Welcome

Your smile says a lot about you. It’s the first thing people see when they meet you. But did you know your smile also says a lot about your overall health?

That’s why it’s so important to protect your smile. Good dental care has been shown to significantly reduce and help prevent some diseases and serious health conditions.

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

As a member, you’ll enjoy:

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

Protect your smile, your health and your budget from serious dental issues. Read on to learn more about Individual Select Dental HMO, offered by The Dental Network, Inc. and CareFirst BlueChoice, Inc. (CareFirst).

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

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

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

Our network

As a member of our Dental HMO plan, you'll select a general dentist from a network of participating providers to coordinate all of your dental care needs. Visit 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. This plan does not cover dental services outside of the provider network.

<table>
<thead>
<tr>
<th>Common Dental Procedures</th>
<th>Regular Cost1</th>
<th>With the Dental HMO plan, In-Network You Pay2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive checkups, (includes routine exams, cleanings and X-rays)</td>
<td>$196 per visit (2 visits per year)</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td>Basic dental services (includes fillings, simple extractions and more)</td>
<td>$142-$340</td>
<td>$20 per office visit</td>
</tr>
<tr>
<td>Soft tissue management (includes periodontal scaling, periodontal maintenance and more)</td>
<td>$272</td>
<td>$70 per office visit</td>
</tr>
<tr>
<td>Porcelain crown (high noble metal)</td>
<td>$1,206</td>
<td>$460</td>
</tr>
<tr>
<td>Root canal therapy (bicuspide, excludes final restoration)</td>
<td>$906</td>
<td>$375 primary dentist or $475 specialty care dentist</td>
</tr>
<tr>
<td>Complete upper dentures</td>
<td>$1,750</td>
<td>$495</td>
</tr>
<tr>
<td>Orthodontia (Braces) Comprehensive—Adolescent</td>
<td>$5,362</td>
<td>$2,500</td>
</tr>
<tr>
<td>Comprehensive—Adult</td>
<td>$5,495</td>
<td>$2,700</td>
</tr>
</tbody>
</table>

1 Based on National Dental Advisory Service Fee Report (2017)
2 Approximate amount. Pricing may vary depending on dental provider’s negotiated rate with CareFirst.

This is a partial listing of services. If you have any questions, please call our product consultants with our dental business team at 410-847-9060 or toll-free at 888-833-8464, Monday-Friday, 8:30 a.m. to 5 p.m.
The rates shown reflect the current premium levels. Your actual premium rate may be higher than the rate shown based on the date of your signed application. All rates are subject to change.
Enroll Today
Enrolling in Your New Dental Plan

Applying is Easy!
You have the option to use the paper application provided or enroll online.

- To enroll online, visit carefirst.com/shopdental
  - Get instant confirmation
  - Have access to real-time help via click-to-call or click-to-chat

- If you use the paper application, return it in the enclosed, postage-paid envelope or mail your completed application to:
  Mail Administrator
  P.O. Box 14651
  Lexington, KY 40512

- You can also enroll through your broker.

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.

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

When you’re ready to review a list of providers, please visit carefirst.com/doctor. Click on the Guest link. Then, click on Dental, select Dental HMO, then IND20. If you prefer a printed list by zip code, 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.

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

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

Please fill out the application on the following pages if you live in Maryland.
INSTRUCTIONS
1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application in the postage-paid return envelope or, mail to Mailroom Administrator, P.O. Box 14651, Lexington, KY 40512
Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

1. APPLICANT INFORMATION

Last Name | First Name | Initial | Social Security #
-----------|------------|---------|---------------------
Residence Address (Number and Street, Apt #) | City | State | Zip Code (9-digit, if known)
Billing Address, if different: (Number and Street, Apt #) | City | State | Zip Code (9-digit, if known)
Date of Birth | Sex | Marital Status
Home Phone | Work/Cell Phone | Dental Office Code | Payment Option

