CareFirst

Individual Select
Preferred Dental

Maryland, the District of Columbia and 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 even prevent premature births.

We're pleased to introduce you to **Individual Select Preferred Dental** – a plan offering 100% coverage for in-network and preventive diagnostic services for you and your family.

As a member of Individual Select Preferred Dental you'll enjoy:

- Lower premiums
- No deductibles
- No referrals
- More than 3,600 dentists throughout Maryland, the District of Columbia and Northern Virginia
- Easy enrollment
- No claim forms to file in-network
- Guaranteed acceptance

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

Read on to learn about **Individual Select Preferred Dental**, offered by CareFirst BlueCross BlueShield. Or, contact our Product Consultants 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.

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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

In-Network

As a member you'll receive 100% coverage in-network for preventive and diagnostic services. Individual Select Preferred combines the freedom to select any dentist from our large regional network with wide-ranging coverage of preventive and diagnostic dental services.

The following are some of the services which are covered in full when visiting an in-network provider:

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

Participating dentists accept 100% of the Allowed Benefit* from CareFirst as payment in full for covered services.

Out-of-Network

You also have the option to seek routine preventive and diagnostic treatment from Non-Participating Providers. If you visit a Non-participating Provider, CareFirst will still pay the Allowed Benefit, but you will be responsible for the difference in cost between the CareFirst Allowed benefit and your dental provider's full charge.

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 they 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 Maria

Maria is a single, healthy 30-year-old web designer. She has an individual health insurance plan to cover medical expenses, but she never thought about dental coverage. Maria visits her local dentist twice a year for her routine cleanings and exams.

	No Coverage	Individual Select Preferred Plan	Savings on Services
Check-ups with X-rays twice a year	$330* (for both visits)	$0 **in-network** (both visits are covered)	$330

* *Based on National Dental Advisory Service Fee Report (2012).*

With no dental coverage, Maria was paying for her bi-annual check-ups. She chose to enroll in the Individual Select Preferred plan. Her current dentist is a participating provider, so her check-ups are now covered in full and she saved $330. With Individual Select Preferred, Maria also has the freedom to try out different general dentists and specialists in her area whenever she likes. With more than 3,600 participating providers in Maryland, the District of Columbia and Northern Virginia she has plenty of choices!

Rates

Maryland

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application	Semi-Annual Rate Second Payment Due by the 1st of the seventh month from the effective date of coverage	
		1st Payment	**2nd Payment**
Individual	$151.80	$80.90	$80.90
Individual & Child(ren)	$280.80	$145.40	$145.40
Individual & Adult	$349.20	$179.60	$179.60
Family	$425.04	$217.52	$217.52

District of Columbia and Northern Virginia

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application	Semi-Annual Rate Second Payment Due by the 1st of the seventh month from the effective date of coverage	
		1st Payment	**2nd Payment**
Individual	$151.44	$80.72	$80.72
Individual & Child(ren)	$280.20	$145.10	$145.10
Individual & Adult	$302.88	$156.44	$156.44
Family	$424.08	$217.04	$217.04

Please note that when selecting the semi-annual payment, a $5 administration fee is already included into each payment. You pay an additional $10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application.

The second payment is due by the 1st of the seventh month from the effective date of coverage. For example, if coverage is effective January 1, the second payment is due July 1.

Apply Today

Apply Today for Individual Select Preferred

Three steps to apply!

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

   Choose the annual or semi-annual payment option.

2) When you're ready to review a listing of providers, please visit **www.carefirst.com/findadoc**. Click on Dental, and select *Individual Select PPO*. Or, if you'd like to request a printed directory, please call a Product Consultant at (410) 356-8000 or toll-free at (800) 544-8703, Monday–Friday, 8 a.m.–8 p.m.

3) Send in your application, with your payment, in the enclosed, postage-paid envelope or mail to:

   CareFirst BlueCross BlueShield
   P.O. Box 79810
   Baltimore, MD 21279-0810

Payments must be deposited on or before the last business day of each month to ensure coverage will be effective on the first of the next month.

CareFirst will mail your membership cards and certificate of coverage to you. Then you can start enjoying all the benefits of good dental care.

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

It takes just three simple steps to start enjoying the benefits of Individual Select Preferred Dental.

Application for Maryland Residents

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

Remember to send in your application, with your payment, so you can start enjoying all the benefits of good dental care!

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application	Semi-Annual Rate Second Payment Due by the 1st of the seventh month from the effective date of coverage	
		1st Payment	2nd Payment
Individual	$151.80	$80.90	$80.90
Individual & Child(ren)	$280.80	$145.40	$145.40
Individual & Adult	$349.20	$179.60	$179.60
Family	$425.04	$217.52	$217.52

Individual Select Preferred Dental Application

Maryland

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 all information.
2. Sign and return this application, with exact payment amount, in the postage-paid return envelope or, to **P.O. Box 79810 Baltimore MD 21279-0810**

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If payment amount is incorrect, the application will be returned.***

1. APPLICANT INFORMATION

Last Name	First Name	Middle Initial	Social Security #

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

Date of Birth / /	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Partner	Payment Option ☐ Annual ☐ Semi-annual
Home Phone ( )	Work/Cell Phone ( )	E-mail Address	

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)

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

"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

	Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/ Yr)	SEX
Spouse/Partner							☐M ☐F
Dependent 1							☐M ☐F
Dependent 2							☐M ☐F
Dependent 3							☐M ☐F
Dependent 4							☐M ☐F
Dependent 5							☐M ☐F

4. 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. 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 semi-annual basis. Those members who elect the semi-annual payment option will be subject to an additional five dollar ($5) fee per payment, which equals ten dollars ($10) annually.
- 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 BlueCross BlueShield policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (888) 833-8464 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: _____

Please make checks payable to:

CAREFIRST BLUECROSS BLUESHIELD
and mail to:

Dental Processing Center
P.O. Box 79810
Baltimore, MD 21279-0810

AGENTS MUST COMPLETE THIS SECTION

Agency Name		
RxMom.com Insurance Service Agent Thomas Musembi AGENT #20200		
Agency Address Number and Street, Apt.#	City and State	Zip Code (9-digit, if known)
4800 Hampden Ln 200 Bethesda MD 20814		
Telephone Number (888) 490-8782	Fax Number ( )	E-mail Address insurance@rxmom.com
Annual or Semi-annual Premium		

Application for District of Columbia Residents

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

Remember to send in your application, with your payment, so you can start enjoying all the benefits of good dental care!

