CareFirst

BlueDental Preferred

MARYLAND

DISTRICT OF COLUMBIA

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

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

We're pleased to introduce you to **BlueDental Preferred**.

As a member of **BlueDental Preferred** you'll enjoy:

- Freedom of choice
- Two different options to suit your budget
- Coverage for numerous dental services
- No referrals
- More than 3,600 dentists throughout Maryland, the District of Columbia and Northern Virginia, and, access to a national network of 63,000 dentists and specialists.
- No charge for oral exams, cleanings and X-rays when you visit an in-network provider
- No claim forms to file in-network
- Medically necessary orthodontia benefit – for children up to age 19
- Guaranteed acceptance
- No charge for in-network covered services after members age 19 and under reach their $350 out-of-pocket maximum.

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

Read on to learn about **BlueDental Preferred**, offered by CareFirst BlueCross BlueShield. Or, contact our Product Specialists at 410-356-8000 or toll-free at 800-544-8703, Monday–Friday, 8 a.m. to 8 p.m.

Did You Know...

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

[1] Andriankaia, OM, et al. The use of different measurements and definitions of periodontal disease in the study of the association between periodontal disease and risk of myocardial infarction. J Periodontol 2006 Jun;77(6):1067-73.
[2] Faria-Almeida R, Navarro A, Bascones A. Clinical and metabolic changes after conventional treatment of type 2 diabetic patients with chronic periodontitis. J Periodontol. 2006 Apr;77(4)591-8.
[3] Lopez NJ, et al. Periodontal therapy reduces the rate of preterm low birth weight in women with pregnancy-associated gingivitis. J Periodontol. 2005 Nov;76(11 Suppl):2144-53.

How your plan works

Manage Your Care and Save

Preventive & Diagnostic Services (Class I)

If you pick the High Option, there is no deductible for the following services which are covered in full when visiting an in-network provider:

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

Basic & Major Services (Classes II, III, IV)

After meeting a deductible, your plan includes fillings, simple extractions, periodontal scaling and 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.

Visiting Non-Participating Providers

You also have the option to seek treatment from 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 all costs at the time of service and submit a claim form to be reimbursed for covered services.

To locate a participating provider, go to **www.carefirst.com/doctor**, *click on "Dental" and select "DP" under "Preferred Dental (PPO)."*

***Allowed Benefit** — The allowed benefit is typically a reduced rate rather than the actual charge. For example: You have just visited your dentist for a routine exam and cleaning. The total charge for the visit comes to $125. If the doctor is a participating provider he/she may be required to accept $75 from CareFirst as payment in full for the visit—this is the allowed benefit. If, however, the dental provider you visit is non-participating then you may be held responsible for the difference between the CareFirst allowed benefit and the dental provider's full charge.

A Plan for You

Meet The Johnsons

– Low Option

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

Common Dental Procedure	No Coverage[1]	BlueDental Preferred Low Option (In-Network)2	Savings on Services[3]
6 month check-ups, including routine exams, cleanings and x-rays *(8 visits, 2 per person)*	$1,344 ($168 per visit)	$0 (after $300 deductible)	$1,044
Filling *(1 filling)*	$135	$10 (deductible applies)	$125
Medically Necessary Orthodontic Services *(1 Child to age 19)*	$5,100	$350	$4,750
Total	**$6,579**	**$660**	**$5,919**

1 Based on National Dental Advisory Service Fee Report (2013).
2 Approximate amount. Pricing may vary depending upon dental provider's negotiated rate with CareFirst.
3 Savings do not include premium costs.

With no dental coverage, the Johnsons paid $6,579 for these services. With **BlueDental Preferred—Low Option** coverage, the Johnsons would have saved more than $5,900 for these services. The Johnsons decided to purchase **BlueDental Preferred—Low Option** coverage to protect themselves against future dental costs.

