CareFirst
Family of health care plans

Individual BlueDental Preferred

2025

MARYLAND ■ WASHINGTON, D.C. ■ NORTHERN VIRGINIA

Welcome

Your smile says a lot about you. It's the first thing people see when they meet you. A healthy smile can make you feel 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 shown to significantly reduce your risk of heart disease. It helps control diabetes, and some studies show it prevents premature births.

We're pleased to introduce you to BlueDental Preferred.

As a member, you'll enjoy:

- Two different deductible options to suit your budget
- Access to more than 4,500 dentists throughout Maryland, Washington, D.C. and Northern Virginia, and to a national network of 135,000 dentists and specialists
- Coverage for numerous dental services
- No referrals
- No charge for oral exams, cleanings and X-rays when you visit an in-network provider
- No claim forms to file in-network
- A medically necessary orthodontia benefit—for children up to age 19
- Guaranteed acceptance
- No charge for in-network covered services for members age 19 and under after they reach their $425 out-of-pocket maximum.

Read on to learn about **BlueDental Preferred**, offered by CareFirst BlueCross BlueShield (CareFirst). Or, contact our product consultants at 855-503-4862, Monday–Thursday, 8 a.m. to 5 p.m. and Friday, 10 a.m. to 5 p.m.

Did You Know...

- **Research suggests that heart disease, clogged arteries and stroke may be linked to the inflammation and infections that oral bacteria can cause.[1]**
- **Diabetic patients with gum disease have a harder time controlling their blood sugar levels.[1]**
- **Periodontal disease has been linked to premature birth and low birth weight.[1]**

[1] www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475, June 4, 2019

Contents

The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or CareFirst.

Your Dental Plan Options

We offer two BlueDental Preferred options: **High Option** and **Low Option**. The High Option has lower deductibles with preventive and diagnostic services covered in full when received from in-network provider without requiring you to meet a deductible. The Low Option has lower premiums with slightly higher deductibles. The following pages can help you decide which BlueDental Preferred option is right for you.

BlueDental Preferred includes:

Preventive and diagnostic services (Class I)

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

If you pick the High Option, there is no deductible or charge for the above services if you visit an in-network provider. If you pick the Low Option, you can receive these services but will pay in full unless you've already met your deductible.

Basic and major services (Classes II, III, IV)

For Members New to CareFirst over the age 19 there is a 12-month waiting period for Class III and Class IV services. After meeting the deductible, both plans cover fillings, simple extractions, periodontal scaling, 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.

BlueDental Preferred has a large network of providers

As a member, you'll enjoy access to more than 4,500 dentists throughout Maryland, Washington, D.C. and Northern Virginia, and access to a national network of 135,000 dentists and specialists. To locate a participating provider, go to **carefirst.com/findadoc** and select *Preferred Dental (PPO & Pediatrics)* from the *Network* drop-down menu.

You also have the option to see 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 up front at the time of service and submit a claim form to be reimbursed for covered services.

***Allowed benefit**—the fee that providers in the network have agreed to accept for a particular service. For example: Dr. Smith charges $100 to see a patient. To be included in-network, he has agreed to accept $50 for the visit. After the member pays their copay or deductible, CareFirst will pay what's left of the $50 charge. A participating provider cannot charge a member more than the allowed benefit (in this example $50) for any covered service.

BlueDental Preferred High Option Summary of Benefits

(for members under age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES II, III, IV		
▪ The family deductible amount is calculated in 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.	$50 Individual deductible; $150 Family deductible	$100 Individual deductible; $300 Family deductible
OUT-OF-POCKET MAXIMUM (CLASSES I–V)	One member pays up to $425; Two or more members pay up to $850	No limit
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[1] 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[1] ▪ Sealants on permanent molars[1] until the end of the year in which member reaches age 19 ▪ Space maintainers[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge	20% of allowed benefit[2]
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ 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, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	50% of allowed benefit[2] after deductible	65% of allowed benefit[2] 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[2]	65% of allowed benefit[2]

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.

[1] Frequency limitations may apply.

[2] 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.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

BlueDental Preferred High Option Summary of Benefits

(for members over age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES II, III, IV		
▪ The family deductible amount is calculated in 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.	$50 Individual deductible; $150 Family deductible	$100 Individual deductible; $300 Family deductible
ANNUAL MAXIMUM (CLASSES I–IV)		
▪ The in-network and out-of-network annual maximum is a combined amount.	Plan pays up to $1,500 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) ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge	20% of allowed benefit[2]
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)[4]		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ 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, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	40% of allowed benefit[2] after deductible	50% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)[4]		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance for members over age 19) ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	50% of allowed benefit[2] after deductible	65% of allowed benefit[2] after deductible

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.

