



Individual Select Preferred Dental Plans 2025

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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.

Individual Select Preferred Dental

What your plan covers

In-network

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

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

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

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

Out-of-network

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

Is your dentist in the network? Search at carefirst.com/findadoc and select *Individual Select Preferred* from the *All Plans* drop-down menu.



***Allowed Benefit**—The Allowed Benefit is typically a reduced rate and not the actual charge. Example: you visited your dentist for a routine exam and cleaning. The total charge for the visit is \$125. If the doctor is a participating provider, they may be required to accept \$75 from CareFirst as payment in full for the visit—this is the Allowed Benefit. However, if you visit a non-participating provider, you may be responsible for the difference between the CareFirst Allowed Benefit and the dental provider's full charge. In this example, that means you would be responsible for an additional \$50.

Individual Select Preferred Dental Summary of Benefits

	In-Network Member Pays	Out-of-Network Member Pays
DEDUCTIBLE	None	
ANNUAL MAXIMUM (CLASSES I-IV)	No maximum	
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)		
<ul style="list-style-type: none"> ▪ Oral exams (two per contract year) ▪ Prophylaxis (two cleanings per contract year) ▪ Bitewing X-rays (two per contract year) ▪ Fluoride treatments (two per contract year, until the end of the year in which member reaches age 19) ▪ Palliative treatments 	<ul style="list-style-type: none"> ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) ▪ Sealants on permanent molars (once per tooth per 36 months until the end of the year in which member reaches age 19) ▪ Space maintainers (once per 60 months) ▪ Emergency oral exam 	<p>No charge</p> <p>Member pays provider's full charge and submits claim to be reimbursed CareFirst's Allowed Benefit. (Member pays any difference between the CareFirst Allowed Benefit and the dentist's billed charge.)</p>
BASIC SERVICES (CLASS II)		
<ul style="list-style-type: none"> ▪ Direct placement fillings using approved materials (one filling per surface per 12 months) ▪ Simple extractions 	<ul style="list-style-type: none"> ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment) 	Not covered
MAJOR SERVICES – SURGICAL (CLASS III)		
<ul style="list-style-type: none"> ▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) 	<ul style="list-style-type: none"> ▪ Oral surgery (surgical extractions, treatment for cysts, tumor, and abscesses, apicoectomy and hemi-section) ▪ General anesthesia required for oral surgery 	Not covered
MAJOR SERVICES – RESTORATIVE (CLASS IV)		
<ul style="list-style-type: none"> ▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) 	<ul style="list-style-type: none"> ▪ Denture adjustments and relining (limits apply for regular and immediate dentures) ▪ Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance) ▪ Dental implants, subject to medical necessity review (once per 60 months) 	Not covered
ORTHODONTIC SERVICES (CLASS V)		
<ul style="list-style-type: none"> ▪ Benefits for orthodontic services are available for covered members until the end of the month in which a member reaches the age of 19 ▪ The in-network and out-of-network lifetime maximum per child is a combined amount 	Not covered	

Individual Select Preferred Dental Plus

What your plan covers

Preventive & Diagnostic Services (Class I)

There is no deductible and no waiting period for the following services, which are covered at 100% when visiting an Individual Select Preferred Dental Plus in-network provider:

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

Basic Services (Class II)

After a low deductible and no waiting period, your plan includes fillings, simple extractions, and periodontal scaling and root planing.

Major Services (Class III, IV)

After a low deductible and 12-month waiting period, you are covered for root canals, oral surgery, dentures, crowns, bridges and more.

Orthodontia (Class V)

Select Preferred Dental Plus offers benefits for braces for children up to age 19, after a 12-month waiting period.

Visiting non-participating providers

You also have the option to seek treatment from non-participating providers. If you visit a non-participating provider, CareFirst will pay a percentage of the Allowed Benefit,* but you may be responsible for the difference in cost between the CareFirst Allowed Benefit and your dental provider's full charge—in addition to any applicable deductibles and coinsurance. You may also be required to pay all costs at the time of service and submit a claim form to be reimbursed for covered services.



