthodontic Services (1 child to age 19)</td>
<td>$5,355</td>
<td>$2,500</td>
<td>$2,855</td>
</tr>
<tr>
<td>Total</td>
<td>$7,021</td>
<td>$2,680</td>
<td>$4,341</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.

With no dental coverage, the Johnsons paid $7,021 for these services. With Individual Select Dental HMO coverage, the Johnsons would have saved more than $4,300 for these services. The Johnsons decided to purchase the Individual Select Dental HMO coverage to protect themselves against future dental costs.
Meet The Smiths

Mary and Charles Smith are active retirees who recently took up golf. They have Medicare and have purchased a Supplement Medicare plan and Medicare prescription drug coverage to protect themselves against medical costs. They didn't think about how their budget might be impacted by major dental expenses until Mary needed root canal therapy and Charles needed a bridge.

<table>
<thead>
<tr>
<th>Common Dental Procedure</th>
<th>No Coverage¹</th>
<th>Individual Select Dental HMO Plan²</th>
<th>Savings on Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-month Checkups (includes routine exams, cleanings and X-rays) (4 visits, 2 per person)</td>
<td>$760 ($190 per visit)</td>
<td>$80 ($20 copay per visit)</td>
<td>$680</td>
</tr>
<tr>
<td>Root Canal (bicuspids)</td>
<td>$875</td>
<td>$375</td>
<td>$500</td>
</tr>
<tr>
<td>Bridge (3-unit)</td>
<td>$3,500</td>
<td>$1,305</td>
<td>$2,195</td>
</tr>
<tr>
<td>Total</td>
<td><strong>$5,135</strong></td>
<td><strong>$1,760</strong></td>
<td><strong>$3,375</strong></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.

With no dental coverage, the Smiths paid $5,135 for these services. They decided to purchase dental coverage to protect themselves against further unexpected dental costs. With Individual Select Dental HMO coverage, the Smiths would have spent only $1,760, a savings of over $3,300 on these dental services. Now they're covered and ready for whatever lies ahead!
# Frequently Used Benefits

<table>
<thead>
<tr>
<th>Common Dental Procedures</th>
<th>Regular Cost</th>
<th>With the Dental HMO plan, In Network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Checkups</strong> (includes routine exams, cleanings and X-rays)</td>
<td>$190 per visit (2 visits per year)</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td><strong>Basic Dental Services</strong> (includes fillings, simple extractions and more)</td>
<td>$146 – $350</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td><strong>Soft Tissue Management</strong> (includes periodontal scaling, periodontal maintenance and more)</td>
<td>$260</td>
<td>$70 per office visit</td>
</tr>
<tr>
<td><strong>Porcelain Crown</strong> (high noble metal)</td>
<td>$1,156</td>
<td>$460</td>
</tr>
<tr>
<td><strong>Root Canal Therapy</strong> (bicuspid, excludes final restoration)</td>
<td>$875</td>
<td>$375 primary dentist or $475 specialty care dentist</td>
</tr>
<tr>
<td><strong>Complete Upper Dentures</strong></td>
<td>$1,750</td>
<td>$495</td>
</tr>
<tr>
<td><strong>Orthodontia (Braces)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive – Adolescent</td>
<td>$5,355</td>
<td>$2,500</td>
</tr>
<tr>
<td>Comprehensive – Adult</td>
<td>$5,446</td>
<td>$2,700</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 listing of services. If you have any questions, please call our Customer Service Associates at 410-847-9060 or toll-free at 888-833-8464, Monday-Friday, 8:30 a.m. to 5 p.m.
## 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>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$142.68</td>
<td>$35.67</td>
<td>$35.67</td>
<td>$35.67</td>
<td>$35.67</td>
<td>$35.67</td>
</tr>
<tr>
<td>Individual &amp; Adult</td>
<td>$328.20</td>
<td>$82.05</td>
<td>$82.05</td>
<td>$82.05</td>
<td>$82.05</td>
<td>$82.05</td>
</tr>
<tr>
<td>Individual &amp; Child(ren)</td>
<td>$264.00</td>
<td>$66.00</td>
<td>$66.00</td>
<td>$66.00</td>
<td>$66.00</td>
<td>$66.00</td>
</tr>
<tr>
<td>Family</td>
<td>$399.48</td>
<td>$99.87</td>
<td>$99.87</td>
<td>$99.87</td>
<td>$99.87</td>
<td>$99.87</td>
</tr>
</tbody>
</table>