[1] Frequency limitations may apply.

[2] 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.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

[4] For Over 19 members there is a 12-month waiting period on Class III and Class IV benefits for New Members.

BlueDental Preferred Low Option Summary of Benefits

(for members under age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES I–IV		
▪ The family deductible amount is calculated in 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)	One member pays up to $425; Two or more members pay up to $850	No limit
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[1] 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[1] ▪ Sealants on permanent molars[1] until the end of the year in which member reaches age 19 ▪ Space maintainers[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge after deductible	20% of allowed benefit[2] after deductible
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ 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, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	50% of allowed benefit[2] after deductible	65% of allowed benefit[2] 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[2]	65% of allowed benefit[2]

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.

[1] Frequency limitations may apply.

[2] 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.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

BlueDental Preferred Low Option Summary of Benefits

(for members over age 19)

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE APPLIES TO CLASSES I–IV		
▪ The family deductible amount is calculated in 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
ANNUAL MAXIMUM (CLASSES I–IV)		
▪ 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) ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray[1] ▪ Palliative treatments ▪ Emergency oral exam	No charge after deductible	20% of allowed benefit[2] after deductible
BASIC SERVICES (CLASS II)		
▪ Direct placement fillings using approved materials[1] ▪ Simple extractions ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment)	20% of allowed benefit[2] after deductible	40% of allowed benefit[2] after deductible
MAJOR SERVICES—SURGICAL (CLASS III)[4]		
▪ Surgical periodontic services including osseous surgery and occlusal adjustments[1] ▪ 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, vestibuloplasty and hemi-section) ▪ General anesthesia required for oral surgery	40% of allowed benefit[2] after deductible	50% of allowed benefit[2] after deductible
MAJOR SERVICES—RESTORATIVE (CLASS IV)[4]		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges[3], crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Denture adjustments and relining[1] ▪ Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance for members over age 19) ▪ Dental implants[3], subject to medical necessity review (once per 60 months)	65% of allowed benefit[2] after deductible	75% of allowed benefit[2] after deductible

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.

[1] Frequency limitations may apply.

[2] 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.

[3] In Maryland, only covered for members age 19 and over. In Washington, D.C. and VA, covered for all members.

[4] For Over 19 members there is a 12-month waiting period on Class III and Class IV benefits for New Members.

Frequently Used Benefits

Below is a partial list of the most commonly used member services. These rates show what you could expect to pay for in-network services. For specific questions, please contact our CareFirst Dental product consultants team at 855-503-4862.

Common Dental Procedures	Regular Cost[1]	In-Network You Pay[2]	
		High Option	Low Option
Preventive checkups *including routine exams, cleanings and X-rays (2 visits per year)*	$206 per visit	$0	$0 after deductible
Fillings and simple extractions	$148–$200	$11–$17 after deductible	$11–$17 after deductible
Periodontal scaling and root planing *(4 or more teeth per quadrant)*	$285	$27 after deductible	$27 after deductible
Root canal therapy *(molar, excluding final restoration)*	$1,183	$264 after deductible	$264 after deductible
Porcelain ceramic crown	$1,250	$354 after deductible	$460 after deductible
Bridge *(3-unit)*	$3,758	$938 after deductible	$1,219 after deductible
Complete upper dentures	$1,883	$334 after deductible	$435 after deductible
Medically necessary orthodontia *(child up to age 19)*	$5,512	$1,481	$1,481

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

[2] Approximate amount for a member over the age of 19. Pricing may vary depending on dental provider's negotiated rate with CareFirst.

2025 Monthly Dental Rates

Figuring out the total monthly premium for the plans you're considering is simple:

1. Based on where you live, find your rate on the chart below.
2. Circle the amount in the column that corresponds with your age when coverage will begin. If you're buying an individual plan, that's it!
3. For a family plan, repeat step 2 for each family member who will be covered by your new plan and add the numbers up.
4. If you want to pay quarterly, then multiply the monthly total by three. If you want to pay annually, multiply the monthly total by 12.