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. I.</th>
<th>Relationship</th>
<th>Social Security #</th>
<th>Date of Birth (Mo/Day/Yr)</th>
<th>Sex</th>
<th>Dental Office Code</th>
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<tbody>
<tr>
<td>Spouse</td>
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<tr>
<td>Domestic Partner</td>
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<tr>
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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 Blue Cross and Blue Shield 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>
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<th>Alternate Email Address</th>
<th>Alternate Cell Phone Number</th>
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</table>

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

- [ ] Email only
- [ ] Cell phone text messaging only
- [ ] Email and cell phone text messaging

Signature: X

CareFirst will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.
5. CONDITIONS OF ENROLLMENT—Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
- This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment.
- Premium payment options are available on an annual and a quarterly basis.
- To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for The Dental Network policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at 866-891-2802 before signing this application.

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

Signature of Applicant: X ____________________________ Date: __________________

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

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>
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<td>Contracted Broker:</td>
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<td>Sub-Agent/Sub-Agency:</td>
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<td>Writing Agent:</td>
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</table>
Application for Washington, D.C. residents

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

1. Please fill out all applicable spaces on this application. Print all information.
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>
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<th>Residence Address (Number and Street, Apt #)</th>
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<th>State</th>
<th>Zip Code (9-digit, if known)</th>
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<th>Billing Address, if different: (Number and Street, Apt #)</th>
<th>City</th>
<th>State</th>
<th>Zip Code (9-digit, if known)</th>
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<th>Home Phone</th>
<th>Work/Cell Phone</th>
<th>Dental Office Code</th>
<th>Payment Option</th>
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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>
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<tbody>
<tr>
<td>Spouse/Domestic, Legal or Civil Union Partner</td>
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<td>Domestic Partner</td>
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<td>Dependent 3</td>
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<td>Dependent 4</td>
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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:

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- An email account that allows me to send and receive emails; and
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<table>
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<tr>
<th>Alternate Email Address</th>
<th>Alternate Cell Phone Number</th>
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<td></td>
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</tbody>
</table>

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

- [ ] Email only
- [ ] Cell phone text messaging only
- [ ] 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:

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

Contracted Broker: __________________________

Sub-Agent/Sub-Agency: __________________________

Writing Agent: __________________________
Application for Northern Virginia residents

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

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

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

<table>
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<th>Residence Address (Number and Street, Apt #)</th>
<th>City</th>
<th>State</th>
<th>Zip Code (9-digit, if known)</th>
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<th>Billing Address, if different: (Number and Street, Apt #)</th>
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<th>Marital Status</th>
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<tbody>
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<tr>
<td></td>
<td></td>
<td>Married</td>
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<td></td>
<td></td>
<td>Domestic Partner</td>
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<thead>
<tr>
<th>Home Phone (              )</th>
<th>Work/Cell Phone (              )</th>
<th>Dental Office Code</th>
<th>Payment Option</th>
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<tr>
<td></td>
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<td>Annually</td>
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</table>

2. COVERAGE SELECTION: (Check one)

- Individual——Provides coverage for one person
- Individual & Child(ren)—Provides coverage for an individual and eligible dependent(s)
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- 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.)

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<th>Relationship</th>
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<td>Dependent 4</td>
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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. Spouses, domestic partners and dependents 18 years of age and older can consent to electronic communications through www.carefirst.com/myaccount. Members can also change email and consent information anytime by logging into www.carefirst.com/myaccount or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

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

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

I understand that to receive notices through text messaging,

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

<table>
<thead>
<tr>
<th>Primary Applicant Name</th>
<th>Email Address</th>
<th>Cell Phone Number</th>
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<tr>
<th>Alternate Email Address</th>
<th>Alternate Cell Phone Number</th>
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</table>

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

☐ Email only  ☐ Cell phone text messaging only  ☐ Email and cell phone text messaging

Signature: X

CareFirst will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.
5. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

**IT IS UNDERSTOOD AND AGREED THAT:**

- A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.
- This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment.
- Premium payment options are available on an annual and a quarterly basis.
- To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for 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.

