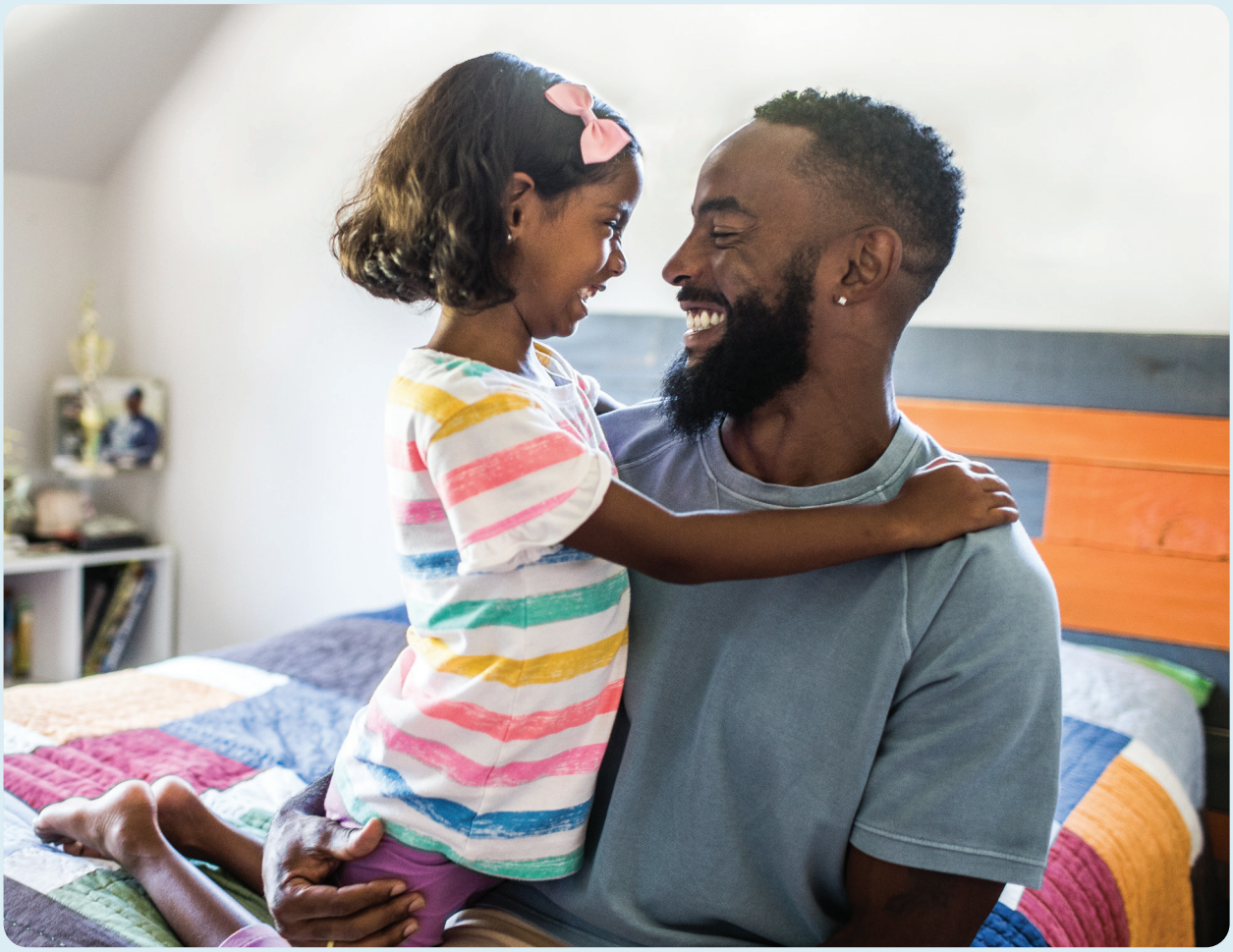
CareFirst
Family of health care plans



Individual BlueDental Preferred

2025

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. A healthy smile can make you feel more appealing, even more youthful. But did you know your smile also says a lot about your overall health?

That's why it's so important to protect your smile. Good dental care has been shown to significantly reduce your risk of heart disease. It helps control diabetes, and some studies show it prevents premature births.

We're pleased to introduce you to BlueDental Preferred.