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

Maryland	
BlueDental Preferred High Option	
0–19	$37.01
20+	$49.49
BlueDental Preferred Low Option	
0–19	$21.53
20+	$26.93

Washington, D.C.	
BlueDental Preferred High Option	
0–19	$33.43
20+	$43.21
BlueDental Preferred Low Option	
0–19	$16.36
20+	$23.25

Virginia	
BlueDental Preferred High Option	
0–19	$42.55
20+	$53.06
BlueDental Preferred Low Option	
0–19	$26.73
20+	$33.33

Enrolling in Your New Dental Plan

Pick one of these four options to enroll:

1. **Enroll online** at **carefirst.com/shopdental**.

2. **Fill out and sign the application that matches where you live**—Maryland, Washington, D.C. or Northern Virginia. Be sure to choose the annual or quarterly payment option and check either the **Low Option** or **High Option** deductible plan on the application. Use the enclosed, postage-paid envelope or your own to mail your application to:

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

3. **Enroll online through your state's Exchange.** Exception—these plans are no longer offered on the Virginia Federally-facilitated Exchange, so if you live in Northern Virginia, you must apply using one of the other three options.
   Maryland—marylandhealthconnection.com
   Washington, D.C.—dchealthlink.com

4. **Enroll through your broker, if you have one.** A broker is an independent agent who represents you (the buyer) and works to find you the best health insurance policy for your needs.

If you have any questions about the application, contact a product consultant at 855-503-4862, Monday–Thursday, 8 a.m. to 5 p.m. and Friday, 10 a.m. to 5 p.m.

Applications may be submitted at any time, but to guarantee your coverage will be effective the first of the following month, we must receive your application before the 20th of the current month. For example: if CareFirst receives an application on March 18, that individual's coverage starts April 1. If an application does not reach us until March 25, coverage would not be in effect until May 1.

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 member ID card(s) 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, Washington, D.C. or one of the following areas of Northern Virginia: City of Alexandria and Fairfax, the town of Vienna, Arlington County and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.

When you're ready to review a list of providers, please visit **carefirst.com/findadocdental.** Click on *Preferred Dental (PPO & Pediatrics).*

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

MAIL ADMINISTRATOR
PO BOX 14651
LEXINGTON KY 40512-9876

Maryland Resident Application

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

BlueDental Preferred Application

Maryland Residents

If you live in Baltimore City or any county in the state of Maryland other than Prince George's or Montgomery County, please check the ***CareFirst of Maryland, Inc.*** *box to the right.*

If you reside in Prince George's or Montgomery County, please check the ***Group Hospitalization and Medical Services, Inc.*** *box to the right.*

◯ **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:
   Mail 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.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

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

Home Phone	Work/Mobile Phone	Payment Option
( )	( )	◯ Annually ◯ Quarterly

2. DEDUCTIBLE SELECTION *(check one)*

◯ **Low Option** ($100 individual in-network deductible)

◯ **High Option** ($50 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. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst health care coverage through email and/or text messaging by providing your email address and/or mobile phone number and consent below.

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

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

You may also receive information on programs related to your current plan(s) and services along with new plans and services that may interest you.

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

I understand that to access the information sent by email, I must have all three of the following:

- Internet access
- An email account that allows me to send and receive emails
- 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 by text message:

- A text messaging plan with my mobile phone provider is required
- Standard text messaging rates will apply

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number
By checking my preference below, I hereby agree to electronic delivery of notices instead of paper delivery. ◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging		
Signature:		

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's behalf or to comply with the law.

5. CONDITIONS OF ENROLLMENT *(please read this section carefully)*

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application will be provided to the 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 Primary Applicant	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	Date

FOR OFFICE USE ONLY:

○ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
General Agency		[redacted]		
Writing Agent				[redacted]

Washington, D.C. Resident Application

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

BlueDental Preferred Application

Washington, D.C. Residents

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:
   Mail 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.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Payment Option	Date of Birth	Sex	Marital Status
◯ Annually ◯ Quarterly	/ /	◯ Male ◯ Female	◯ Single ◯ Married ◯ Domestic Partner/Other

Home Phone	Work/Mobile Phone
( )	( )

2. DEDUCTIBLE SELECTION *(check one)*

◯ **Low Option** ($100 individual in-network deductible)

◯ **High Option** ($50 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/Civil Union 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. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst health care coverage through email and/or text messaging by providing your email address and/or mobile phone number and consent below.

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

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

You may also receive information on programs related to your current plan(s) and services along with new plans and services that may interest you.