*Rates effective December 1, 2016.*

### District of Columbia

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$142.68</td>
<td>$35.67</td>
<td>$35.67</td>
<td>$35.67</td>
<td>$35.67</td>
<td>$35.67</td>
</tr>
<tr>
<td>Individual &amp; Adult</td>
<td>$328.20</td>
<td>$82.05</td>
<td>$82.05</td>
<td>$82.05</td>
<td>$82.05</td>
<td>$82.05</td>
</tr>
<tr>
<td>Individual &amp; Child(ren)</td>
<td>$264.00</td>
<td>$66.00</td>
<td>$66.00</td>
<td>$66.00</td>
<td>$66.00</td>
<td>$66.00</td>
</tr>
<tr>
<td>Family</td>
<td>$399.48</td>
<td>$99.87</td>
<td>$99.87</td>
<td>$99.87</td>
<td>$99.87</td>
<td>$99.87</td>
</tr>
</tbody>
</table>

*Rates effective December 1, 2016.*

### Northern Virginia

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$148.08</td>
<td>$37.02</td>
<td>$37.02</td>
<td>$37.02</td>
<td>$37.02</td>
<td>$37.02</td>
</tr>
<tr>
<td>Individual &amp; Adult</td>
<td>$296.16</td>
<td>$74.04</td>
<td>$74.04</td>
<td>$74.04</td>
<td>$74.04</td>
<td>$74.04</td>
</tr>
<tr>
<td>Individual &amp; Child(ren)</td>
<td>$273.96</td>
<td>$68.49</td>
<td>$68.49</td>
<td>$68.49</td>
<td>$68.49</td>
<td>$68.49</td>
</tr>
<tr>
<td>Family</td>
<td>$414.60</td>
<td>$103.65</td>
<td>$103.65</td>
<td>$103.65</td>
<td>$103.65</td>
<td>$103.65</td>
</tr>
</tbody>
</table>

*Rates effective March 1, 2017.*
Ways to enroll in your new dental plan

Three steps to apply!

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

   Choose the annual or quarterly payment option.

   In order for your coverage to begin on the first of the following month, your application must be received in our office before the 20th of the previous month. For example, for coverage to begin May 1, CareFirst must receive your application on or before April 20.

2) When you’re ready to review a listing of providers, please visit www.carefirst.com/doctor. Click on the Guest link. Then, click on Dental and enter your zip code, select Dental HMO, then IND20. If you prefer a printed directory, please call our dental product consultants at 855-503-4862, Monday–Thursday, 8 a.m. to 5 p.m. and Friday, 10 a.m. to 5 p.m.

3) Send your application in the enclosed, postage-paid envelope to:

   Mail Administrator
   PO Box 14651
   Lexington, KY 40512-9876

**Please do not send payment with your application.** Once your application is received, we will send you a bill. Your bill will detail your plan, your selected payment option, your premium information and payment due date. Payments are due on an annual or quarterly basis.

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

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

Please fill out the Maryland Individual Select Dental HMO 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 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>
</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>
</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>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td>Single</td>
</tr>
</tbody>
</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>
<td></td>
<td></td>
</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 up to two eligible adults and eligible dependent(s)

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

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

3. ENROLLING FAMILY MEMBER(S) — Complete only if you select Individual & Child(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. l.</th>
<th>Relationship</th>
<th>Social Security #</th>
<th>Date of Birth (Mo/Day/Yr)</th>
<th>Sex</th>
<th>Dental Office Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. Group Hospitalization and Medical Services, Inc., CareFirst of Maryland, Inc. and The Dental Network are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the BlueCross and BlueShield Association.
4. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield and The Dental Network, Inc. (CareFirst) want 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
- Reminders
- Notice of HIPAA Privacy Practices
- 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate Email Address</td>
<td>Alternate Cell Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

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

- [ ] Email only
- [x] 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.