<table>
<thead>
<tr>
<th>Signature of Primary Applicant: X</th>
<th>Date</th>
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<tr>
<td>Parent or Legal Guardian's Signature: X</td>
<td>Date</td>
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**FOR BROKER USE ONLY:**

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

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

A. Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;
B. 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. Loss or theft of bridgework or dentures previously supplied under the PLAN;
K. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
L. Any implantation;
M. General anesthesia;
O. Services that cannot be performed because of the general health of the patient;
P. Teeth Cleaning (Prophylaxis) 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
Virginia

PLAN LIMITATIONS. The following limitations shall apply:

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

B. Unlisted procedures will be provided at the dentist's 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.
Notice of Nondiscrimination and Availability of Language Assistance Services

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

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address  P.O. Box 8894
                 Baltimore, Maryland 21224

Email Address   civilrightscoordinator@carefirst.com

Telephone Number 410-528-7820
                Fax Number 410-505-2011

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

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


REV. (12/17)
Foreign Language Assistance

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

Амхарского языка (Amharic)-: ይወስኝ ብስታወቂያ ውስጥ ወቅት ምክንያት ውስጥ ይፋስ ይህም። ከተለያዩ ላይ-ወቅት በልማር መስጠት ከንጉት ከስድር ለበር ከኔ ያሉም ከየወስኝ በእር ይመር በመስጠት ውስጥ ከለም። ከእኔ ከስድር ከሆነ ከርም ያስክትክለ ለጠየቁም ወድን በማጋቁ የስልክ ከሚያስችሉ። ከወስኝ ከነቡም ወቅት በእር መስጠት:
855-258-6518 ይወስኝ ውስጥ ወቅት ምክንያት ውስጥ ይፋስ ይህም። ገንዘብ ወቅት ውስጥ ከለም። ማለይንድ ከሚያስችሉ። ከስልክ ከያስፈልግ በእር መስጠት:

Èdè Yorùbá (Yoruba) Itétítéloko: Akiyésì yi nì iwífún nipa isé adójútòfò rẹ. Ò le ní awọn dèèti pátọ o si le ní láti gbé ighésé ní awọn ojó gbédéke kan. O ní ëtò láti gba iwífún yií ați íranlówó ní èdè rẹ lójèé. Àwọn ọmọ-égbé gbódò pe nónmbà fóonú tọ wá léyín kàádì idámimọ wọn. Àwọn míran le pe 855-258-6518 kí o sí dúró nípasè ijíròrò tíí a ò fi sí fún ọ láti tẹ 0. Nígbàti aṣojú kan bá dálùn, sọ èdè tí o fẹ a ó sí so ó pọ mó ègbufó kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc gọi hỏi cho đến khi được nhắc nhở thêm 0. Khi một thông điệp trả lời, hãy nói rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một tổng đắc viên.


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.

Русский (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 можете бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут 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.
This statement contains information about your insurance. It may contain important dates and requires action before a specific deadline. You have the right to obtain this information in any language and receive assistance in your native language.

ال声明包含关于您的保险的相关信息。它可能包含重要的日期，要求在特定期限前采取行动。您有权免费获取该信息，并以您选择的语言获得协助。

Les abolition de cet accord entre les parties est nécessaire et doit être effectuée au plus tard avant un certain délai. Vous avez le droit d'obtenir cette information en toute langue et de recevoir l'aide en langue de votre choix.
Igbo (Igbo) Nrúbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. Ọ nwere ike ụbọchị ndị mkpa, ị nwere ike ime ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ike ihe ozi na enyemaka a n’asụsụ gị na akwụghị ụgwọ ọ bula. Ndi otu kwesịrị ikpo akara ekwenti di n’asụgu nke kaadi njirimara ha. Ndi ọzọ nne nwere ike ọkpo 855-258-6518 wee chere ụbọchị ahụ rhu mgbe amanyere ụpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-eji ọ gị na onye ọkwa 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 아닙니다메이 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Policy Form Numbers

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

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

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