Please note: This consent for electronic communications applies to the primary applicant only. A spouse/domestic partner and/or dependent(s) 18 years of age and older can consent to electronic communications at **carefirst.com/myaccount**. You can also change email and consent information anytime by logging into **carefirst.com/myaccount** or by calling the customer service phone number on your member ID card. You can also request a paper copy of electronic notices by calling the customer service phone number on your member ID card.

I understand that to access the information sent by email, I must have all three of the following:

- Internet access
- An email account that allows me to send and receive emails
- 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 by text message:

- A text messaging plan with my mobile phone provider is required
- Standard text messaging rates will apply

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number
By checking my preference below, I hereby agree to electronic delivery of notices instead of paper delivery. ◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging		
Signature:		

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's behalf or to comply with the law.

5. CONDITIONS OF ENROLLMENT *(please read this section carefully)*

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application 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 (888) 892-9901 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 Primary Applicant	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	Date

FOR OFFICE USE ONLY:

○ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
General Agency		[redacted]		
Writing Agent				[redacted]

Northern Virginia Resident Application

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
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:
   Mail 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.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Payment Option	Date of Birth	Sex	Marital Status
◯ Annually ◯ Quarterly	/ /	◯ Male ◯ Female	◯ Single ◯ Married ◯ Domestic Partner

Home Phone	Work/Mobile Phone
( )	( )

2. DEDUCTIBLE SELECTION *(check one)*

◯ **Low Option** ($100 individual in-network deductible)

◯ **High Option** ($50 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. ELECTRONIC COMMUNICATION CONSENT

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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 mobile phone number and consent below.

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

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

You may also receive information on programs related to your current plan(s) and services along with new plans and services that may interest you.

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

I understand that to access the information sent by email, I must have all three of the following:

- Internet access
- An email account that allows me to send and receive emails
- 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 by text message:

- A text messaging plan with my mobile phone provider is required
- Standard text messaging rates will apply

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number
By checking my preference below, I hereby agree to electronic delivery of notices instead of paper delivery. ◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging		
Signature:		

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's behalf or to comply with the law.

5. CONDITIONS OF ENROLLMENT *(please read this section carefully)*

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the 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.

A coordination of benefits may apply as the result of the existence of other similar insurance providing coverage for the same dental services.

Signature of Primary Applicant	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	Date
Signature of Agent (if applicable):	Date

FOR OFFICE USE ONLY:

○ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
General Agency		[redacted]		
Writing Agent				[redacted]

Exclusions and Limitations

For Maryland 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. CareFirst benefits will cover treatment based upon the CareFirst allowance for the least expensive procedure, provided that the least expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the least expensive procedure. However, if the Subscriber and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

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. Replacement of stainless steel crowns (until the end of the calendar year in which the member turns age 19) if judged by CareFirst to be adequate and functional.
E. Treatment or services for temporomandibular joint (TMJ) disorders, including but not limited to radiographs and/or tomographic surveys, except for TMJ arthograms, including injection, and other TMJ films, by report, for members up to age 19.
F. Gold foil fillings.
G. Periodontal appliances.
H. 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.
I. Nightguards for members over age 19 or other oral orthotic appliances, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
J. 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.
K. Intentional tooth reimplantation or transplantation for members over age 19.
L. Interim prosthetic devices (fixed or removable) not part of a permanent or restorative prosthetic service.

M. 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.
N. Transseptal fiberotomy.
O. Orthognathic surgery.
P. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service in the dental benefits Agreement.
Q. Any orthodontic services after the last day of the month in which Covered Dental Services ended, except as specifically described in the dental benefits Agreement.
R. Services or supplies that are not medically necessary as determined by CareFirst.
S. Services not specifically listed in the dental benefits Agreement as a Covered Dental Service, even if medically necessary.
T. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
U. 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 by them.
V. Telephone consultations, failure to keep a scheduled visit, completion of forms or administrative services.
W. Services or supplies that are experimental or investigational in nature.
X. Orthodontic or any other services for cosmetic purposes.
Y. Transitional orthodontic appliances, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
Z. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.
AA. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

For Washington, D.C. 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 and custom denture teeth.
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. CareFirst benefits will cover treatment based upon the CareFirst allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the less expensive procedure. However, if the Subscriber and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

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, implants, 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, 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.
K. Interim prosthetic devices (fixed or removable) 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.
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 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 appliances, 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. Provision splinting (intracoronal and extracoronal).
AA. Endodontic implants.
BB. Fabrication of athletic mouthguards.
CC. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.
DD. Adjustments to maxillofacial prosthetic appliance.
EE. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral).
FF. Any orthodontic services after the last day of the calendar year in which the member turned age 19.
GG. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

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. CareFirst benefits will cover treatment based upon the CareFirst allowance for the least expensive procedure, provided that the least expensive procedure meets accepted standards of professional dental treatment. CareFirst's decision does not commit the Subscriber to the least expensive procedure. However, if the Subscriber and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those approved or allowed by CareFirst.