Signature of Parent or Legal Guardian: 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>
</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>
<td></td>
</tr>
<tr>
<td>Writing Agent:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Application for District of Columbia residents

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

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application in the postage-paid return envelope 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>
<td></td>
<td></td>
<td></td>
</tr>
</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>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Male</td>
<td>□ Female</td>
<td>□ Single □ Married □ Domestic Partnership/Other</td>
</tr>
</tbody>
</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>
<td></td>
<td></td>
</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 up to two eligible adults and eligible dependent(s)

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

3. ENROLLING FAMILY MEMBER(S)—Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage (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. L.</th>
<th>Relationship</th>
<th>Social Security</th>
<th>Date of Birth (Mo/Day/Yr)</th>
<th>Sex</th>
<th>Dental Office Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Domestic, Legal or Civil Union Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) want 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
- Reminders
- Notice of HIPAA Privacy Practices
- 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. 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternate Email Address</th>
<th>Alternate Cell Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</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
- [ ] 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 DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, CAREFIRST BLUECHOICE, INC. MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**Signature of Applicant:** X ___________________________ Date:_________________

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

**Signature of Parent or Legal Guardian:** 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>
</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>
<td></td>
</tr>
<tr>
<td>Writing Agent:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Application for Northern Virginia residents

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

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application in the postage-paid return envelope 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>
<td></td>
<td></td>
<td></td>
</tr>
</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>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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>
<td></td>
<td></td>
</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 up to two eligible adults and eligible dependent(s)

A "Child" means your eligible child up to age 26. Eligibility requirements are defined in your contract. An “Adult” means the Spouse or Domestic Partner 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. L.</th>
<th>Relationship</th>
<th>Social Security #</th>
<th>Date of Birth (Mo/Day/Yr)</th>
<th>Sex</th>
<th>Dental Office Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueChoice, Inc. (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
- Reminders
- Notice of HIPAA Privacy Practices
- 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternate Email Address</th>
<th>Alternate Cell Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</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
- [ ] 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 Primary Applicant: X ____________________________ Date: ________________

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

Signature of Parent or Legal Guardian: 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:
Notice of nondiscrimination and availability of language assistance services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and The Dental Network (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 aids 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 that 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:

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>410-528-7820</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address</td>
<td>P.O. Box 8894, Baltimore, Maryland 21224</td>
</tr>
<tr>
<td>Fax Number</td>
<td>410-505-2011</td>
</tr>
<tr>
<td>Email Address</td>
<td><a href="mailto:civilrightscoordinator@carefirst.com">civilrightscoordinator@carefirst.com</a></td>
</tr>
</tbody>
</table>

You can file a grievance by mail, fax, or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

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 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.

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 аборенты могут звонить 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.
हिंदी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्यतः तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना जरूरी हो। आपके यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिये गए फोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतिक्रिया करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएं और आपको व्याख्यातार से कनेक्ट कर दिया जाएगा।


বাংলা (Bengali) নথিকরণ: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গ্র্যপয্যন্ত তথ্য থাকতে পারে এবং নিউক্স তাজিকতখ্যাত মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনামূল্যে নিজের ভাষায় এই তথ্য পাওয়া ও সহায়তা পাওয়া অধিকার আপনার আছে। সদস্যের তারকের পরিধিসমূহে নিষ্ঠায থাকা নথির কল করতে হবে। আমরা 855-258-6518 নম্বর কল করে 0 টিমেট না বলা পূর্বে অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দেওয়ার সময় সম্বুজ করা হবে।