Meet The Smiths

– High Option

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

Common Dental Procedure	No Coverage[1]	BlueDental Preferred—High Option (In-Network)[2]	Savings on Services[3]
6 month check-ups, including routine exams, cleanings and x-rays *(4 visits, 2 per person)*	$720 ($180 per visit)	$0	$720
Root Canal *(bicuspid)*	$825	$97 (after $60 deductible)	$668
Bridge *(3-unit)*	$3,200	$985 (after $60 deductible)	$2,155
Total	**$4,745**	**$1,202**	**$3,543**

1 Based on National Dental Advisory Service Fee Report (2013).
2 Approximate amount. Pricing may vary depending upon dental provider's negotiated rate with CareFirst.
3 Savings do not include premium costs.

With no dental coverage, the Smiths paid $4,745 for these services. They decided to purchase dental coverage to protect themselves against further unexpected dental costs. With **BlueDental Preferred—High Option** coverage, the Smiths would have spent only $1,202, a savings of over $3,500 on these dental services. Now they're covered and ready for whatever lies ahead!

Frequently Used Benefits

Common Dental Procedures	Regular Cost[1]	In-Network You Pay[2]
Preventive check-ups, including routine exams, cleanings and x-rays	$168 per visit (2 visits per year)	$0 after deductible for Low—Option Plan
Fillings and simple extractions	$135–$166	$10–$16 after deductible
Periodontal scaling and root planing *(4 or more teeth per section of the mouth)*	$248	$26 after deductible
Porcelain crown *(high noble metal)*	$1,082	$328 after deductible
Root canal therapy *(molar, excluding final restoration)*	$990	$126 after deductible
Complete upper dentures	$1,650	$355 after deductible
Medically Necessary Orthodontia *(Child up to age 19)*	$5,100	$350

[1] Based on National Dental Advisory Service Fee Report (2013)
[2] Approximate amount. Pricing may vary depending upon dental provider's negotiated rate with CareFirst.

This is a partial listing of services. For specific questions please contact CareFirst Dental Services toll-free at 866-891-2802.

BlueDental Preferred—High Option

Summary of Benefits	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES II, III, IV		
▪ The family deductible amount is calculated in the 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.	$60 Individual Deductible $180 Family Deductible	$120 Individual Deductible $360 Family Deductible
OUT-OF-POCKET MAXIMUM (CLASSES I–V) FOR MEMBERS UP TO AGE 19	One member pays up to $350; Two or more members pay up to $700	No limit
ANNUAL MAXIMUM (CLASSES I-IV) FOR MEMBERS OVER AGE 19		
▪ 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) ▪ Fluoride treatments* 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* ▪ Sealants on permanent molars* until the end of the year in which member reaches age 19 ▪ Space maintainers* ▪ Palliative treatments ▪ Emergency oral exam	No charge	20% of Allowed Benefit**
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials* ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of Allowed Benefit** after deductible	40% of Allowed Benefit** after deductible
MAJOR SERVICES – SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments* ▪ 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, apicoectomy and hemi-section) ▪ General anesthesia required for oral surgery	20% of Allowed Benefit** after deductible	40% of Allowed Benefit** after deductible
MAJOR SERVICES – RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining* ▪ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance for members over age 19) ▪ Dental implants, subject to medical necessity review (once per 60 months)	50% of Allowed Benefit** after deductible	65% of Allowed Benefit** 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**	65% of Allowed Benefit**

*Frequency limitations may apply.
**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.
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.

BlueDental Preferred—Low Option

Summary of Benefits	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES I–IV		
▪ The family deductible amount is calculated in the 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) FOR MEMBERS UP TO AGE 19	One member pays up to $350; Two or more members pay up to $700	No limit
ANNUAL MAXIMUM (CLASSES I-IV) FOR MEMBERS OVER AGE 19		
▪ 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) ▪ Fluoride treatments* 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* ▪ Sealants on permanent molars* until the end of the year in which member reaches age 19 ▪ Space maintainers* ▪ Palliative treatments ▪ Emergency oral exam	No charge after deductible	20% of Allowed Benefit** after deductible
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials* ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of Allowed Benefit** after deductible	40% of Allowed Benefit** after deductible
MAJOR SERVICES – SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments* ▪ 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, apicoectomy and hemi-section) ▪ General anesthesia required for oral surgery	20% of Allowed Benefit** after deductible	40% of Allowed Benefit** after deductible
MAJOR SERVICES – RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining* ▪ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance for members over age 19) ▪ Dental implants, subject to medical necessity review (once per 60 months)	50% of Allowed Benefit** after deductible	65% of Allowed Benefit** 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**	65% of Allowed Benefit**