***Allowed Benefit**—The Allowed Benefit is typically a reduced rate and not the actual charge. Example: you visited your dentist for a routine exam and cleaning. The total charge for the visit is \$125. If the doctor is a participating provider, they may be required to accept \$75 from CareFirst as payment in full for the visit—this is the Allowed Benefit. However, if you visit a non-participating provider, you may be responsible for the difference between the CareFirst Allowed Benefit and the dental provider's full charge. In this example, that means you would be responsible for an additional \$50.

Individual Select Preferred Dental Plus

Summary of Benefits

	In-Network Member Pays	Out-of-Network Member Pays	
DEDUCTIBLE (CLASSES II, III & IV)			
<ul style="list-style-type: none"> The family deductible amount is calculated in the aggregate. However, no family member will be charged more than the individual deductible amount. The in-network and out-of-network deductible will be a separate amount. 	\$25 Ind. deductible/ \$75 Family deductible	\$50 Ind. deductible/ \$150 Family deductible	
ANNUAL MAXIMUM (CLASSES I-IV)			
<ul style="list-style-type: none"> 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)			
<ul style="list-style-type: none"> Oral exams (two per contract year) Prophylaxis (two cleanings per contract year) Bitewing X-rays (two per contract year) Fluoride treatments (two per contract year, until the end of the year in which member reaches age 19) Palliative treatments 	<ul style="list-style-type: none"> Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) Sealants on permanent molars (once per tooth per 36 months until the end of the year in which member reaches age 19) Space maintainers (once per 60 months) Emergency oral exam 	No charge	20% of Allowed Benefit*
BASIC SERVICES (CLASS II)			
<ul style="list-style-type: none"> Direct placement fillings using approved materials (one filling per surface per 12 months) Simple extractions 	<ul style="list-style-type: none"> Periodontal scaling and root planing (once per 24 months, one full mouth treatment) 	20% of Allowed Benefit* after deductible	40% of Allowed Benefit* after deductible
MAJOR SERVICES – SURGICAL (CLASS III)			
<ul style="list-style-type: none"> Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) 	<ul style="list-style-type: none"> Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) General anesthesia required for oral surgery 	20% of Allowed Benefit* after deductible and 12-month waiting period	40% of Allowed Benefit* after deductible and 12-month waiting period
MAJOR SERVICES – RESTORATIVE (CLASS IV)			
<ul style="list-style-type: none"> Full and/or partial dentures (once per 60 months) Fixed bridges, crowns, inlays and onlays (once per 60 months) Recementation of crowns, inlays and/or bridges (once per 12 months) 	<ul style="list-style-type: none"> Denture adjustments and relining (limits apply for regular and immediate dentures) Repair of prosthetic appliances as required (once in any 12-month period per specific area of appliance) Dental implants, subject to medical necessity review (once per 60 months) 	50% of Allowed Benefit* after deductible and 12-month waiting period	65% of Allowed Benefit* after deductible and 12-month waiting period
ORTHODONTIC SERVICES (CLASS V)			
<ul style="list-style-type: none"> Benefits for orthodontic services are available for covered members until the end of the month in which a member reaches the age of 19 	50% of Allowed Benefit* after deductible and 12-month waiting period	65% of Allowed Benefit* after deductible and 12-month waiting period	
<ul style="list-style-type: none"> The in-network and out-of-network lifetime maximum per child is a combined amount 	Plan pays up to \$800 per child up to age 19		

*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 member for the difference between the Allowed Benefit and their charges.

Enrolling in Your New Dental Plan

To apply for Individual Select Preferred Dental (preventive dental only)

You have the option to use the paper application provided or enroll online.

- To enroll online, visit carefirst.com/shopdental
 - Get instant confirmation
 - Have access to real-time help via click-to-call or click-to-chat
- If you use the paper application, return it in the enclosed, postage-paid envelope or mail your completed application to:
Mail Administrator
P.O. Box 14651
Lexington, KY 40512
- Enroll through your broker

To apply for Individual Select Preferred Dental Plus

- Use the paper application provided in this book. Return it in the enclosed, postage-paid envelope or mail your completed application to:
Mail Administrator
P.O. Box 14651
Lexington, KY 40512
- Enroll through your broker

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



When will my dental coverage start?

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

Example: For coverage to begin on May 1, we must receive your application on/before April 20th. We will send your first bill confirming we received your application and indicating when payment is due for coverage to begin May 1.



Have questions?