As a member, you'll enjoy:

- Two different deductible options to suit your budget
- Access to more than 4,500 dentists throughout Maryland, Washington, D.C. and Northern Virginia, and to a national network of 135,000 dentists and specialists
- Coverage for numerous dental services
- No referrals
- No charge for oral exams, cleanings and X-rays when you visit an in-network provider
- No claim forms to file in-network
- A medically necessary orthodontia benefit—for children up to age 19
- Guaranteed acceptance
- No charge for in-network covered services for members age 19 and under after they reach their $425 out-of-pocket maximum.

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

Did You Know...

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

[1] www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475, June 4, 2019

Contents

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

Your Dental Plan Options

We offer two BlueDental Preferred options: **High Option** and **Low Option**. The High Option has lower deductibles with preventive and diagnostic services covered in full when received from in-network provider without requiring you to meet a deductible. The Low Option has lower premiums with slightly higher deductibles. The following pages can help you decide which BlueDental Preferred option is right for you.

BlueDental Preferred includes:

Preventive and diagnostic services (Class I)

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

If you pick the High Option, there is no deductible or charge for the above services if you visit an in-network provider. If you pick the Low Option, you can receive these services but will pay in full unless you've already met your deductible.

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

For Members New to CareFirst over the age 19 there is a 12-month waiting period for Class III and Class IV services. After meeting the deductible, both plans cover fillings, simple extractions, periodontal scaling, root planing, root canals, oral surgery, dentures, crowns and more!

Orthodontia (Class V)

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

BlueDental Preferred has a large network of providers

As a member, you'll enjoy access to more than 4,500 dentists throughout Maryland, Washington, D.C. and Northern Virginia, and access to a national network of 135,000 dentists and specialists. To locate a participating provider, go to **carefirst.com/findadoc** and select *Preferred Dental (PPO & Pediatrics)* from the *Network* drop-down menu.

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

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

BlueDental Preferred High Option Summary of Benefits

(for members under age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES II, III, IV		
▪ The family deductible amount is calculated in aggregate. However, no family member will be charged more than the individual deductible amount. ▪ The in-network and out-of-network deductible will be a separate amount.	$50 Individual deductible; $150 Family deductible	$100 Individual deductible; $300 Family deductible
OUT-OF-POCKET MAXIMUM (CLASSES I–V)	One member pays up to $425; Two or more members pay up to $850	No limit
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)		
▪ Oral exams (one per six months) ▪ Prophylaxis (one cleaning per six months) ▪ Bitewing X-rays (one per six months) ▪ Fluoride treatments[1] until the end of the year in which member reaches age 19 ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray[1] ▪ Sealants on permanent molars[1] until the end of the year in which member reaches age 19 ▪ Space maintainers[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge	20% of allowed benefit[2]
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	50% of allowed benefit[2] after deductible	65% of allowed benefit[2] after deductible
ORTHODONTIC SERVICES (CLASS V)		
▪ Benefits for medically necessary orthodontic services are available for covered members until the end of the calendar year in which a member reaches the age of 19.	50% of allowed benefit[2]	65% of allowed benefit[2]

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

[1] Frequency limitations may apply.

[2] CareFirst payments are based on the CareFirst allowed benefit. Participating and preferred dentists accept 100% of the CareFirst allowed benefit as payment in full for covered services. Non-participating dentists may bill the members for the difference between the allowed benefit and their charges.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

BlueDental Preferred High Option Summary of Benefits

(for members over age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES II, III, IV		
▪ The family deductible amount is calculated in aggregate. However, no family member will be charged more than the individual deductible amount. ▪ The in-network and out-of-network deductible will be a separate amount.	$50 Individual deductible; $150 Family deductible	$100 Individual deductible; $300 Family deductible
ANNUAL MAXIMUM (CLASSES I–IV)		
▪ The in-network and out-of-network annual maximum is a combined amount.	Plan pays up to $1,500 per member	
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)		
▪ Oral exams (one per six months) ▪ Prophylaxis (one cleaning per six months) ▪ Bitewing X-rays (one per six months) ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge	20% of allowed benefit[2]
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)[4]		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	40% of allowed benefit[2] after deductible	50% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)[4]		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance for members over age 19) ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	50% of allowed benefit[2] after deductible	65% of allowed benefit[2] after deductible

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

[1] Frequency limitations may apply.

