Dental Provider e-Manual - 2014 Updates

NEW DENTAL INFORMATION for 2014

Pediatric Oral Health

Effective, January 1, 2014, the Affordable Care Act (ACA) mandate makes available Pediatric Oral Health benefits to children up to age 19. Pediatric Oral Health benefits include a full range of dental services including preventive, basic, major and medically necessary orthodontia services covered under the medical plan for dependents covered under certain small group or individual medical policies with Blue Cross and Blue Shield of North Carolina (BCBSNC). Pediatric Oral Health benefits may be available to large groups, as well.

Covered Services	In Network	Out of Network
Diagnostic and Preventive	$25 copay	$50 copay
Basic & Major	80% after medical deductible	60% after medical deductible
Medically necessary Orthodontia (subject to a 12 month waiting period)*	80% after medical deductible	60% after medical deductible

*Waiting Period for Medically necessary Orthodontia must be satisfied.

Pediatric Dental Services Covered under Medical	Standard benefits
Available benefits	
Preventive and diagnostic	Oral exams and teeth cleanings Bitewing X-rays Full mouth X-ray Fluoride treatment Sealants Space maintainers
Basic and Major	Simple restorative services (fillings) Simple teeth removal Oral surgery Endodontics and periodontics Crowns, inlays, onlays Bridges Dentures Implants

Orthodontics	Medically necessary, Prior approval required*

*Criteria for medical necessity and prior approval process will be posted as an addendum to the Dental eManual. Providers are reminded to always verify a member's actual benefits and eligibility.

Claims for members with pediatric dental benefits must be submitted to the BCBSNC medical plan first for reimbursement. The member's medical plan is considered primary. Once the claim is processed and payment issued, the provider or member may submit a claim to the member's dental carrier for reimbursement. BCBSNC dental plans will always be considered secondary to the member's medical plan for pediatric dental services.

Member Eligibility, benefits and claims status

Dental providers may contact customer service at the phone number listed on the back of the member's ID card to verify eligibility, benefits and claims status for pediatric dental services. Providers may also verify benefits by visiting the ***Blue e*** website available to providers.

Dental providers can identify a member under age 19 with pediatric dental by viewing the back of the member's medical ID card. If ***Emdeon Dental Payer ID #61472 appears under the medical mailing address, then the member*** has pediatric dental benefits included. The claim should be submitted to either Emdeon #61472 or the medical mailing address.

New FEDVIP dental plan – FEP BlueDental

Effective January 1, 2014, BCBSNC will participate in the Federal Employee Dental and Vision Insurance Program (FEDVIP) offering dental benefits. BCBSNC will be one of many carriers available to Federal Employees and retirees. Enrollees of the FEDVIP dental plan have a full range of dental benefits, including preventive, basic, major and orthodontia services.

The FEDVIP dental plan, known as **FEP BlueDental,** offers a choice of two plan options (High Plan and Standard Plan). FEP BlueDental is a dental benefit program sanctioned by the federal government for federal employees and retirees. The benefits defined below are specific to federal employees and retirees who purchase a standalone dental plan.

Federal Employee Health Benefit Plan (BCBS medical coverage includes some dental benefits)	
Customer service	1-800-222-4739
Dental claims covered under Federal Employee Health Benefit Plan (FEHBP) filed with CDT codes on ADA form	Dental Emdeon payer #61472 (electronic claims filing)
	BCBSNC Claims P.O. Box 35 Durham, NC 27702-0035
Medical claims (Medical / accident / TMJ filed with CPT codes)	Enrollment for electronic medical claims available through the Web at bcbsnc.com/content/providers/edi/
	BCBSNC Claims P.O. Box 35 Durham, NC 27702-0035
Web sites	bcbsnc.com/content/fep/index.ht m fepblue.org opm.gov/insure/index.aspx

FEP BlueDental - claims must be submitted to member's medical carrier first if BCBSNC is the medical carrier. BCBSNC will automatically transfer claims to the FEP BlueDental processor. If the member has coverage other than BCBS medical carrier, a copy of the EOB is needed and must be submitted to the following address for claims processing.

FEP BlueDental Claims
P O Box 75
Minneapolis, MN 55440-0075

FEP BlueDental	
Customer service	1-855-504-BLUE(2583)
FEP Blue Dental Claims	PO Box 75 Minneapolis, MN 55440-0075
Web sites	Fepblue.org

FEP Blue Dental				
	Standard		High Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance				
Preventive services	**100%**	60%	**100%**	90%
Basic services	**55%**	40%	**70%**	60%
Major services	**35%**	20%	**50%**	40%
Orthodontics	**50%**	50%	**50%**	50%
Deductibles and maximums				
Individual annual maximum options (applies to diagnostic and preventive, basic and major services	**$0**	$75	**$0**	$50
Lifetime maximum for orthodontics	**$2,000**	$1,000	**$3,500**	$3,500

Non-Orthodontic annual maximum per person	**$1,500**	$750	**$10,000**	$10,000

Available benefits	
Preventive and diagnostic	Oral exams, teeth cleanings Bitewing X-ray Fluoride treatment Sealants
Basic	Simple restorative services (fillings) Simple teeth removal Periodontal scaling Oral Surgery
Major	Endodontics Periodontics Onlays, Crowns, Dental implants Prosthodontics (bridges, dentures)
Orthodontics	Covers Adult and Children

Dental Waiting periods

Diagnostic and Preventive services	None
Basic services	None
Major services	None
Orthodontics	12 months

FEP BlueDental -Exclusions/Limitations

The exclusions list applies to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.**

The following services are not covered:

• Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;

• Services and treatment which are experimental or investigational;

• Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;

• Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;

• Services and treatment performed prior to your effective date of coverage;

• Services and treatment incurred after the termination date of your coverage unless otherwise indicated;

• Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.

• Services and treatment resulting from your failure to comply with professionally prescribed treatment;

• Telephone consultations;

• Any charges for failure to keep a scheduled appointment;

• Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

• Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);

• Services or treatment provided as a result of intentionally self-inflicted injury or illness;

• Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;

• Office infection control charges;

• Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;

• State or territorial taxes on dental services performed;

• Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;

• Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;

• Those for which the member would have no obligation to pay in the absence of this or any similar coverage;

• Those which are for specialized procedures and techniques;

• Those performed by a dentist who is compensated by a facility for similar covered services performed for members;

• Duplicate, provisional and temporary devices, appliances, and services;

• Plaque control programs, oral hygiene instruction, and dietary instructions;

• 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;

• Gold foil restorations;

• Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;

• Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;

• Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);

• Charges by the provider for completing dental forms;

• Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;

- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic services provided to a member who has not met the 12 month waiting period requirement.
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center;
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non-eligible implants;
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by FEP BlueDental.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by this plan.
- All out-of-network services listed in Section 5 are subject to the maximum allowable amount as defined by FEP BlueDental. The member is responsible for all remaining charges that exceed the allowable maximum.

Dental payments issued to participating providers only

Effective January 1, 2014, BCBSNC will no longer issue claims payment directly to non-participating providers. Members receiving services from a non-participating dental provider will receive payment directly and will be responsible for reimbursing non-participating providers. Non-participating providers may bill upfront or collect payment directly from the member for dental services.