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



2025 Dental Rates

Individual Select Preferred Dental

	Annually			Quarterly		
	MD	DC	VA	MD	DC	VA
Individual	\$357.48	\$339.72	\$353.52	\$89.37	\$84.93	\$88.38
Individual & Child(ren)*	\$661.32	\$628.44	\$654.00	\$165.33	\$157.11	\$163.50
Individual & Adult**	\$714.96	\$679.44	\$707.04	\$178.74	\$169.89	\$176.76
Family	\$1,000.92	\$951.24	\$989.88	\$250.23	\$237.81	\$424.80

Rates effective January 1, 2025

Individual Select Preferred Dental Plus

	Annually			Quarterly		
	MD	DC	VA	MD	DC	VA
Individual	\$569.76	\$519.72	\$606.84	\$142.44	\$129.93	\$151.71
Individual & Child(ren)*	\$1,054.08	\$961.44	\$1,122.60	\$263.52	\$240.36	\$280.65
Individual & Adult**	\$1,139.52	\$1,039.44	\$1,213.68	\$284.88	\$259.86	\$303.42
Family	\$1,595.28	\$1,455.24	\$1,699.20	\$398.82	\$363.81	\$424.80

Rates effective January 1, 2025

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

** "Adult" means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in the contract.

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 Resident Application



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

Individual Select Preferred Dental Application

Maryland



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
<p>1. Please fill out all applicable spaces on this application. Print all information.</p> <p>2. Sign and return this application, in the postage-paid return envelope if provided, or mail to: Mailroom Administrator P.O. Box 14651, Lexington, KY 40512</p> <p>Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.</p>



1. APPLICANT INFORMATION				
Last Name		First Name	Initial	Social Security #
Residence Address: (Number and Street, Apt #)		City	State	Zip Code (9-digit, if known)
Billing Address, if different: (Number and Street, Apt #)		City	State	Zip Code (9-digit, if known)
Date of Birth / /	Sex <input type="radio"/> Male <input type="radio"/> Female	Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Partner		
Home Phone ()	Work/Cell Phone ()	Payment Option <input type="radio"/> Annually <input type="radio"/> Quarterly		

2. COVERAGE SELECTION—CHECK ONE
<p><input type="radio"/> Individual—Provides coverage for one person</p> <p><input type="radio"/> Individual & Child(ren)—Provides coverage for an individual and eligible dependent(s)</p> <p><input type="radio"/> Individual & Adult—Provides coverage for two eligible adults</p> <p><input type="radio"/> Family—Provides coverage for two eligible adults and eligible dependent(s)</p> <p><i>A "Child" means your eligible child up to age 26. Eligibility requirements are defined in your contract.</i></p> <p><i>An "Adult" means the Spouse or Partner of the Subscriber who satisfies the eligibility requirements defined in your contract.</i></p>

3. ENROLLING FAMILY MEMBER(S)—COMPLETE ONLY IF YOU SELECT INDIVIDUAL & CHILD(REN), INDIVIDUAL & ADULT OR FAMILY COVERAGE							
Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex	
Spouse						<input type="radio"/> M <input type="radio"/> F	
Partner						<input type="radio"/> M <input type="radio"/> F	
Dependent 1						<input type="radio"/> M <input type="radio"/> F	
Dependent 2						<input type="radio"/> M <input type="radio"/> F	
Dependent 3						<input type="radio"/> M <input type="radio"/> F	
Dependent 4						<input type="radio"/> M <input type="radio"/> F	
Dependent 5						<input type="radio"/> M <input type="radio"/> F	

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

4. PLAN SELECTION—CHECK ONE

- Individual Select Preferred Dental is a Preferred Provider Organization (PPO) plan underwritten by Group Hospitalization and Medical Services, Inc. *This is a preventive services only plan.*
- Individual Select Preferred Dental Plus is a Preferred Provider Organization (PPO) plan underwritten by:
*(Check the box on the left to choose this plan **and** check the box below based on where you live)*

For residents of Montgomery or Prince George’s counties only, check here:
Group Hospitalization and Medical Services, Inc.

For residents of Baltimore City or any other county in the state of Maryland excluding Montgomery and Prince George’s counties, check here:
CareFirst of Maryland, Inc.

All individuals listed on this application will be enrolled in the plan selected. Any individual who wants to enroll in a different plan must fill out a separate application.

