2025 FCL Dental Manual

A Dental Administrative Guide

Florida Combined Life
An Independent Licensee of the
Blue Cross and Blue Shield Association

This publication is subject to periodic revisions and additions. For questions about these materials, please contact your Provider Network Manager.

Edition 15 1/1/2025

Welcome to Florida Combined Life!

We are pleased to provide you with the latest edition of the Florida Combined Life Insurance Inc. (FCL) Dental Manual; an administrative guide to help you and your staff provide our members – your patients, with the best possible service.

This Dental Manual, along with the CDT Dental Procedure Guidelines, provides you with the policies and procedures necessary to support your practice when doing business with us. TheDental Manual is an accompaniment to your Participating Provider Agreement ("Agreement"), providing comprehensive details regarding the terms of your Agreement. Both the Dental Manual and the CDT Dental Procedure Guidelines are located on our website Plans and documents | Florida Blue Dental.

Your Provider Network Manager is available to assist you with any questions you have relative to your Agreement, the Dental Manual, or the CDT Guidelines. You can find your Provider Network Manager's contact information in Section 2 of this Dental Manual.

Thank you for the role you and your staff play in providing a welcoming and professional experience for our members who are seeking care for their dental health. From time to time, you can expect to see updates to this Dental Manual to keep you apprised of changes and additional information as it becomes available. If you have any suggestions as to content you would like to see included in the Dental Manual, please contact your Provider Network Manager.

We appreciate the quality service you provide to our members and look forward to continuing our mutually beneficial relationship with you and your staff.

Your Florida Blue Dental Team

Contents

Section 1: Definitions

The definitions of capitalized terms that are not otherwise defined in the body of the Participating Provider Agreement are set forth in this section of the Dental Manual.

Account	An employer, union, association, or other group that has entered into an insurance policy or agreement with FCL or a Network Plan to provide Covered Services to Members of that Account.
ACA	The Patient Protection and Affordable Care Act, commonly called the AffordableCare Act, is a United States federal statute signed into law on March 23, 2010.
Affiliated Parties	Dentist's employees, affiliates, subsidiaries, members of its board of directors, key management, or executive staff.
Agreement	The "Participating Provider Agreement" between a Network Dentist and LSV, as Administrator for FCL's dental plans.
Applicable Laws	Any statutes, regulations, or other legal requirements applicable to the matter being referenced in the Agreement.
Allowable Expense	The maximum amount of payment allowed by FCL for Dental Benefits covered under the applicable Insured's Dental Program.
Administrator	LSV performs administrator services for Responsible Payors in accordance with the terms of its contracts with such Responsible Payors and the Agreement.
Application	The form that a Dentist has completed setting forth requested information concerning his or her professional qualifications, experience, and other relevant credentialing information.
Benefit Plan	The written agreement entered into by a Responsible Payor with an Account oran individual, which specifies the terms, conditions, limitations and exclusions applicable to the Member's Covered Services.
Centers for Medicare and Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for administration of Medicare.
Clean Claim	A claim for Covered Services that is submitted for adjudication in accordance with applicable terms and conditions of this Dental Manual. A claim is considered to be clean when it requires no further information, adjustment or alteration in order to be processed and paid by the Responsible Payor.
Co-insurance	The sharing of expenses of Dental Benefits between the members andFCL The amount of any such expense is set forth in the applicable Dental Program.
Conditions of Participation	The minimum qualifications and standards required to be credentialed toparticipate in a Provider Network, including: 1. Any information set forth or referenced in the Dentist's Application, which is incorporated into the Agreement by reference, shall be true, accurate and correct in all material respects throughout the term of the Agreement, and 2. The Dentist shall notify LSV in a timely manner of any materialchanges in that information.

