CareFirst

Family of health care plans

Individual Select Dental HMO 2022

MARYLAND ▪ WASHINGTON, D.C. ▪ NORTHERN VIRGINIA

Welcome

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

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

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

As a member, you'll enjoy:

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

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

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

Contents

How Your Plan Works

Your Dental Plan

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

Individual Select Dental HMO offers reliable dental care with predictable copayments for routine and major dental services such as:

- Preventive and diagnostic dental care
- Surgical extractions
- Root canal therapy
- Comprehensive orthodontic treatment (adults and adolescents)

Our network

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

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

Common Dental Procedures	Regular Cost[1]	With the Dental HMO plan, In-Network You Pay[2]
Preventive checkups *(includes routine exams, cleanings and X-rays)*	$202 per visit (2 visits per year)	$20 per office visit
Basic dental services *(includes fillings, simple extractions and more)*	$146-$198	$20 per office visit
Soft tissue management *(includes periodontal scaling, periodontal maintenance and more)*	$280	$70 per office visit
Porcelain crown *(high noble metal)*	$1,220	$460
Root canal therapy *(bicuspid, excludes final restoration)*	$1,138	$375 primary dentist or $475 specialty care dentist
Complete upper dentures	$1,837	$495
Orthodontia *(braces)* **Comprehensive—Adolescent** **Comprehensive—Adult**	 $5,480 $5,495	 $2,500 $2,700

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

[2] Approximate amount. Pricing may vary depending on dental provider's negotiated rate with CareFirst.

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

2022 Dental Rates

Maryland

Coverage Type	Annual Rate	Quarterly Rate			
		1st Payment	2nd Payment	3rd Payment	4th Payment
Individual	$220.08	$55.02	$55.02	$55.02	$55.02
Individual & Adult	$440.16	$110.04	$110.04	$110.04	$110.04
Individual & Child(ren)	$407.16	$101.79	$101.79	$101.79	$101.79
Family	$616.20	$154.05	$154.05	$154.05	$154.05

Washington, D.C.

Coverage Type	Annual Rate	Quarterly Rate			
		1st Payment	2nd Payment	3rd Payment	4th Payment
Individual	$225.60	$56.40	$56.40	$56.40	$56.40
Individual & Adult	$451.20	$112.80	$112.80	$112.80	$112.80
Individual & Child(ren)	$417.36	$104.34	$104.34	$104.34	$104.34
Family	$631.68	$157.92	$157.92	$157.92	$157.92

Northern Virginia

Coverage Type	Annual Rate	Quarterly Rate			
		1st Payment	2nd Payment	3rd Payment	4th Payment
Individual	$289.32	$72.33	$72.33	$72.33	$72.33
Individual & Adult	$578.64	$144.66	$144.66	$144.66	$144.66
Individual & Child(ren)	$535.20	$133.80	$133.80	$133.80	$133.80
Family	$810.12	$202.53	$202.53	$202.53	$202.53

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

Enroll Today

Enrolling in Your New Dental Plan

Applying is Easy!

Return the paper application in the enclosed, postage-paid envelope or mail your completed application to:

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

You can also enroll through your broker.

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

When will my dental coverage start?

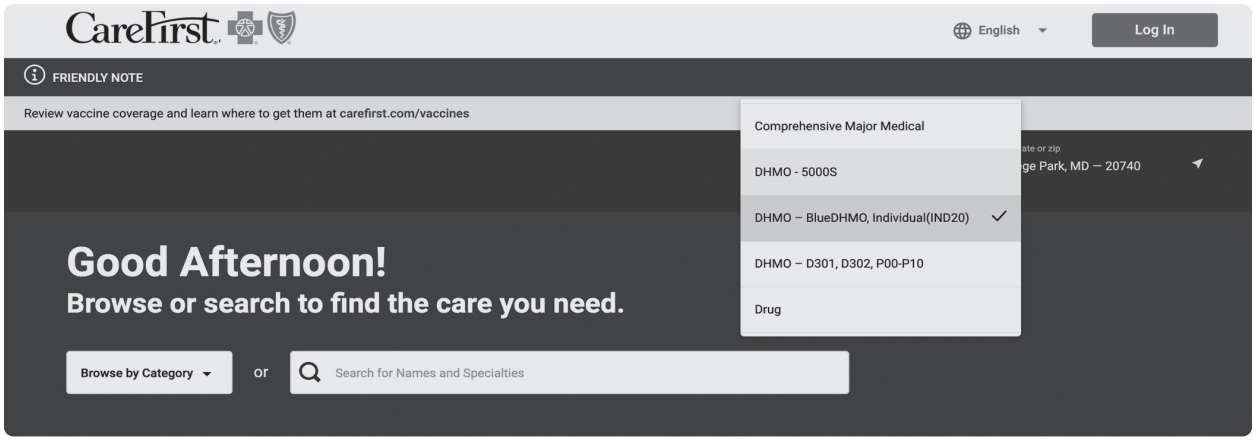
The effective date of coverage is based on the 20th of the month. If we receive your application before the 20th of the month and your premium is paid by the due date, your coverage will become effective on the first day of the following month.