*Frequency limitations may apply.
**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.
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.

Calculating your total monthly premium

Figuring out the total monthly premium for the plans you're considering is actually pretty simple. Here are the three things you need to keep in mind:

1. Find your rate sheet on the following page.
2. For the plan you're considering, circle the amount in that column that corresponds with your age when coverage will begin.
3. If you're buying an individual plan, that's it! If it's a family plan, repeat step 2 for each family member who will be covered by your new plan. If you want to pay quarterly, then multiply the monthly total by three or by 12 for an annual payment.

Need a "for instance?"

Michael and Samantha are married with 3 kids—Meredith age 15, Robin age 17, and Nathan age 23. They live in Howard County and want to calculate their family's monthly premium for the BlueDental Preferred–High Option.

Using the rate chart, they find their plan's column and find and circle:

- Meredith and Robin's rate in their age row (0-19)—they make a note to add that rate twice, once for each daughter
- Nathan's rate in his age row (20+) (age 23)
- Samantha's rate in her age row (20+) (age 48)
- Michael's rate in his age row (20+) (age 53)

Then they just add it up.

	Maryland
	Baltimore City; Anne Arundel, Baltimore, Harford and Howard Counties
BlueDental Preferred **High Option**	
0-19	$28.83 x2
20+	$25.81 x3
	$135.09 monthly total
	$405.27 quarterly total
	$1,621.08 annual total

Monthly Dental Rates

	Maryland			
	Montgomery and Prince George's Counties	Baltimore City; Anne Arundel, Baltimore, Harford and Howard Counties	Allegany, Carroll, Frederick, Garrett and Washington Counties	Calvert, Caroline, Cecil, Charles, Dorchester, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Wicomico and Worcester Counties
BlueDental Preferred High Option				
0-19	$27.99	$28.83	$26.57	$27.42
20+	$25.02	$25.81	$23.78	$24.54
BlueDental Preferred Low Option				
0-19	$22.74	$23.43	$21.59	$22.28
20+	$21.49	$22.15	$20.41	$21.06

	DC	Virginia
BlueDental Preferred High Option		
0-20	$24.99	$27.08
21+	$26.62	$26.29
BlueDental Preferred Low Option		
0-20	$19.78	$21.87
21+	$23.19	$22.95

Enroll today

Enroll Today for BlueDental Preferred

It takes just three simple steps to start enjoying the benefits of BlueDental Preferred.

Three steps to enroll!

1. Fill out and sign the application that matches where you live – Maryland, the District of Columbia or Northern Virginia.
2. *Be sure to check either the Low Option or High Option deductible plan on the enclosed application.*
3. When you're ready to review a listing of providers, please visit **www.carefirst.com/doctor**. Click on *dental*, and select *DP* under *preferred dental PPO*. Or, if you'd like assistance, please call a Product Specialist at 410-356-8000 or toll-free at 800-544-8703, Monday–Friday, 8 a.m.–8 p.m.
4. Send in your application in the enclosed, postage-paid envelope or mail to:

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

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 membership ID card 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, the District of Columbia or one of the following areas of Northern Virginia: City of Alexandria and Fairfax, the town of Vienna, Arlington county and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.

Application for Maryland Residents

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

BlueDental Preferred Application

Maryland Residents

☐ **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: **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. ***If incomplete, the application will be returned and your coverage will be delayed.***

If you reside in Prince George's or Montgomery county, please check the Group Hospitalization and Medical Services, Inc. box above. If you live in Baltimore City or any other county in the state of Maryland, please check the CareFirst of Maryland, Inc. box above.