5. ELECTRONIC COMMUNICATION CONSENT

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

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

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

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

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

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

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

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

I understand that to receive notices through text messaging,

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

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

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery by:
 Email only Cell phone text messaging only Email and cell phone text messaging

Signature: X

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

6. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Subscriber (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 BlueCross BlueShield policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at 866-891-2802 before signing this application.

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

Signature of Applicant: X _____ Date: _____

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

Parent or Legal Guardian Signature: X _____ Date: _____

FOR OFFICE USE ONLY:

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

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

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

Washington, D.C. Resident Application



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

Individual Select Preferred Dental Application

District of Columbia



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

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
 2. Sign and return this application, in the postage-paid return envelope if provided, or mail to:
Mailroom Administrator
P.O. Box 14651, Lexington, KY 40512
- Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.



1. APPLICANT INFORMATION

Last Name		First Name	Initial	Social Security #
Residence Address: (Number and Street, Apt #)		City	State	Zip Code (9-digit, if known)
Billing Address, if different: (Number and Street, Apt #)		City	State	Zip Code (9-digit, if known)
Date of Birth / /	Sex <input type="radio"/> Male <input type="radio"/> Female	Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Domestic Partnership/Other		
Home Phone ()	Work/Cell Phone ()	Payment Option <input type="radio"/> Annually <input type="radio"/> Quarterly		

2. COVERAGE SELECTION—CHECK ONE

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

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

An "Adult" means the Spouse, Domestic or Civil Union Partner of the subscriber who satisfies the eligibility requirements defined in your contract.

3. ENROLLING FAMILY MEMBER(S)—COMPLETE ONLY IF YOU SELECT INDIVIDUAL & CHILD(REN), INDIVIDUAL & ADULT OR FAMILY COVERAGE

Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse						<input type="radio"/> M <input type="radio"/> F
Domestic Partner; Legal Partner; or Civil Union Partner						<input type="radio"/> M <input type="radio"/> F
Dependent 1						<input type="radio"/> M <input type="radio"/> F
Dependent 2						<input type="radio"/> M <input type="radio"/> F
Dependent 3						<input type="radio"/> M <input type="radio"/> F
Dependent 4						<input type="radio"/> M <input type="radio"/> F
Dependent 5						<input type="radio"/> M <input type="radio"/> F

4. PLAN SELECTION—CHECK ONE

- Individual Select Preferred Dental is a Preferred Provider Organization (PPO) plan underwritten by Group Hospitalization and Medical Services, Inc. *This is a preventive services only plan.*
- Individual Select Preferred Dental Plus is a Preferred Provider Organization (PPO) underwritten by Group Hospitalization and Medical Services, Inc.

All individuals listed on this application will be enrolled in the plan selected. Any individual who wants to enroll in a different plan must fill out a separate application.

5. ELECTRONIC COMMUNICATION CONSENT

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

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

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

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

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

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

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

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

I understand that to receive notices through text messaging,

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

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

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

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

Signature: X

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

6. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Subscriber (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 BlueCross BlueShield policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at 866-891-2802 before signing this application.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, CAREFIRST MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature of Applicant: X _____ Date: _____

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

Parent or Legal Guardian Signature: X _____ Date: _____

FOR OFFICE USE ONLY:

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

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

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

FOR OFFICE USE ONLY:

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

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

Northern Virginia Resident Application



Please fill out the Virginia Individual Select Preferred Dental application on the following pages if you live in: the cities of Alexandria and Fairfax, the town of Vienna, Arlington County and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.

Individual Select Preferred Dental Application

Virginia



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

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
 2. Sign and return this application, in the postage-paid return envelope if provided, or mail to:
Mailroom Administrator
P.O. Box 14651, Lexington, KY 40512
- Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

Are you applying for new coverage or are you making changes to a current policy? Check one box.

- 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)
Date of Birth / /	Sex <input type="radio"/> Male <input type="radio"/> Female	Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Domestic Partner		
Home Phone ()	Work/Cell Phone ()	Payment Option <input type="radio"/> Annually <input type="radio"/> Quarterly		

2. COVERAGE SELECTION—CHECK ONE

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

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

An "Adult" means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in your contract.