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application	Semi-Annual Rate Second Payment Due by the 1st of the seventh month from the effective date of coverage	
		1st Payment	**2nd Payment**
Individual	$151.44	$80.72	$80.72
Individual & Child(ren)	$280.20	$145.10	$145.10
Individual & Adult	$302.88	$156.44	$156.44
Family	$424.08	$217.04	$217.04

Individual Select Preferred Dental Application

District of Columbia

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 all information.
2. Sign and return this application, with exact payment amount, in the postage-paid return envelope or, to **P.O. Box 79810 Baltimore MD 21298-8159**

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If payment amount is incorrect, the application will be returned.***

1. APPLICANT INFORMATION

Last Name	First Name	Middle Initial	Social Security #

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

Date of Birth / /	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Domestic Partnership	Payment Option ☐ Annual ☐ Semi-annual

Home Phone ( )	Work/Cell Phone ( )	E-mail Address

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 Domestic Partner who satisfies the eligibility requirements defined in your contract.

3. ENROLLING FAMILY MEMBER(S) – **Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage**

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX
Spouse/Domestic Partner						☐M ☐F
Dependent 1						☐M ☐F
Dependent 2						☐M ☐F
Dependent 3						☐M ☐F
Dependent 4						☐M ☐F

4. 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. 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 semi-annual basis. Those members who elect the semi-annual payment option will be subject to an additional five dollar ($5) surcharge per payment, which equals ten dollars ($10) annually.
- To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (888) 833-8464 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 BLUECROSS BLUESHIELD MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature of Applicant: X _____ Date: _____

Signature of Dependent: 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: _____

Please make checks payable to:

CAREFIRST BLUECROSS BLUESHIELD
and mail to:

Dental Processing Center
P.O. Box 79810
Baltimore, MD 21298-8159

AGENTS MUST COMPLETE THIS SECTION

Agency Name		
Agency Address: Number and Street, Apt.#	City and State	Zip Code (9-digit, if known)
Telephone Number ( )	Fax Number ( )	E-mail Address
Annual or Semi-annual Premium		

Application for Northern Virginia Residents

Please fill out the Virginia Individual Select Preferred Dental 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.

Remember to send in your application, with your payment, so you can start enjoying all the benefits of good dental care!

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application	Semi-Annual Rate Second Payment Due by the 1st of the seventh month from the effective date of coverage	
		1st Payment	**2nd Payment**
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Individual & Adult	$302.88	$156.44	$156.44
Family	$424.08	$217.04	$217.04

Individual Select Preferred Dental Application

Virginia

CareFirst BlueCross BlueShield

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

INSTRUCTIONS

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Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If payment amount is incorrect, the application will be returned.***

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

Date of Birth / /	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Payment Option ☐ Annual ☐ Semi-annual

Home Phone ( )	Work/Cell Phone ( )	E-mail Address

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 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**

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX
Spouse						☐M ☐F
Domestic Partner						☐M ☐F
Dependent 1						☐M ☐F
Dependent 2						☐M ☐F
Dependent 3						☐M ☐F

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- Premium payment options are available on an annual and a semi-annual basis. Those members who elect the semi-annual payment option will be subject to an additional five dollar ($5) surcharge per payment, which equals to ten dollars ($10) annually.
- To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (888) 833-8464 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: _____

Signature of Dependent: 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 _____

Please make checks payable to:

CAREFIRST BLUECROSS BLUESHIELD
and mail to:
Dental Processing Center
P.O. Box 79810
Baltimore, MD 21298-8159

AGENTS MUST COMPLETE THIS SECTION

Agency Name		
Agency Address: Number and Street, Apt.#	City and State	Zip Code (9-digit, if known)
Telephone Number ( )	Fax Number ( )	E-mail Address
Annual or Semi-annual Premium		

Additional Information

Exclusions and Limitations

Limitations.

A. Covered Dental Services must be performed by or under the supervision of a Dentist, 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.

Exclusions. Benefits will not be provided for:

A. 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.

B. Services not specifically listed in the Subscriber's Agreement as a Covered Dental Service, even if Medically Necessary.

C. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).

D. 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.

E. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.

F. Services or supplies that are Experimental or Investigational in nature.

Policy Form Numbers:

MD/GHMSI/DB/IEA-DENTAL (2/08)
MD/GHMSI/DB/DOCS-DENTAL (2/08)
MD/GHMSI/DB/ES-DENTAL (2/08)

DC/GHMSI/DB/IEA-DENTAL (2/08)
DC/GHMSI/DB/DOCS-DENTAL (2/08)
DC/GHMSI/DB/ES-DENTAL (2/08)

VA/GHMSI/DB/IEA-DENTAL (2/08)
VA/GHMSI/DB/DOCS-DENTAL (2/08)
VA/GHMSI/DB/ES-DENTAL (2/08)

and any amendments.

Please visit us online at

www.carefirst.com/findadoc

And please remember to keep this book
for your records.

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
www.carefirst.com

CDS1045-1P (1/13)