1. APPLICANT INFORMATION

Last Name	First Name	M.I.	Social Security #

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

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

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

Home Phone ( )	Work/Cell Phone ( )	Payment Option ☐ Annually ☐ Quarterly

2. DEDUCTIBLE SELECTION (Check One)

☐ **Low Option** ($100 Individual In-Network deductible)

☐ **High Option** ($60 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. RECURRING AUTOMATED PREMIUM PAYMENT

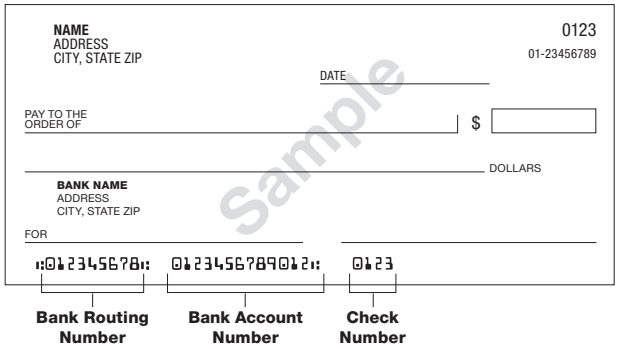
CareFirst wants to help you save time! Our standard method of payment for members is recurring automated payment by bank withdrawal. To take advantage of this time-saving payment option, please fill out the information below.

If you **do not wish** to set up an automated payment account and intend to pay by submitting paper checks or by credit card then **please check this box**. ☐

Information Required for Recurring Automated Payment:

☐ **Checking Account** ☐ **Savings Account**

Bank Name:	
Routing Number:	Account Number:
Name that appears on the Account:	



I hereby authorize Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) or CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) to charge my account for the payment of premiums due for an unpaid invoice. If any check draft is dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, CareFirst agrees that the financial institution will not be held liable. I understand that non-payment of premiums due to dishonored auto-draft payment attempts may result in termination of coverage. I also understand that if the Applicant elects to pay premium through an electronic payment, CareFirst may not debit or charge the amount of the premium due prior to the premium due date, except as authorized by the Applicant. In order for coverage to begin, the initial payment will be taken from my account on the first day of the requested effective month of coverage. Future annual payments will be taken on the 6th day of January. If quarterly payments are elected by the Applicant, future payments will be taken on the 6th day of the beginning month of the quarter (including holidays). Members registered for recurring payment will not receive a paper bill in the mail. However, you may view and print your invoice during the recurring payment period from the invoice history online at **www.carefirst.com/myaccount**.

Signature of Account Holder X	Date:

5. ELECTRONIC COMMUNICATION CONSENT

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, you may change your 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.

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

Applicant Name	Email Address	Cell Phone Number
	Alternate Email Address	Alternate Cell Phone Number
Spouse or Domestic Partner Name	Email Address	Cell Phone Number
Eligible Dependent Name(s)	Email Address	Cell Phone Number

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.

6. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Primary 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 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's Signature: X	Date

For Broker Use Only:	Name:	NPN#	SSN/Tax ID #	CareFirst-Assigned ID #
Contracted Broker:	Mindy Guisewite	6834121		177081
Sub-Agent/Sub-Agency:				
Writing Agent:	Mindy Guisewite			

Application for District of Columbia Residents

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

BlueDental Preferred Application

District of Columbia Residents

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

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: **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. ***If incomplete, the application will be returned and your coverage will be delayed.***

1. APPLICANT INFORMATION

Last Name	First Name	M.I.	Social Security #

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

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

Date of Birth	Sex	Marital Status
/ /	☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner
Home Phone	**Work/Cell Phone**	**Payment Option**
( )	( )	☐ Annually ☐ Quarterly

2. DEDUCTIBLE SELECTION (Check One)

☐ **Low Option** ($100 Individual In-Network deductible)	☐ **High Option** ($60 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. RECURRING AUTOMATED PREMIUM PAYMENT