Have questions?

Contact us at 855-503-4862, Monday-Thursday from 8 a.m. to 5 p.m. and Friday from 10 a.m. to 5 p.m.

Need to find a dentist?

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



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

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

Application for Maryland Residents

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

Individual Dental HMO Application

Maryland

The Dental Network

10455 Mill Run Circle, Owings Mills, MD 21117

INSTRUCTIONS

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

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

1. APPLICANT INFORMATION

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 ○ Male ☐ Female	Marital Status ○ Single ☐ Married ☐ Partner/Other	
Home Phone ( )	Work/Cell Phone ( )	Dental Office Code	Payment Option ○ Annually ☐ Quarterly

2. COVERAGE SELECTION—CHECK ONE

○ **Individual**—Provides coverage for one person
☐ **Individual & Child(ren)**—Provides coverage for an individual and eligible dependent(s)
☐ **Individual & Adult**—Provides coverage for two eligible adults
☐ **Family**—Provides coverage for two eligible adults and eligible dependent(s)

A "Child" means your eligible child up to age 26. Eligibility requirements are defined in your contract.
An "Adult" means the Spouse or Partner who satisfies the eligibility requirements defined in your contract.

3. ENROLLING FAMILY MEMBER(S)—COMPLETE ONLY IF YOU SELECT INDIVIDUAL & CHILD(REN), INDIVIDUAL & ADULT OR FAMILY COVERAGE (DENTAL HMO PLAN MUST HAVE A DENTAL OFFICE CODE. EACH PERSON MAY SELECT THEIR OWN DENTIST.)

Last Name		First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex	Dental Office Code
Spouse							○ M ☐ F	
Domestic Partner							○ M ☐ F	
Dependent 1							○ M ☐ F	
Dependent 2							○ M ☐ F	
Dependent 3							○ M ☐ F	
Dependent 4							○ 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 cell phone number and consent below.

Electronic notices regarding your CareFirst health care coverage include, but are not limited to:

- Explanation of Benefits Alerts
- Notice of HIPAA Privacy Practices
- Reminders
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

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

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

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

I understand that to receive notices through text messaging,

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

<table>
<tr><th>PRIMARY APPLICANT NAME</th><th>EMAIL ADDRESS</th><th>CELL PHONE NUMBER</th></tr>
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<tr><td>ALTERNATE EMAIL ADDRESS</td><td>ALTERNATE CELL PHONE NUMBER</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td colspan="3">Signature: X</td></tr>
</table>

CareFirst will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.

5. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

IT IS UNDERSTOOD AND AGREED THAT:

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

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

Signature of Applicant: X_____Date:_____

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

Parent or Legal Guardian Signature: X_____Date:_____

FOR OFFICE USE ONLY:

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

Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:		[redacted]		
Sub-Agent/Sub-Agency:				[redacted]
Writing Agent:				

Application for Washington, D.C. Residents

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

Individual Dental HMO Application

District of Columbia

CareFirst BlueChoice, Inc.
840 First Street, NE, Washington, DC 20065

INSTRUCTIONS

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

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

1. APPLICANT INFORMATION

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 ☐ Male ☐ Female	Marital Status ○ Single ☐ Married ☐ Domestic Partnership/Other	
Home Phone ( )	Work/Cell Phone ( )	Dental Office Code	Payment Option ☐ Annually ☐ Quarterly

2. COVERAGE SELECTION—CHECK ONE

○ **Individual**—Provides coverage for one person
☐ **Individual & Child(ren)**—Provides coverage for an individual and eligible dependent(s)
☐ **Individual & Adult**—Provides coverage for two eligible adults
☐ **Family**—Provides coverage for two eligible adults and eligible dependent(s)

A "Child" means your eligible child up to age 26. Eligibility requirements are defined in your contract.
An "Adult" means the Spouse, 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.)

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex	Dental Office Code
Spouse/Domestic, Legal or Civil Union Partner							☐ M ☐ F	
Domestic Partner							☐ M ☐ F	
Dependent 1							☐ M ☐ F	
Dependent 2							☐ M ☐ F	
Dependent 3							☐ M ☐ F	
Dependent 4							☐ M ☐ F	

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- Explanation of Benefits Alerts
- Notice of HIPAA Privacy Practices
- Reminders
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note: This consent for electronic communications applies to the primary applicant only. Spouse, domestic, legal or civil union partners and dependents 18 years of age and older can consent to electronic communications through **www.carefirst.com/myaccount**. Members can also change email and consent information anytime by logging into **www.carefirst.com/myaccount** or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

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

- Internet access;
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5. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

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- 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.

Parent or Legal Guardian Signature: X_____Date:_____

FOR OFFICE USE ONLY:

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

Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:		[redacted]		
Sub-Agent/Sub-Agency:				[redacted]
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.