[2] CareFirst payments are based on the CareFirst allowed benefit. Participating and preferred dentists accept 100% of the CareFirst allowed benefit as payment in full for covered services. Non-participating dentists may bill the members for the difference between the allowed benefit and their charges.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

[4] For Over 19 members there is a 12-month waiting period on Class III and Class IV benefits for New Members.

BlueDental Preferred Low Option Summary of Benefits

(for members under age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES I–IV		
▪ The family deductible amount is calculated in aggregate. However, no family member will be charged more than the individual deductible amount. ▪ The in-network and out-of-network deductible will be a separate amount.	$100 Individual deductible; $300 Family deductible	$200 Individual deductible; $600 Family deductible
OUT-OF-POCKET MAXIMUM (CLASSES I–V)	One member pays up to $425; Two or more members pay up to $850	No limit
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)		
▪ Oral exams (one per six months) ▪ Prophylaxis (one cleaning per six months) ▪ Bitewing X-rays (one per six months) ▪ Fluoride treatments[1] until the end of the year in which member reaches age 19 ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray[1] ▪ Sealants on permanent molars[1] until the end of the year in which member reaches age 19 ▪ Space maintainers[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge after deductible	20% of allowed benefit[2] after deductible
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	50% of allowed benefit[2] after deductible	65% of allowed benefit[2] after deductible
ORTHODONTIC SERVICES (CLASS V)		
▪ Benefits for medically necessary orthodontic services are available for covered members until the end of the calendar year in which a member reaches the age of 19.	50% of allowed benefit[2]	65% of allowed benefit[2]

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

[1] Frequency limitations may apply.

[2] CareFirst payments are based on the CareFirst allowed benefit. Participating and preferred dentists accept 100% of the CareFirst allowed benefit as payment in full for covered services. Non-participating dentists may bill the members for the difference between the allowed benefit and their charges.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

BlueDental Preferred Low Option Summary of Benefits

(for members over age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES I–IV		
▪ The family deductible amount is calculated in aggregate. However, no family member will be charged more than the individual deductible amount. ▪ The in-network and out-of-network deductible will be a separate amount.	$100 Individual deductible; $300 Family deductible	$200 Individual deductible; $600 Family deductible
ANNUAL MAXIMUM (CLASSES I–IV)		
▪ The in-network and out-of-network annual maximum is a combined amount.	Plan pays up to $1,000 per member	
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)		
▪ Oral exams (one per six months) ▪ Prophylaxis (one cleaning per six months) ▪ Bitewing X-rays (one per six months) ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge after deductible	20% of allowed benefit[2] after deductible
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)[4]		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	40% of allowed benefit[2] after deductible	50% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)[4]		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance for members over age 19) ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	65% of allowed benefit[2] after deductible	75% of allowed benefit[2] after deductible

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

[1] Frequency limitations may apply.

[2] CareFirst payments are based on the CareFirst allowed benefit. Participating and preferred dentists accept 100% of the CareFirst allowed benefit as payment in full for covered services. Non-participating dentists may bill the members for the difference between the allowed benefit and their charges.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

[4] For Over 19 members there is a 12-month waiting period on Class III and Class IV benefits for New Members.

Frequently Used Benefits

Below is a partial list of the most commonly used member services. These rates show what you could expect to pay for in-network services. For specific questions, please contact our CareFirst Dental product consultants team at 855-503-4862.

Common Dental Procedures	Regular Cost[1]	In-Network You Pay[2]	
		High Option	Low Option
Preventive checkups *including routine exams, cleanings and X-rays (2 visits per year)*	$206 per visit	$0	$0 after deductible
Fillings and simple extractions	$148–$200	$11–$17 after deductible	$11–$17 after deductible
Periodontal scaling and root planing *(4 or more teeth per quadrant)*	$285	$27 after deductible	$27 after deductible
Root canal therapy *(molar, excluding final restoration)*	$1,183	$264 after deductible	$264 after deductible
Porcelain ceramic crown	$1,250	$354 after deductible	$460 after deductible
Bridge *(3-unit)*	$3,758	$938 after deductible	$1,219 after deductible
Complete upper dentures	$1,883	$334 after deductible	$435 after deductible
Medically necessary orthodontia *(child up to age 19)*	$5,512	$1,481	$1,481

[1] Based on National Dental Advisory Service Fee Report (2020)

[2] Approximate amount for a member over the age of 19. Pricing may vary depending on dental provider's negotiated rate with CareFirst.