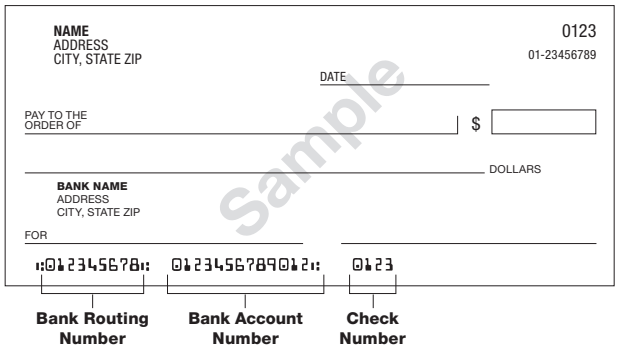
CareFirst BlueCross BlueShield wants to help you save time! Our standard method of payment for members is recurring automated payment by bank withdrawal. To take advantage of this time-saving payment option, please fill out the information below.

If you **do not** wish to set up an automated payment account and intend to pay by submitting paper checks or by credit card then **please check this box**. ☐

Information Required for Recurring Automated Payment:

☐ **Checking Account** ☐ **Savings Account**

Bank Name:	
Routing Number:	Account Number:
Name that appears on the Account:	



I hereby authorize Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) to charge my account for the payment of premiums due for an unpaid invoice. If any check draft is dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, CareFirst agrees that the financial institution will not be held liable. I understand that non-payment of premiums due to dishonored auto-draft payment attempts may result in termination of coverage. I also understand that if the Applicant elects to pay premium through an electronic payment, CareFirst may not debit or charge the amount of the premium due prior to the premium due date, except as authorized by the Applicant. In order for coverage to begin, the initial payment will be taken from my account on the first day of the requested effective month of coverage. Future annual payments will be taken on the 6th day of January. If quarterly payments are elected by the Applicant, future payments will be taken on the 6th day of the beginning month of the quarter (including holidays). Members registered for recurring payment will not receive a paper bill in the mail. However, you may view and print your invoice during the recurring payment period from the invoice history online at **www.carefirst.com/myaccount**.

Signature of Account Holder X	Date:

5. ELECTRONIC COMMUNICATION CONSENT

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, you may change your 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.

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

Applicant Name	Email Address	Cell Phone Number
	Alternate Email Address	Alternate Cell Phone Number
Spouse or Domestic Partner Name	Email Address	Cell Phone Number
Eligible Dependent Name(s)	Email Address	Cell Phone Number

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.

6. 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 (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, AN INSURER 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's Signature: X	Date

For Broker Use Only:	Name:	NPN#	SSN/Tax ID #	CareFirst-Assigned ID #
Contracted Broker:	Mindy Guisewite	6834121		177081
Sub-Agent/Sub-Agency:				
Writing Agent:	Mindy Guisewite			

Application for Northern Virginia Residents

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

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: **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. ***If incomplete, the application will be returned and your coverage will be delayed.***

1. APPLICANT INFORMATION

Last Name	First Name	M.I.	Social Security #

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

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

Date of Birth	Sex	Marital Status
/ /	☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner
Home Phone	**Work/Cell Phone**	**Payment Option**
( )	( )	☐ Annually ☐ Quarterly

2. DEDUCTIBLE SELECTION (Check One)

☐ **Low Option** ($100 Individual In-Network deductible)	☐ **High Option** ($60 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. RECURRING AUTOMATED PREMIUM PAYMENT

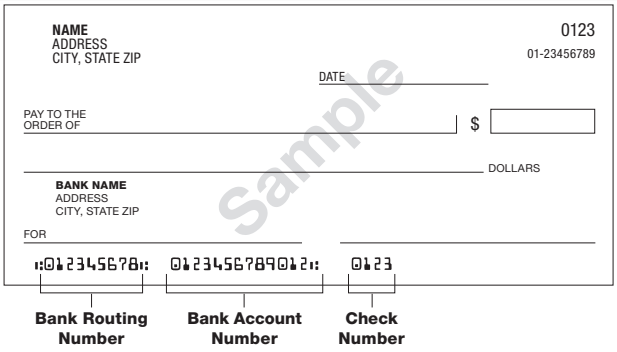
CareFirst BlueCross BlueShield wants to help you save time! Our standard method of payment for members is recurring automated payment by bank withdrawal. To take advantage of this time-saving payment option, please fill out the information below.