Individual Dental HMO Application

Virginia

CareFirst BlueChoice

CareFirst BlueChoice, Inc.
840 First Street, NE, Washington, DC 20065

INSTRUCTIONS

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   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
/ /	☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner

Home Phone	Work/Cell Phone	Dental Office Code	Payment Option
( )	( )		○ Annually ☐ Quarterly

2. COVERAGE SELECTION—CHECK ONE

- ☐ **Individual**—Provides coverage for one person
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- ☐ **Individual & Adult**—Provides coverage for two eligible adults
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	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex	Dental Office Code
Spouse							☐ M ☐ F	
Domestic Partner							☐ M ☐ F	
Dependent 1							☐ M ☐ F	
Dependent 2							☐ M ☐ F	
Dependent 3							☐ M ☐ F	
Dependent 4							☐ M ☐ F	

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- Reminders
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You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note: This consent for electronic communications applies to the primary applicant only. 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.

PRIMARY APPLICANT NAME	EMAIL ADDRESS	CELL PHONE NUMBER
	ALTERNATE EMAIL ADDRESS	ALTERNATE CELL PHONE NUMBER

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 Applicant: X_____ Date:_____

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

Parent or Legal Guardian Signature: X_____ Date:_____

Signature of Agent: X_____ Date:_____

FOR OFFICE USE ONLY:

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

Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:		[redacted]		
Sub-Agent/Sub-Agency:				[redacted]
Writing Agent:				

Additional Information

Exclusions and Limitations

Maryland

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

- Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws;
- Services which are provided without cost to the Covered Individual and/or Dependent(s) by any municipality, county or other political subdivision (with the exception of Medicaid);
- Services which, in the opinion of the Participating DENTIST, are not necessary for the Covered Individual and/or Dependent(s) health;
- Payment of any claim or bill will not be made for prohibited referrals;
- Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient's dental health;
- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
- Dispensing of drugs, except those used as a local anesthetic;
- Hospitalization for any dental procedure;
- Loss or theft of bridgework or dentures previously supplied under the PLAN;
- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
- Any implantation;
- General anesthesia;
- Services that cannot be performed because of the general health of the patient;
- Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period.
- Unlisted procedures will be provided at the dentist's charge unless The Dental Network, Inc. determines the procedure is a covered benefit that has not yet been added to the Schedule of Benefits and Copayments. If so determined, the Covered Individual Copayments will be determined by The Dental Network, Inc. If a Covered Individual has questions about the Covered Individual Copayment for an unlisted CDT code, the Covered Individual should call the telephone number located on the Covered Individual's Membership Identification Card;
- Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
- Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual and/or Dependent('s) General Participating DENTIST; all services listed on the Schedule of Benefits and Copayments will be provided by a general Participating DENTIST or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an Approved Specialist or recommend that the Covered Individual or Dependent contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care, and a referral to a non-participating general dentist or specialist;
- Services which cannot be performed in the dental office of the "Personal Participating DENTIST" or "Approved Specialist" due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).
- Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

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

ALL PRICES ARE EXCLUSIVE OF GOLD

Washington, D.C.

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

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

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

ALL PRICES ARE EXCLUSIVE OF GOLD

Virginia

PLAN LIMITATIONS. The following limitations shall apply:

A. All services listed on the Schedule of Benefits and Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an approved Specialist or recommend that the Covered Individual or Dependent contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care;
B. Unlisted procedures will be provided at the dentist's charge unless CareFirst BlueChoice, Inc. determines the procedure is a covered benefit that has not yet been added to the Schedule of Benefits and Copayments. If so determined, the Covered Individual Copayments will be determined by CareFirst BlueChoice, Inc.;
C. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual's General Participating DENTIST
D. OUT-OF-AREA EMERGENCY CARE: Members are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest PLAN Dental Office. Limited to $50 per member per emergency.

EXCLUSIONS. Benefits will not be provided for:

A. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws;
B. Services which are provided without cost to the Covered Individual by any municipality, county or other political subdivision (with the exception of Medicaid);
C. Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Individual's health;
D. Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient's dental health;
E. Oral surgery requiring the setting of fractures or dislocations;
F. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
G. Dispensing of drugs, except those used as a local anesthetic;
H. Hospitalization for any dental procedure;
I. Loss or theft of bridgework or dentures previously supplied under the PLAN;
J. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
K. Any implantation;
L. General anesthesia;
M. Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;
N. Services which are obtained outside the dental office in which enrolled and which are not preauthorized by the PLAN. This does not apply to out-of-area emergency dental services;
O. Services which cannot be performed in the dental office of the "Personal Participating DENTIST" or "Approved Specialist" due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).
P. All Member Copayments listed on the Schedule of Benefits and Copayments are exclusive of gold;
Q. Payment of any claim or bill will not be made for prohibited referrals.
R. Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

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

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

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

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.*

አማርኛ(Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò títí a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi 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 đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

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

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 имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут 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.

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

Bǎsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fùà-fű́á-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓédɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɖé nì ɓídɖí-wùdù mú ɓɛ́ m̀ ké se wídɖí dɔ̀ pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ dɖá fűùn-nɔ̀ɓà nìà dɖé waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàdɖàìn hwè. Ɔ jǔ ké nyɔ dɔ̀ dyi m̀ gɔ̌ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dɔ̀ mu ɓó nììn ɓɛ́ ɔ ké nì wudɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

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

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

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

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