2025 Monthly Dental Rates

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

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

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

Maryland	
BlueDental Preferred High Option	
0–19	$37.01
20+	$49.49
BlueDental Preferred Low Option	
0–19	$21.53
20+	$26.93

Washington, D.C.	
BlueDental Preferred High Option	
0–19	$33.43
20+	$43.21
BlueDental Preferred Low Option	
0–19	$16.36
20+	$23.25

Virginia	
BlueDental Preferred High Option	
0–19	$42.55
20+	$53.06
BlueDental Preferred Low Option	
0–19	$26.73
20+	$33.33

Enrolling in Your New Dental Plan

Pick one of these four options to enroll:

1. **Enroll online** at **carefirst.com/shopdental**.

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

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

3. **Enroll online through your state's Exchange.** Exception—these plans are no longer offered on the Virginia Federally-facilitated Exchange, so if you live in Northern Virginia, you must apply using one of the other three options.
   Maryland—marylandhealthconnection.com
   Washington, D.C.—dchealthlink.com

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

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

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

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

Please note: In order to purchase coverage, you must live in Maryland, Washington, D.C. or one of the following areas of Northern Virginia: City of Alexandria and Fairfax, the town of Vienna, Arlington County and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.

When you're ready to review a list of providers, please visit **carefirst.com/findadocdental.** Click on *Preferred Dental (PPO & Pediatrics).*

NO POSTAGE
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UNITED STATES

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

POSTAGE WILL BE PAID BY ADDRESSEE

MAIL ADMINISTRATOR
PO BOX 14651
LEXINGTON KY 40512-9876

Maryland Resident Application

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

BlueDental Preferred Application

Maryland Residents

If you live in Baltimore City or any county in the state of Maryland other than Prince George's or Montgomery County, please check the ***CareFirst of Maryland, Inc.*** *box to the right.*

If you reside in Prince George's or Montgomery County, please check the ***Group Hospitalization and Medical Services, Inc.*** *box to the right.*

◯ **CareFirst of Maryland, Inc.**
10455 Mill Run Circle, Owings Mills, MD 21117

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

A private not-for-profit health service plan.

INSTRUCTIONS

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

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and your coverage will be delayed.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Residence County	Date of Birth	Sex	Marital Status
	/ /	◯ Male ◯ Female	◯ Single ◯ Married ◯ Domestic Partner

Home Phone	Work/Mobile Phone	Payment Option
( )	( )	◯ Annually ◯ Quarterly

2. DEDUCTIBLE SELECTION *(check one)*

◯ **Low Option** ($100 individual in-network deductible)

◯ **High Option** ($50 individual in-network deductible)

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

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							◯ M ◯ F
Domestic Partner							◯ M ◯ F
Dependent 1							◯ M ◯ F
Dependent 2							◯ M ◯ F
Dependent 3							◯ M ◯ F
Dependent 4							◯ M ◯ F
Dependent 5							◯ M ◯ F
Dependent 6							◯ M ◯ F
Dependent 7							◯ M ◯ F
Dependent 8							◯ M ◯ F

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 mobile 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 current plan(s) and services along with new plans and services that may interest you.

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

I understand that to access the information sent by email, I must have all three of the following:

- Internet access
- An email account that allows me to send and receive emails
- 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 by text message:

- A text messaging plan with my mobile phone provider is required
- Standard text messaging rates will apply

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number
By checking my preference below, I hereby agree to electronic delivery of notices instead of paper delivery. ◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging		
Signature:		

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's behalf or to comply with the law.

5. CONDITIONS OF ENROLLMENT *(please read this section carefully)*

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application will be provided to the applicant or application filer.

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

Premium payment options are available on an annual or quarterly basis.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for, a CareFirst policy.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (866) 891-2802 before signing this application.