Confidential Information	1. All data, reports, interpretations, forecasts, documents, records and other information fixed in a tangible medium, which contain information concerning a party that: 2. Is marked, otherwise identified as, or legally entitled to protection asconfidential, proprietary, privileged or trade secret information; and 3. Is disclosed by or on behalf of a party (the "Disclosing Party") to theother party (the "Receiving Party").
Confidential Information	Confidential Information does not include information that: 1. Is based on documents in the Receiving Party's possession prior to disclosure of Information that was not acquired directly or indirectly from the Disclosing Party; or 2. Was in the public domain at the time of disclosure or subsequently became part of the public domain through no fault of the Receiving Party;or 3. Was legally received on a non-confidential basis from a third party,who is not known to be bound by a confidentiality agreement preventing the disclosure of such information; or 4. Was independently developed by the Receiving Party without reliance on or knowledge of the Disclosing Party's Confidential Information.
Coordination of Benefits (COB)	The determination of which Payors have primary and secondary responsibilitiesfor paying for Covered Services in accordance with the rules set forth in the Member's Benefit Plan when that Member is eligible for Covered Services from more than one payor, including from a governmental or self-funded payor.
Copayment	A fixed-dollar amount that a Network Dentist must collect directly from a member as a portion of the Maximum Allowable Charge for Covered Services.
Cost Sharing	Any and all charges that a Dentist may collect directly from a member in accordance with the terms of the Member's Benefit Plan, which includesCopayments, Deductibles or Coinsurance.
Covered Services	Necessary and Appropriate dental care services and supplies rendered toMembers in accordance with the terms of the Member's Benefit Plan, the applicable Dental Manual and the Agreement.
Deductible	The aggregate dollar amount that a member must pay in accordance with the Member's Benefit Plan before the Responsible Payor is required to pay for Covered Services. The Member must pay 100% of the Dentist's Maximum Allowable Charges for Covered Services until the Member satisfies the applicable Deductible.
Delegated Entity	Any party that enters into an agreement with FCL to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents. To the extent that Dentist provides services to FCL's QHP Members thereof, Dentist is a Delegated Entity.
Dental Benefits	Those covered dental services and supplies, together with exclusions and limitations, as set forth in the applicable Dental Program.
Dental Program	The dental benefit program under which the Insured is covered by, or through (e.g., under a reciprocity or other agreement with FCL for the provision of Dental Benefits) FCL, and which specifies the covered DentalBenefits.
Dependent	A Member who is eligible and enrolled in a Benefit Plan based upon his or her relationship with a Subscriber.

Downstream Entity	Downstream Entities include Dentist and any of Dentist's subcontractors andtheir subcontractors down to the level of the ultimate provider of health and administrative goods and services to MA Members under the terms of the Agreement.
EHB	Essential Health Benefit
EPO	Exclusive Provider Organization

Exchange or Health Insurance Marketplace	A governmental agency or non-profit entity that meets the applicable standardsof 45 C.F.R. § 155 subpart D and makes QHP available to individuals and employers. This term includes both state and Federally Facilitated Exchanges.
FCL Dental Manual	This document, which sets forth the policies, procedures, and requirements applicable to Network Dentists providing dental services to Members.
First Tier Entity	First Tier Entities consist of MA Plan's subcontractors, including FCL, that provide administrative services or health care services to MA Members.
GRID	The National Dental GRID and The National Dental GRID+ allows reciprocityamong most of the nation's Blue plans.
HCR	Health Care Reform See"ACA"
HIPAA	The Health Insurance Portability and Accountability Act of 1996 and itsregulations.
HITECH	The Health Information Technology for Economic and Clinical Health Act andits implementing regulations.
Insured	Each individual covered under a Dental Program.
Late Claim	The submission of a Claim for Covered Services to LSV's Responsible Payor that is more than 365 days (one year) from the date of service or the completion of a course of treatment. LSV may deny a Late Claim unless it determines, at itsdiscretion, that there was good cause for the delay in submitting that claim.
LSV	Life & Specialty Ventures, LLC
Medicare Advantage Plan	Florida Blue, a Medicare Advantage Organization offering Medicare AdvantagePrograms through an MA Contract.
MA Contract	The contract between CMS and MA Plan.
Maximum Allowable Charge Schedule	The amount that LSV has determined to be the maximum amount payable for aCovered Service rendered to a member as set forth in the applicable Maximum Allowable Charge Schedule contained in Exhibit A of the Responsible Payor'sAgreement.
Member	A person eligible to receive Covered Services under a Benefit Plan.
Member Payments	Any and all charges that a Dentist may collect directly from a member in accordance with the terms of the Member's Benefit Plan; which includesCopayments, Deductibles or Coinsurance.
MOOP	Maximum Out of Pocket
National Provider Identifier (NPI)	The government-issued, 10-digit identification number for individual healthcare providers and entities.