3. ENROLLING FAMILY MEMBER(S)—COMPLETE ONLY IF YOU SELECT INDIVIDUAL & CHILD(REN), INDIVIDUAL & ADULT OR FAMILY COVERAGE

Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse						<input type="radio"/> M <input type="radio"/> F
Domestic Partner						<input type="radio"/> M <input type="radio"/> F
Dependent 1						<input type="radio"/> M <input type="radio"/> F
Dependent 2						<input type="radio"/> M <input type="radio"/> F
Dependent 3						<input type="radio"/> M <input type="radio"/> F
Dependent 4						<input type="radio"/> M <input type="radio"/> F
Dependent 5						<input type="radio"/> M <input type="radio"/> F

4. PLAN SELECTION—CHECK ONE

- Individual Select Preferred Dental is a Preferred Provider Organization (PPO) plan underwritten by Group Hospitalization and Medical Services, Inc. *This is a preventive services only plan.*
- Individual Select Preferred Dental Plus is a Preferred Provider Organization (PPO) underwritten by Group Hospitalization and Medical Services, Inc.

All individuals listed on this application will be enrolled in the plan selected. Any individual who wants to enroll in a different plan must fill out a separate application.

5. ELECTRONIC COMMUNICATION CONSENT

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

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

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

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

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

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

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

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

I understand that to receive notices through text messaging,

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

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

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

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

Signature: X

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

6. CONDITIONS OF ENROLLMENT—PLEASE READ THIS SECTION CAREFULLY

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Subscriber (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 BlueCross BlueShield policy.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at 866-891-2802 before signing this application.

WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED VIRGINIA STATE LAW.

The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Signature of Applicant: X _____ Date: _____

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

Parent or Legal Guardian Signature: X _____ Date: _____

Signature of Agent: X _____ Date: _____

FOR OFFICE USE ONLY:

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

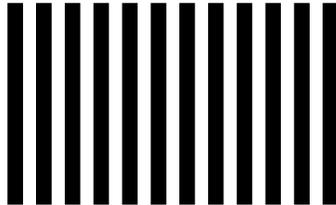
Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

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

Fold and Detach Along Perforation →



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



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

POSTAGE WILL BE PAID BY ADDRESSEE

CAREFIRST BLUECROSS BLUESHIELD
PO BOX 14651
LEXINGTON KY 40512-9876



Exclusions and Limitations

Individual Select Preferred Dental Limitations.

- A. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained.
- B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques.

Exclusions. Benefits will not be provided for:

- A. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours.
- B. Services not specifically listed in the Subscriber's Agreement as a Covered Dental Service, even if Medically Necessary.
- C. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
- D. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist's charges and billed for by them.
- E. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
- F. Services or supplies that are Experimental or Investigational in nature.
- G. Services required solely for administrative purposes including but not limited to employment, insurance, adoption, foreign travel, school, camp admissions or participation in sports activities.

Individual Select Preferred Dental Plus Limitations.

- A. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained.
- B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques 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.

Exclusions. Benefits will not be provided for:

- A. Any services, tests, procedures or supplies which CareFirst determines are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
- B. Any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in CareFirst's judgment, is Experimental/ Investigational, or not in accordance with accepted dental practices and standards in effect at the time of treatment.
- C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this Agreement or under any dental insurance, or any charge or any portion of a charge which