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

Signature of Primary Applicant	Date

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

Parent or Legal Guardian's Signature	Date

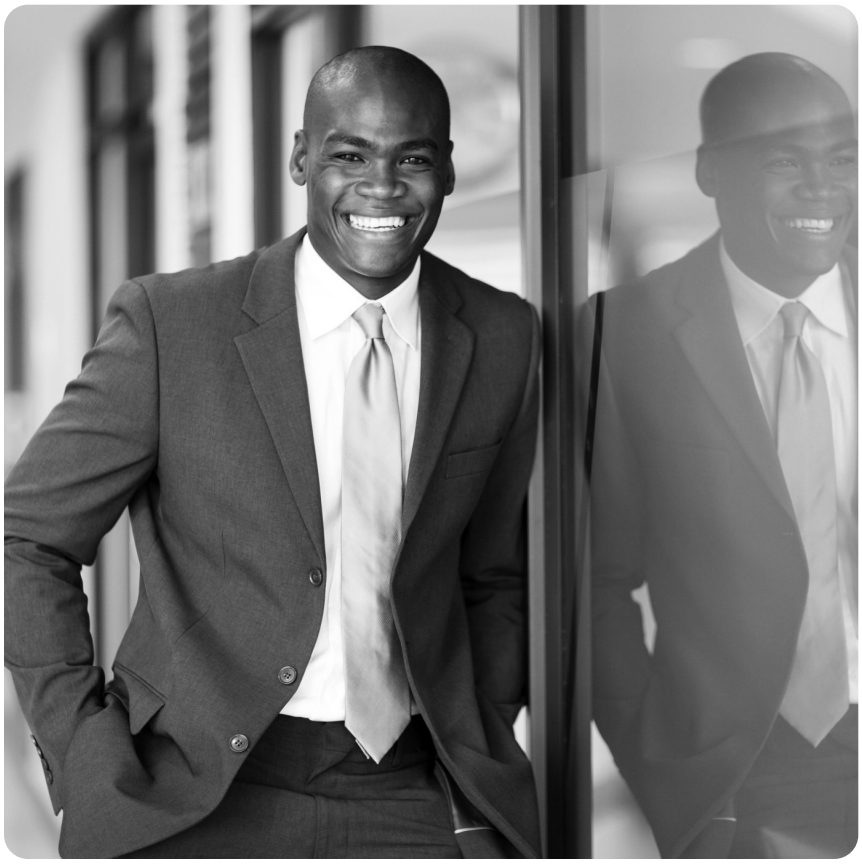
FOR OFFICE USE ONLY:

○ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
General Agency		[redacted]		
Writing Agent				[redacted]

Washington, D.C. Resident Application



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

BlueDental Preferred Application

Washington, D.C. Residents

Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065
A private not-for-profit health service plan.

INSTRUCTIONS

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

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and your coverage will be delayed.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Payment Option	Date of Birth	Sex	Marital Status
◯ Annually ◯ Quarterly	/ /	◯ Male ◯ Female	◯ Single ◯ Married ◯ Domestic Partner/Other

Home Phone	Work/Mobile Phone
( )	( )

2. DEDUCTIBLE SELECTION *(check one)*

◯ **Low Option** ($100 individual in-network deductible)

◯ **High Option** ($50 individual in-network deductible)

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

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							◯ M ◯ F
Domestic/Civil Union Partner							◯ M ◯ F
Dependent 1							◯ M ◯ F
Dependent 2							◯ M ◯ F
Dependent 3							◯ M ◯ F
Dependent 4							◯ M ◯ F
Dependent 5							◯ M ◯ F
Dependent 6							◯ M ◯ F
Dependent 7							◯ M ◯ F
Dependent 8							◯ M ◯ F

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 mobile 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 current plan(s) and services along with new plans and services that may interest you.

Please note: This consent for electronic communications applies to the primary applicant only. A spouse/domestic partner and/or dependent(s) 18 years of age and older can consent to electronic communications at **carefirst.com/myaccount**. You can also change email and consent information anytime by logging into **carefirst.com/myaccount** or by calling the customer service phone number on your member ID card. You can also request a paper copy of electronic notices by calling the customer service phone number on your member ID card.

I understand that to access the information sent by email, I must have all three of the following:

- Internet access
- An email account that allows me to send and receive emails
- 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 by text message:

- A text messaging plan with my mobile phone provider is required
- Standard text messaging rates will apply

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number
By checking my preference below, I hereby agree to electronic delivery of notices instead of paper delivery. ◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging		
Signature:		

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's behalf or to comply with the law.