Necessary and Appropriate	Dental services and supplies that are: 1. Rendered consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic and relateddiseases). 2. Furnished in accordance with standards of good dental practice. 3. Provided in the most appropriate site and at the most appropriate levelof service based upon the Member's condition. 4. Not provided solely to improve a member's condition beyond normalvariation in individual development and aging, including improving physical appearance that is within normal individual variation. 5. As beneficial as any established alternative; and 6. Not rendered solely for the Dentist's, Member's or a thirdparty's convenience.
Network Dentists	Dentists who participate in the Provider Network(s)
Network Plan	A United Concordia Advantage Plus Plan and Florida Blue (Florida Blue) dental plan with which FCL has a reciprocity or alliance arrangement, which permits members of the FloridaBlue plan to access care rendered by the FCL Provider Network. As Florida Blue (BCBSF), offers certain dental products to members utilizing FCL's network, participating dentists will also participate in such network offerings by agreeing to provide services to BCBSF members who seek such services in Florida.
Non-Covered Services	Services and supplies that are not covered by or limited in coverage pursuant to the Member's Benefit Plan; also, services or supplies, other than Non-Reimbursable Services, for which the Dentist does not receive reimbursement from a Responsible Payor after exhausting the Dispute Resolution Procedure set forth in the applicable Dental Manual.
Non-Reimbursable Services	Services that would have been Covered Services but for the fact that the Dentist: 1. Rendered services that were not Necessary and Appropriate, or 2. Failed to comply with applicable requirements of the Dental Manual in connection with the provision of such Services, or 3. Failed to submit a claim for such services within the submission deadlines established by the applicable Dental Manual.
Participating Dentist	A duly licensed dentist who has contracted with FCL to participate in its Dental Network(s).
Provider Network	A group of Dentists who contract with LSV/FCL to render Covered Services to Members.
Plan	A dental plan offered by FCL or one of its affiliates.
Predetermination of Benefits	A Dentist's submission of information to the Responsible Payor prior to rendering services, to request the Responsible Payor inform the Dentist if services may be Covered Services and what Allowable Charge, Copayment, Coinsurance and Deductible amounts may apply. A Predetermination of Benefits is not a guarantee of benefits and does not imply any obligation to pay any amount for services rendered. A Predetermination is subject to: • the accuracy and completeness of the Dentist's submission of information, • such services being Necessary and Appropriate, • the Member's eligibility at the time services are rendered, • the Responsible Payor's allowed payment for such services, and • the terms of the Member's Benefit Plan at the time services are rendered.

QHP	Qualified Health Plan
QHP Issuer Agreement	The agreement(s) between CMS and FCL to offer QHPs through the Exchangeor Health Insurance Marketplace.
Responsible Payor	The Plan responsible for paying benefits for Covered Services rendered to a Member.
State	The State of Florida
Subscriber	A Member who is eligible and enrolled in a Benefit Plan as an individual or as anemployee or member of an Account.
Unbundling of Procedures	The "unbundling" of charges has been recognized on a national level as a contributing factor to the increasing cost of healthcare. Examples of unbundling include the use of more than one procedure code to bill for a procedure that canbe adequately described by a lesser number of codes, filing for services that arean integral part of a procedure, and filing for procedures (such as "sterilization", services, or supplies) that are required in rendering dental services. When these and other unbundled claims are identified, partial denials of payment or refundrequest will result.
Utilization Management Program	The review process used to evaluate whether a service rendered to a Member is Necessary and Appropriate.

Section 2: Contact Information

Dental provider relations team

For general questions, email our team at Dental Provider Relations. The dental network manager for your territory will respond to you.