اردو (Urdu) توجہ: پہلے نوش اپ کے انتخاب کیا جسے متعلق معلومات پر مشتمل ہے اس میں کلیدی تاریخی بو سکیں بین اور ممکن الگی۔ کہ آپ کو مخصوص آخری تاریخ تک کاروباری کرنا چاہتے ہیں کی یہ ضرورت ہے۔ آپ کے پاس متعلق معلومات حاصل کرنا ہے اور بغیر حرج کہ آپ نے اسی مد میں حاصل کرنا کا حق ہے۔ ممبران کو اپنے نشانختی کارہ کی پہچان پر موجود وہ نمبر پر کال کریں جابہ۔ سبھی دیگر لوگوں 855-258-6518 کال کر سکیں بین اور 0 دبائی کو جاں جاں تک انتظام کریں۔ ایچکہ کہ جواب دیے پر اپنی مطلوبہ زبان پہنچنے اور متعلقہ مربوطہ جابہ کے۔

فارسی (Farsi) توجه: این علامتی ایک اطلاعی دوبارہ پوچش بیم شما است. ممکن است حاوی تاريخی های مهمی باشد ولزم است تا تاريخ مقرر شده خاصی اقامت کنید. شما از این حق برخوردار هستید این اطلاعات و راهنماي را به صورت رایگان به زبان خواندن دریافت کنید. اعضا بايد با شماره درج شده در پيدا شده شما نشاندي شما مي توانيد پيدا شما 855-258-6518 تا ملاحظه کنيد تا آنجا حوزه سود عدد 0 را فشار دهند. بعد از پاسخگویي توسط یک از ایرانيها، زبان مورد نياز را تنظيم کنيا تا به مترجم مربوطه وصل شويد.

لغة العربية (Arabic) تابع: يجب ان يكون هذا الاخطار على معلومات بشأن تطبيقات التامينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول موعد انتهاء محددة. يحق لك الحصول على هذه المصادر والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الإتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للأطراف الإتصال على الرقم 855-258-6518 واتصالات خارج المحالة حيث تطلب منهم الضغط على رقم 0 عند إعادة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وس يتم توصيلك بأحد المنحنيين الفرنسيين.

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。會員請撥打在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請口出您需要使用的語言，這樣您就能與口譯人員連線。
Igbo (Igbo) Nrubama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. Ọ nwere ike ihe ụbọchị ndị ị mkpa, ị nwere ike ụmụtụ ndị ụbọchị njedebe. Ị nwere ikike ānweta ozi na ānụmaka a n’asụsụ gi na ụkwughị ugwọ ọ bula. Ndị otu kwesịrị ịkpọ akara ekwenti di n’azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbọchị ahụ ruo mgbe amanyere ịpụ 0. Mgbe onye mnochite anya zara, kwuo asụsụ i chọrọ, a ga-ejiko gi na onye okowa 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.
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) at intervals of less than six (6) months;
- Unlisted procedures will be provided at the dentist’s charges;
- 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).

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
DISTRICT OF COLUMBIA

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

A. Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;
B. Services which are provided without cost to the Covered Individual and/or Dependent(s) 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 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. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
K. Any implantation;
L. Any anesthesia;
M. General anesthesia;
O. Services that cannot be performed because of the general health of the patient;
P. Teeth Cleaning (Prophylaxis) at intervals of less than six (6) months;
Q. Unlisted procedures will be provided at the dentist’s charge;
R. Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
S. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual 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;
T. Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

OUT-OF-AREA EMERGENCY CARE: Covered Individuals and/or Dependents are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 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
PLAN LIMITATIONS. The following limitations shall apply:

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

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

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

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

EXCLUSIONS. Benefits will not be provided for:

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

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

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

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

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

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

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

H. Hospitalization for any dental procedure;

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

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

K. Any implantation;

L. General anesthesia;

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

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

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

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

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

Individual Select Dental HMO District of Columbia
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/COC (R. 1/10),
VA/BC/DB/SOB (R. 1/10),
and any amendments