CareFirst

The CareFirst BlueCross BlueShield family of health care plans.

Individual Select
Dental HMO

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 Dental HMO** – a plan offering comprehensive coverage for in-network and preventive diagnostic services for you and your family.

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

- Lower premiums
- No deductibles
- Predictable out-of-pocket costs
- More than 580 dentists throughout Maryland, the District of Columbia and Northern Virginia
- Easy enrollment
- No claim forms to file
- Guaranteed acceptance

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

Read on to learn about **Individual Select Dental HMO**, offered by The Dental Network and CareFirst BlueChoice, Inc. 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

Get maximum savings on major dental services and access to a network of 580+ participating dentists.

What Your Plan Covers

Individual Select Dental HMO offers you 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)

As a member of our Dental Health Maintenance Organization (Dental HMO) plan, you'll select a general dentist from a network of participating providers to coordinate all of your dental care needs. Visit **www.carefirst.com/findadoc** to find a dentist. When specialized care is needed, your general dentist will refer you to a specialist within the Dental HMO network.

A Plan For You

Meet The Johnsons

Anna and Jeff Johnson are an energetic couple with two children. They own a catering business, and have purchased a family health insurance plan. 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]	Individual Select Dental HMO Plan	Savings on Services
6 month check-ups, including routine exams, cleanings and x-rays (8 visits, 2 per person)	$1,320 ($165 per visit)	$160 ($20 copay per visit)	$1,160
Filling (1 filling)	$130	$20 copay per visit	$110
Orthodontic Services (1 Child to age 19)	$5,045	$2,500	$2,545
Total	**$6,495**	**$2,680**	**$3,815**

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

With no dental coverage, the Johnsons paid $6,495 for these services. With **Individual Select Dental HMO** coverage, the Johnsons would have saved more than $3,800 for these services. The Johnsons decided to purchase the **Individual Select Dental HMO** coverage to protect themselves against future dental costs.

A Plan For You

Meet The Smiths

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]	Individual Select Dental HMO Plan	Savings on Services
6 month check-ups, including routine exams, cleanings and x-rays (4 visits, 2 per person)	$660 ($165 per visit)	$80 ($20 copay per visit)	$580
Root Canal (bicuspid)	$800	$375	$425
Bridge (3-unit)	$3,000	$1,305	$1,695
Total	**$4,460**	**$1,760**	**$2,700**

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

With no dental coverage, the Smiths paid $4,460 for these services. They decided to purchase dental coverage to protect themselves against further unexpected dental costs. With **Individual Select Dental HMO** coverage, the Smiths would have spent only $1,760, a savings of over $2,700 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 (includes routine exams, cleanings and X-rays)	$165 per visit (2 visits per year)	$20 per office visit
Basic Dental Services (includes fillings, simple extractions and more)	$130 – $320	$20 per office visit
Soft Tissue Management (includes periodontal scaling, periodontal maintenance and more)	$240	$70 per office visit
Porcelain crown (high noble metal)	$1,050	$460
Root canal therapy (bicuspid, excludes final restoration)	$800	$375 Primary Dentist or $475 Specialty Care Dentist
Complete upper dentures	$1,595	$495
Orthodontia (Braces) **Comprehensive – Adolescent** **Comprehensive – Adult**	 $5,045 $5,020	 $2,500 $2,700

[1] *Based on National Dental Advisory Service Fee Report (2012)*

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

This is a partial listing of services. If you have any questions, please call our Customer Service Associates at (410) 847-9060 or toll free at (888) 833-8464, Monday–Friday, 8:30 a.m.–5:00 p.m.

Rates

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	$120	$65	$65
Individual & Child	$204	$107	$107
Individual & Adult	$240	$125	$125
Family	$360	$185	$185

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 Dental HMO

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 Dental HMO*. Or, if you'd like to request a printed directory, please call our Product Consultants 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 premium payment**, in the enclosed, postage-paid envelope or mail to:

   The Dental Network and CareFirst BlueChoice, Inc.
   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.

We 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 Dental HMO.

Application for Northern Virginia Residents

Please fill out the Virginia Individual Select Dental HMO 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 Select Dental HMO Application

Virginia

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, 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.***

For Faster Processing Please Make Check Payable to: THE DENTAL NETWORK, INC and Mail to:

THE DENTAL NETWORK
P O BOX 79810
Baltimore MD 21279-0810

Questions ! Please call Tom at (888)490-8782 or email : insurance@rxmom.com

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 Partner	Dental Office Code

Home Phone ( )	Work/Cell Phone ( )	E-mail Address	Payment Option ☐ Annual ☐ Semi-annual

2. COVERAGE SELECTION: (Check one)

☐ **Individual** - Provides coverage for one person
☐ **Individual & Child** - Provides coverage for an individual and eligible dependent (if you have more than one child, you must select Family coverage)
☐ **Individual & Adult** - Provides coverage for two eligible adults
☐ **Family** - Provides coverage for up to two eligible adults and eligible dependent(s)

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

An "Adult" means the Spouse or 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, Individual & Adult or Family Coverage**

(You must have a dental code. Each person may select their own dentist.)

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	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. 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) 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 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 (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.

Signature of Legal Guardian: X _____ Date: _____

Signature of Agent: X _____ Date: _____

Please make checks payable to:

CAREFIRST BLUECHOICE, INC.
and mail to:

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

AGENTS MUST COMPLETE THIS SECTION

Agency Name

RXMOM INSURANCE AGENT: THOMAS MUSEMBI AGENT# 20200

Agency Address: Number and Street, Apt.#	City and State	Zip Code (9-digit, if known)
4800 HAMPDEN LN SUITE 200	BETHESDA MD	20814

Telephone Number	Fax Number	E-mail Address
(888) 490-8782	(866) 204-8857	INSURANCE@RXMOM.COM

Annual or Semi-annual Premium

Additional Information

Exclusions and Limitations

MARYLAND

PLAN LIMITATIONS. 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;
- 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) Personal Participating DENTIST; all services listed on the Schedule of Benefits and Copayments will be provided by a general Participating DENTIST or an Approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an Approved Specialist or recommend that the Covered Individual or Dependent contact an Approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an Approved Specialist, with an exception for out-of-area emergency care, and a referral to a non-participating general dentist or specialist;
- Services which cannot be performed in the dental office of the "Personal Participating DENTIST" or "Approved Specialist" due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

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

ALL PRICES ARE EXCLUSIVE OF GOLD

DISTRICT OF COLUMBIA

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

A. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws;

B. Services which are provided without cost to the Covered Individual 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. 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;

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'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.

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).

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, minus member's copay.

ALL PRICES ARE EXCLUSIVE OF GOLD

VIRGINIA

PLAN LIMITATIONS. The following limitations shall apply:

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

B. Unlisted procedures will be provided at the dentist's charges;

C. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual's General Participating DENTIST

D. OUT-OF-AREA EMERGENCY CARE: Members are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest PLAN Dental Office. Limited to $50 per member per emergency, minus member's copay.

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.

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

Individual Select Dental HMO District of Columbia
CareFirst BlueChoice, Inc.
DN001DC (R. 1/10),
FORM DN4001DC (R. 1/10),
and any amendments

Please visit us online at

www.carefirst.com/findadoc

And please remember to keep this book
for your records.

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

www.carefirst.com

The CareFirst BlueCross BlueShield
family of health care plans.

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