BlueDental plans administered by Florida Combined Life:

BlueDental Choice & Choice Plus PPO
BlueDental Choice Copayment PPO
BlueDental Freedom
BlueDental Choice Q & QF Plans
BlueDental Copayment Q & QF Plans
1-866-445-5148

Florida Blue plans administered by Florida Combined Life:

BlueOptions Health and Dental
BlueOptions
BlueSelect
BlueCare HMO
Miami Dade Blue
BlueMedicare
myBlue
SimplyBlue
Blue Options Hospital Surgical Plus
Blue Select Hospital Surgical Plus
FPCP Pediatric Essential Dental Plan
1-866-445-5148

BlueDental Care prepaid plans

1-877-325-3979

Federal Employee Program (FEP)

1-800-727-2227

FEP Dental program

1-855-504-2583

Grid/Grid+, out-of-State GRID member

Call the number on the member's ID card

Section 3: Your Relationship with FCL

The relationship between FCL and a Participating Dentist is solely an independent contractor relationship. FCL shall not interfere with a Participating Dentist's judgment with respect to treatment proposed or rendered or within the dentist/patient relationship. Additionally, the parties acknowledge that FCL exercises no control over judgmentand/or decisions related to patient care, and that a Participating Dentist is solely responsible for such judgments and decisions.

FCL is not liable for any action by a Participating Dentist or any person acting on behalf of a Participating Dentist.

Dentist's Responsibilities

As a Participating Dentist, you are solely responsible for making treatment recommendations and decisions for your patients. You are also responsible for ensuring that all clean claims you submit are accurate, complete and in adherence with recognized standards of coding. A Participating dentist cannot bill patients for charges FCL considers "unbundled" services that should be billed as one procedure, so there is no "cost shifting" to members. A Participating Dentist must meet the General Conditions, Standards, Requirements and Contractual Conditions detailed in section five of this manual.

FCL's Responsibilities

FCL reserves the authority to make eligibility and coverage determinations and to make claims-processing decisions that may include re-bundling or down-coding. FCL will exercise best efforts to adjudicate and pay each Clean Claim for Dental Benefits directly to the Dentist within thirty (30) days of receipt or in accordance with applicable federal or state prompt payment laws. FCL will market and promote its Dental Programs, and provide a list of Participating Dentists to Members, employer groups and other Participating Dentists, in conformity with FCL's marketing program then in effect. FCL will also provide other programs that support, service and educate the Dentists and office staffs in conformity with FCL's programs then in effect.

Relationship between FCL and LSV

Life and Specialty Ventures (LSV), LLC is a Delaware limited Liability Company. LSV is acting as a support company providing administrative services to independent licensees of the Blue Cross and Blue Shield Association (BCBSA), including FCL. LSVis not licensed by BCBSA and is not a joint venture, agent, or representative of BCBSA. LSV is solely responsible for the provision of administrative support services in accordance with the terms of the Agreement.

Section 4: Working with FCL

What We Offer You

At FCL, we are committed to helping you provide the best care to your patients, our members. We have established a reputation based upon trust and excellent customer service, the same qualities you deliver to your patients. We offer:

- Fast, dependable, and accurate electronic claims processing, with payments issued directly to the Participating Dentist
- Dedicated Provider Network Managers
- Website access to self-service tools and collateral materials
- Competitive reimbursement rates driven by the market
- The FCL Preferred Provider Organization (PPO) network, which gives you:
    - Access to more than 625,000 members
    - A listing in our online Provider Directory, which members can use to search for you by location or specialty. You may access the directory at Find a dentist | Florida Blue Dental to view your listing.

We are now using our website, Providers | Florida Blue Dental for all communication with our participating dental providers. Updates and announcements are available to you at your convenience 24/7.

Section 5: Conditions of Participation in Our Network

Conditions of Participation

To participate in the FCL network, each dentist must meet the General Conditions, Standards and Requirements and Contractual Conditions described below.