5. CONDITIONS OF ENROLLMENT *(please read this section carefully)*

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application will be provided to the applicant (or to a person authorized to act on his/her behalf).

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

Premium payment options are available on an annual and a quarterly basis.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for, a CareFirst policy.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (888) 892-9901 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, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature of Primary Applicant	Date

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

Parent or Legal Guardian's Signature	Date

FOR OFFICE USE ONLY:

○ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
General Agency		[redacted]		
Writing Agent				[redacted]

Northern Virginia Resident Application

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

BlueDental Preferred Application

Virginia Residents

Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065
A private not-for-profit health service plan.

INSTRUCTIONS

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

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and your coverage will be delayed.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Payment Option	Date of Birth	Sex	Marital Status
◯ Annually ◯ Quarterly	/ /	◯ Male ◯ Female	◯ Single ◯ Married ◯ Domestic Partner

Home Phone	Work/Mobile Phone
( )	( )

2. DEDUCTIBLE SELECTION *(check one)*

◯ **Low Option** ($100 individual in-network deductible)

◯ **High Option** ($50 individual in-network deductible)

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

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							◯ M ◯ F
Domestic Partner							◯ M ◯ F
Dependent 1							◯ M ◯ F
Dependent 2							◯ M ◯ F
Dependent 3							◯ M ◯ F
Dependent 4							◯ M ◯ F
Dependent 5							◯ M ◯ F
Dependent 6							◯ M ◯ F
Dependent 7							◯ M ◯ F
Dependent 8							◯ M ◯ F

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 mobile 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 current plan(s) and services along with new plans and services that may interest you.

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

I understand that to access the information sent by email, I must have all three of the following:

- Internet access
- An email account that allows me to send and receive emails
- 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 by text message:

- A text messaging plan with my mobile phone provider is required
- Standard text messaging rates will apply

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number
By checking my preference below, I hereby agree to electronic delivery of notices instead of paper delivery. ◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging		
Signature:		

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's 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 applicant (or to a person authorized to act on his/her behalf).

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

Premium payment options are available on an annual and a quarterly basis.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for, a CareFirst 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 (if applicable) certify that the applicant has read, or had read to him/her, the completed application, and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

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

Signature of Primary Applicant	Date
NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.	
Parent or Legal Guardian's Signature	Date
Signature of Agent (if applicable):	Date

FOR OFFICE USE ONLY:

○ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
General Agency		[redacted]		
Writing Agent				[redacted]

Exclusions and Limitations

For Maryland residents:

3.1 Limitations.

A. Covered dental services must be performed by or under the supervision of a dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.
B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments, custom denture teeth and implant supported fixed or removable prostheses.
C. If a member switches from one dentist to another during a course of treatment, or if more than one dentist renders services for one dental procedure, CareFirst shall pay as if only one dentist rendered the service.
D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).
E. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative. CareFirst benefits will cover treatment based upon the CareFirst allowance for the least expensive procedure, provided that the least expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the least expensive procedure. However, if the Subscriber and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

3.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge or crown as a result of loss or theft.
B. Replacement of an existing denture, bridge or crown that is determined by CareFirst to be satisfactory or repairable.
C. Replacement of dentures, bridges, metal and/or porcelain crowns, inlays, onlays and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the dental benefits Agreement and are judged by CareFirst to be adequate and functional.
D. Replacement of stainless steel crowns (until the end of the calendar year in which the member turns age 19) if judged by CareFirst to be adequate and functional.
E. Treatment or services for temporomandibular joint (TMJ) disorders, including but not limited to radiographs and/or tomographic surveys, except for TMJ arthograms, including injection, and other TMJ films, by report, for members up to age 19.
F. Gold foil fillings.
G. Periodontal appliances.
H. Prescription drugs including but not limited to antibiotics administered by the member, inhalation of nitrous oxide (except for members under age 19), injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
I. Nightguards for members over age 19 or other oral orthotic appliances, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
J. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs and other pathology procedures, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
K. Intentional tooth reimplantation or transplantation for members over age 19.
L. Interim prosthetic devices (fixed or removable) not part of a permanent or restorative prosthetic service.