If you **do not wish** to set up an automated payment account and intend to pay by submitting paper checks or by credit card then **please check this box.** ☐

Information Required for Recurring Automated Payment:

☐ **Checking Account** ☐ **Savings Account**

Bank Name:	
Routing Number:	Account Number:
Name that appears on the Account:	



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Signature of Account Holder X	Date:

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- Notice of HIPAA Privacy Practices
- Reminders
- Certification of Creditable Coverage

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

Please note, you may change your 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,

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

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

Applicant Name	Email Address	Cell Phone Number
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Eligible Dependent Name(s)	Email Address	Cell Phone Number

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.

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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.

I understand the dental benefits provided by this agreement may be reduced as the result of existence of other similar insurance providing coverage for the same dental care services.

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's Signature: X	Date
Signature of Agent (if applicable): X	Date

For Broker Use Only:	Name:	NPN#	SSN/Tax ID #	CareFirst-Assigned ID #
Contracted Broker:	Mindy Guisewite	6834121		177081
Sub-Agent/Sub-Agency:				
Writing Agent:	Mindy Guisewite			

Fold and Detach Along Perforation

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

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

POSTAGE WILL BE PAID BY ADDRESSEE

CAREFIRST BLUECROSS BLUESHIELD
PO BOX 14651
LEXINGTON KY 40512-9876

Additional information

Exclusions and Limitations

For Maryland and District of Columbia Residents:

Please refer to your dental contract for your Exclusions and Limitations.

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 procedure.

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 and 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, 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 appliance, 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.

Policy Form Numbers

Maryland – CareFirst of Maryland, Inc.

BlueDental Preferred HIGH OPTION –
CFMI/DEN/IEA (1/14),
CFMI/DB/PREF DENT DOCS-SOB (R. 1/15),
CFMI/DB/2015 DENTAL AMEND (1/15),
and any amendments

BlueDental Preferred LOW OPTION –
CFMI/DEN/IEA (1/14),
CFMI/DB/PREF DENT DOCS-SOB LOW (1/15),
CFMI/DB/2015 DENTAL AMEND (1/15),
and any amendments

Maryland – Group Hospitalization and Medical Services

BlueDental Preferred HIGH OPTION –
MD/CF/DEN/IEA (1/14),
MD/CF/DB/PREF DENT DOCS-SOB (R. 1/15),
MD/CF/DB/2015 DENTAL AMEND (1/15),
and any amendments

BlueDental Preferred LOW OPTION –
MD/CF/DEN/IEA (1/14),
MD/CF/DB/PREF DENT DOCS-SOB LOW (1/15),
MD/CF/DB/2015 DENTAL AMEND (1/15),
and any amendments

District of Columbia

BlueDental Preferred HIGH OPTION –
DC/CF/DB/DENTAL/IEA (1/14), DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15),
DC/CF/DB/2015 DENTAL AMEND (REV 1/15), and any amendments.

BlueDental Preferred LOW OPTION –
DC/CF/DB/DENTAL/IEA (1/14), DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15),
DC/CF/DB/2015 DENTAL AMEND (REV 1/15), and any amendments

Virginia

BlueDental Preferred HIGH OPTION – VA/CF/DB/PREF DENT (R. 1/15)
BlueDental Preferred LOW OPTION – VA/CF/DB/PREF DENT LOW (1/15)
DVAAP (4/14)

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

www.carefirst.com

CareFirst

Connect with us:

CDS1108-1P (11/14)