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) 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, unless required to attain functional capacity for Members up to age 19 until the end of the calendar year in which the Member turns age 19.

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 appliances, 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.

AA. Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

Foreign Language Assistance

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

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

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

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

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

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

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

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

Bàsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǔá-tìĭn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓédɛ́ wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɛ́ nì ɓídí-wùdù mú ɓɛ́ m̀ ké se wídí dɔ̀ péè. Kpooɔ̀ nyɔ ɓě mɛ dá fǔùn-nɔɓà nìà dɛ́ waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dá nɔɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔɓà mɔà 0 kɛɛ dyi pàdàìn hwè. Ɔ jǔ ké nyɔ dɔ̀ dyi m̀ gɔ̌ jǔĭn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dɔ̀ mu ɓó nììn ɓɛ́ ɔ ké nì wudɔ̀ mú zà.

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

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

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

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

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

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

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

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

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

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

Policy Form Numbers

Maryland

CFMI—MD Individual Dental—ON Exchange

BlueDental Preferred HIGH Option: CFMI/EXC/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB HIGH ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: CFMI/EXC/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

CFMI—MD Individual Dental—OFF Exch

BlueDental Preferred HIGH Option: CFMI/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB HIGH ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: CFMI/DEN/IEA (R. 1/24); CFMI/DB/SADP DOCS ON-OFF EXCH (1/24); CFMI/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); CFMI/CD/DOL APPEAL (1/24) and any amendments

GHMSI—MD Individual Dental—ON Exch

BlueDental Preferred HIGH Option: MD/CF/EXC/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB HIGH ON-OFF EXC (R. 1/25); MD/GHMSI/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: MD/CF/EXC/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); MD/GHMSI/CD/DOL APPEAL (1/24) and any amendments

GHMSI—MD Individual Dental—OFF Exch

BlueDental Preferred HIGH Option: MD/CF/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB HIGH ON-OFF EXC (R. 1.25); MD/GHMSI/CD/DOL APPEAL (1/24) and any amendments

BlueDental Preferred LOW Option: MD/CF/DEN/IEA (R. 1/24); MD/CF/DB/SADP DOCS ON-OFF EXCH (1/24); MD/CF/DB/SADP SOB LOW ON-OFF EXC (R. 1/25); MD/GHMSI/CD/DOL APPEAL (1/24) and any amendments

Washington, D.C.

DC GHMSI CD ON Exchange:

BlueDental Preferred HIGH Option: DC/CF/DB/EXC/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15); DC/CF/EXC/DB/2025 DENTAL AMEND HIGH (1/25); DC GHMSI – HEALTH GUARANTY 5/21

BlueDental Preferred LOW Option: DC/CF/DB/EXC/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15); DC/CF/EXC/DB/2024 DENTAL AMEND LOW (1/25); DC GHMSI – HEALTH GUARANTY 5/21

DC GHMSI CD OFF Exchange:

BlueDental Preferred HIGH Option: DC/CF/DB/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15); DC/CF/DB/2025 DENTAL AMEND (1/25); DC GHMSI – HEALTH GUARANTY 5/21

BlueDental Preferred LOW Option: DC/CF/DB/DENTAL/IEA (R. 1/22); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15); DC/CF/DB/2025 DENTAL AMEND LOW (1/25); DC GHMSI – HEALTH GUARANTY 5/21

Virginia

Virginia GHMSI CD ON EXCH:

These plans are no longer offered on the Virginia Exchange.

Virginia GHMSI CD OFF EXCH:

BlueDental Preferred HIGH Option: VA/CF/DB/PREF DENT HIGH (R. 1/25)

BlueDental Preferred LOW Option: VA/CF/DB/PREF DENT LOW (R. 1/25)

Notes

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

CareFirst Family of health care plans

CONNECT WITH US:

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