M. Additional fees charged for visits by a dentist to the member's home, to a hospital, to a nursing home or for office visits after the dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the dentist's office during normal office hours.
N. Transseptal fiberotomy.
O. Orthognathic surgery.
P. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
Q. Any orthodontic services after the last day of the month in which Covered Dental Services ended, except as specifically described in the dental benefits Agreement.
R. Services or supplies that are not medically necessary as determined by CareFirst.
S. Services not specifically listed in the dental benefits Agreement as a Covered Dental Service, even if medically necessary.
T. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
U. Separate billings for dental care services or supplies furnished by an employee of a dentist which are normally included in the dentist's charges and billed by them.
V. Telephone consultations, failure to keep a scheduled visit, completion of forms or administrative services.
W. Services or supplies that are experimental or investigational in nature.
X. Orthodontic or any other services for cosmetic purposes.
Y. Transitional orthodontic appliances, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
Z. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.
AA. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

For Washington, D.C. residents:

3.1 Limitations.

A. Covered dental services must be performed by or under the supervision of a dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.
B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments and custom denture teeth.
C. If a member switches from one dentist to another during a course of treatment, or if more than one dentist renders services for one dental procedure, CareFirst shall pay as if only one dentist rendered the service.
D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).
E. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative. CareFirst benefits will cover treatment based upon the CareFirst allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the less expensive procedure. However, if the Subscriber and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

3.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge or crown as a result of loss or theft.
B. Replacement of an existing denture, bridge or crown that is determined by CareFirst to be satisfactory or repairable.

C. Replacement of dentures, bridges, implants, metal and/or porcelain crowns, inlays, onlays and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the dental benefits Agreement and are judged by CareFirst to be adequate and functional.
D. Treatment or services for temporomandibular joint (TMJ) disorders, including but not limited to radiographs and/or tomographic surveys.
E. Gold foil fillings.
F. Periodontal appliances.
G. Prescription drugs including but not limited to antibiotics administered by the member, inhalation of nitrous oxide, injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
H. Nightguards for members over age 19 or other oral orthotic appliances, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
I. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs and other pathology procedures, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
J. Intentional tooth reimplantation or transplantation.
K. Interim prosthetic devices (fixed or removable) not part of a permanent or restorative prosthetic service.
L. Additional fees charged for visits by a dentist to the member's home, to a hospital, to a nursing home or for office visits after the dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the dentist's office during normal office hours.
M. Transseptal fiberotomy.
N. Orthognathic surgery.
O. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
P. Any orthodontic services after the last day of the month in which Covered Dental Services ended.
Q. Services or supplies that are not medically necessary as determined by CareFirst.
R. Services not specifically listed in the dental benefits Agreement as a Covered Dental Service, even if medically necessary.
S. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
T. Separate billings for dental care services or supplies furnished by an employee of a dentist which are normally included in the dentist's charges and billed by them.
U. Telephone consultations, failure to keep a scheduled visit, completion of forms or administrative services.
V. Services or supplies that are experimental or investigational in nature.
W. Orthodontic or any other services for cosmetic purposes.
X. Transitional orthodontic appliances, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
Y. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.
Z. Provision splinting (intracoronal and extracoronal).
AA. Endodontic implants.
BB. Fabrication of athletic mouthguards.
CC. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.
DD. Adjustments to maxillofacial prosthetic appliance.
EE. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral).
FF. Any orthodontic services after the last day of the calendar year in which the member turned age 19.
GG. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

For Virginia residents:

3.1 Limitations.

A. Covered dental services must be performed by or under the supervision of a dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.
B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments, custom denture teeth and implant supported fixed or removable prostheses.
C. If a member switches from one dentist to another during a course of treatment, or if more than one dentist renders services for one dental procedure, CareFirst shall pay as if only one dentist rendered the service.
D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).
E. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative. CareFirst benefits will cover treatment based upon the CareFirst allowance for the least expensive procedure, provided that the least expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the least expensive procedure. However, if the Subscriber and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