- by law the provider is not permitted to bill or collect from the Member directly.
- D. Any service, supply or procedure that is not specifically listed in this Description of Covered Dental Services and Schedule of Benefits as Covered Dental Services (even if Medically Necessary) or that do not meet all other conditions and criteria for coverage as determined by CareFirst.
 - E. Replacement of a denture, bridge or crown as a result of loss or theft.
 - F. Replacement of an existing denture, bridge or crown that is determined by CareFirst to be satisfactory or repairable.
 - G. Replacement of dentures, bridges or crowns within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of this Description of Covered Dental Services and Schedule of Benefits.
 - H. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys.
 - I. Gold foil fillings.
 - J. Dental services in connection with birth defects or mainly for Cosmetic reasons; with the following exceptions:
 1. Benefits will be provided for dental services received by the Member due to trauma to whole Sound Natural Teeth when the dental services are received after the Effective Date of coverage under the Agreement only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst, and
 2. Benefits will be provided for dental services in connection with birth defects, including cleft lip or cleft palate or both, only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst.
 - K. Periodontal appliances.
 - L. 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 service in this Description of Covered Dental Services and Schedule of Benefits.
 - M. Splinting.
 - N. Nightguards, occlusal guards or other oral orthotic appliances.
 - O. 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 this Description of Covered Dental Services and Schedule of Benefits.
 - P. Intentional tooth reimplantation or transplantation.
 - Q. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning.
 - R. 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.
 - S. Transseptal fibrotomy or vestibuloplasty.
 - T. Orthognathic Surgery or other oral Surgery covered under the Member's medical benefit plan.
 - U. The repair or replacement of any orthodontic appliance.
 - V. Any orthodontic services after the last day of the month in which Covered Dental Services ended, except as specifically described in this Description of Covered Dental Services and Schedule of Benefits and the attached Agreement.
 - W. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be Covered Dental Services).
 - X. 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.
 - Y. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
 - Z. Services that are beyond the scope of the license of the provider performing the service.
 - AA. Services and supplies that are not Medically Necessary.
 - BB. 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 civilrightscordinator@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>.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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 መደን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን 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) Ìtẹ̀tílẹ̀kọ: Àkíyèsí yìí ní iwífún nípa isẹ̀ adójú tòfò rẹ̀. Ó le ní àwọn déèti pátó o sì le ní láti gbé igbésẹ̀ ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yí àti irànlówó ní èdè rẹ̀ lófèé. Àwọn omo-egbé gbòdò pe nòmbà fòdùn tò wà léyìn káàdi idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijiròrò tí tí a ó fí sọ fún ọ̀ láti tẹ̀ 0. Nígbà tí a sọjú kan bá dáhùn, sọ èdè tí o fẹ̀ a ó sì so ọ̀ pò mò ògbufò 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।

Bàsɔ̀-wùdù (Bassa) Tò Ìdùù Cáo! Bǎ̀ nǎ̀ ké bá nyo bě ké m̄ gbo kpá bó nì fùà-fúá-tiǎ̀ nyɛɛ jè dyí. Bǎ̀ nǎ̀ ké bédé wé jéé bě bē m̄ ké dɛ wa m̄ m̄ ké nyuɛɛ nyu hwè bē wé bēá ké zi. ɔ̀ m̄ nì kpé bē m̄ ké bǎ̀ nǎ̀ ké kè gbo-kpá-kpá m̄ m̄ɔ̀ɛ dyé dé nì bídí-wùdù mú bē m̄ ké se wídí dò péé. Kpoò̀ nyo bē m̄ dǎ́ fúùn-nòbà nǎ̀ dé wàà I.D. káà̀ dɛín nyɛ. Nyo tò̀ sèín m̄ dǎ́ nòbà nǎ̀ ké: 855-258-6518, ké m̄ m̄ fò tee bē wa kée m̄ gbo cē bē m̄ ké nòbà m̄à 0 kɛɛ dyi pàdà̀n hwè. ɔ̀ jù ké nyo dò dyi m̄ gǎ̀ jǎ̀n, po wuɖu m̄ m̄ pòe dyie, ké nyo dò mu bó nìin bē ɔ̀ ké nì wuɖù 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 855-258-6518 پر 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 شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس 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 للأخريين 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) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughị ugwo o bula. Ndi otu kwesiri ikpo akara ekwentị di n'azu nke kaadi njirimara ha. Ndi ozọ niile nwere ike ikpo 855-258-6518 wee chere ububo ahụ ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejikọ gi na onye okowa 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 아닌 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 íł hane'ígíí bii' dahólq bee éédahózin béeso ách'áq̄h naanil ník'ist'i'ígíí bá. Bii' dahólq doo íiyisíí yoolkáálígíí dóó t'áádoó le'é ádadoolyííllígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íh. Bee ná ahóót'i' díí bee íł hane' dóó níká'ádoowot' t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóó náánáta' éi koji' dahódoonih 855-258-6518 dóó yii diilts'íł yat'ígíí t'áá níléijí áádóó éi bikéé'dóó naasbaas bił adidiilchił. Áká'ánidaalwó'ígíí neidiitáq̄go, saad bee yánilt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoowot'.

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