3.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge or crown as a result of loss or theft.
B. Replacement of an existing denture, bridge or crown that is determined by CareFirst to be satisfactory or repairable.
C. Replacement of dentures, bridges, metal and/or porcelain crowns, inlays, onlays and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the dental benefits Agreement and are judged by CareFirst to be adequate and functional.
D. Treatment or services for temporomandibular joint (TMJ) disorders including but not limited to radiographs and/or tomographic surveys.
E. Gold foil fillings.
F. Periodontal appliances.
G. Prescription drugs including but not limited to antibiotics administered by the member, inhalation of nitrous oxide (except for members under age 19), injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
H. Nightguards for members over age 19 or other oral orthotic appliances, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
I. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs and other pathology procedures, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
J. Intentional tooth reimplantation or transplantation for members over age 19.
K. Interim prosthetic devices (fixed or removable) not part of a permanent or restorative prosthetic service.
L. Additional fees charged for visits by a dentist to the member's home, to a hospital, to a nursing home or for office visits after the dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the dentist's office during normal office hours.
M. Transseptal fiberotomy.
N. Orthognathic Surgery, unless required to attain functional capacity for Members up to age 19 until the end of the calendar year in which the Member turns age 19.

O. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
P. Any orthodontic services after the last day of the month in which Covered Dental Services ended.
Q. Services or supplies that are not medically necessary as determined by CareFirst.
R. Services not specifically listed in the dental benefits Agreement as a Covered Dental Service, even if medically necessary, except as required to be covered under state or federal laws and regulations.
S. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
T. Separate billings for dental care services or supplies furnished by an employee of a dentist which are normally included in the dentist's charges and billed for by them.
U. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
V. Services or supplies that are experimental or investigational in nature.
W. Orthodontic or any other services for cosmetic purposes.
X. Transitional orthodontic appliances, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
Y. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.
Z. Local anesthesia services are included in the benefit for restorative services and surgical services and are not separately reimbursed.

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

Policy Form Numbers

Maryland

CFMI—MD Individual Dental—ON Exchange

BlueDental Preferred HIGH Option: CFMI/EXC/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB HIGH ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: CFMI/EXC/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

CFMI—MD Individual Dental—OFF Exch

BlueDental Preferred HIGH Option: CFMI/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB HIGH ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: CFMI/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

GHMSI—MD Individual Dental—ON Exch

BlueDental Preferred HIGH Option: MD/CF/EXC/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB HIGH ON-OFF EXC (R. 1/25); MD/GHMSI/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: MD/CF/EXC/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); MD/GHMSI/CD/DOL APPEAL (1/24) and any amendments

GHMSI—MD Individual Dental—OFF Exch

BlueDental Preferred HIGH Option: MD/CF/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB HIGH ON-OFF EXC (R. 1.25); MD/GHMSI/CD/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: MD/CF/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); MD/GHMSI/CD/DOL APPEAL (1/24) and any amendments

Washington, D.C.

DC GHMSI CD ON Exchange:

BlueDental Preferred HIGH Option: DC/CF/DB/EXC/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15); DC/CF/EXC/DB/2025 DENTAL AMEND HIGH (1/25); DC GHMSI – HEALTH GUARANTY 5/21

BlueDental Preferred LOW Option: DC/CF/DB/EXC/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15); DC/CF/EXC/DB/2024 DENTAL AMEND LOW (1/25); DC GHMSI – HEALTH GUARANTY 5/21

DC GHMSI CD OFF Exchange:

BlueDental Preferred HIGH Option: DC/CF/DB/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15); DC/CF/DB/2025 DENTAL AMEND (1/25); DC GHMSI – HEALTH GUARANTY 5/21

BlueDental Preferred LOW Option: DC/CF/DB/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15); DC/CF/DB/2025 DENTAL AMEND LOW (1/25); DC GHMSI – HEALTH GUARANTY 5/21

Virginia

Virginia GHMSI CD ON EXCH:

These plans are no longer offered on the Virginia Exchange.

Virginia GHMSI CD OFF EXCH:

BlueDental Preferred HIGH Option: VA/CF/DB/PREF DENT HIGH (R. 1/25)

BlueDental Preferred LOW Option: VA/CF/DB/PREF DENT LOW (R. 1/25)

Notes

CareFirst BlueCross BlueShield
CareFirst BlueChoice, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

CareFirst Family of health care plans

CONNECT WITH US:

CDS1215-1P (9/24)

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 4/15/2025)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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