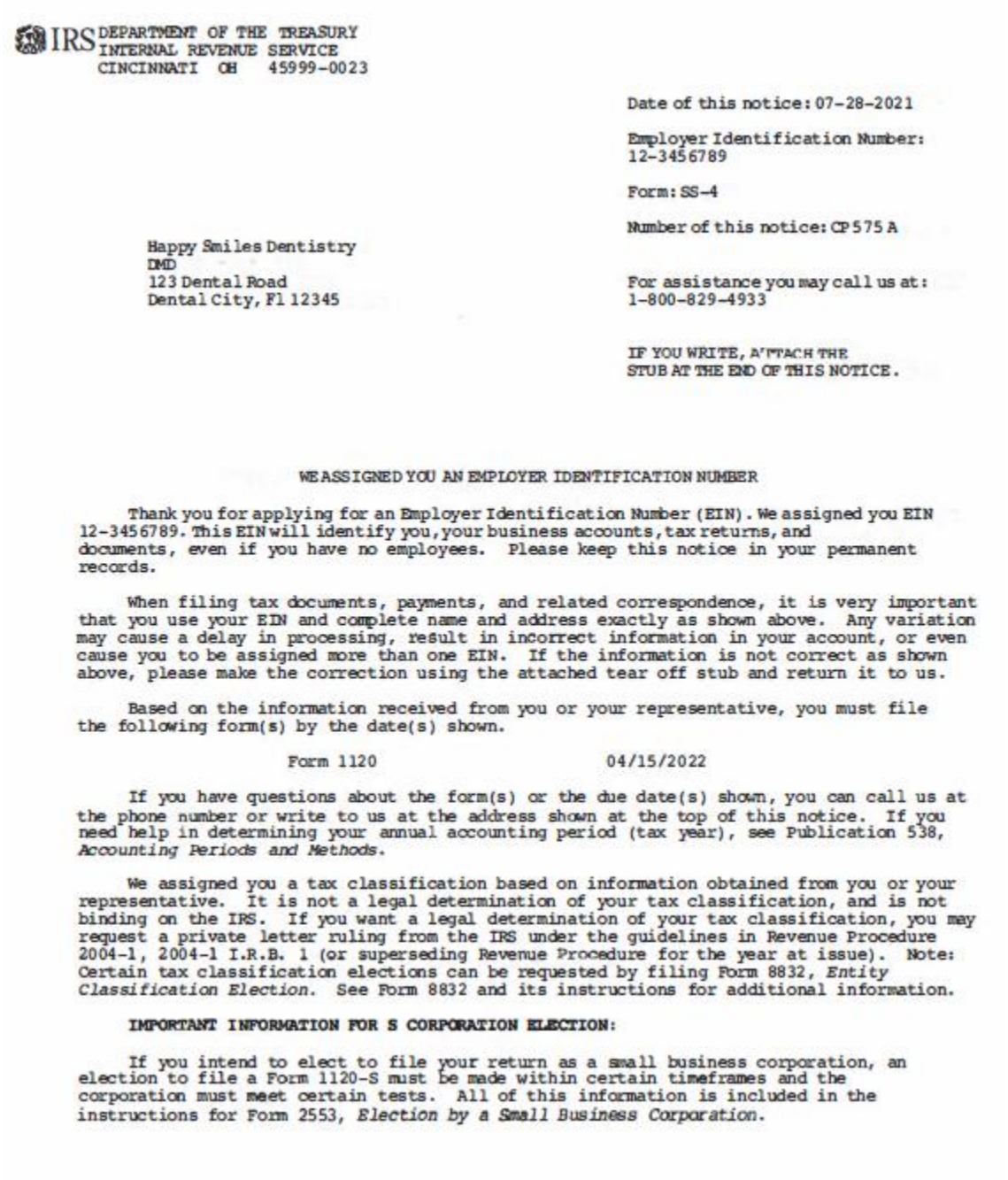
General Conditions	• Dentist must complete an online Provider Application with associated attachments found here: Join our network | Florida Blue Dental • Submit a W-9 or a tax coupon or letter from the Department of Treasury (IRS) CP 575C. • Submit a Type 1 NPI number • Submit a Type 2 NPI number if applicable

Standards and Requirements	• Dentist warrants that Dentist, and all health care practitioners, including employees, contractors, and agents of Dentist, who render Covered Servicesto MA Members and QHP Members, shall be at all times during the term hereof, properly licensed by the state in which such services are rendered, certified, qualified and in good standing in accord with all applicable local, state, and federal laws. Dentist, Dentist's sites, and all providers rendering services hereunder shall meet applicable requirements and be properly certified under the Medicare programs, as set forth in in Title XVIII of the Social Security Act. Upon request, Dentist shall provide satisfactory documentary evidence of such licensure, certification, and qualifications of Dentist, Dentist's sites, and other health care providers rendering services atDentist's sites. Either the MA Plan will review the credentials of Dentist and other medical professionals affiliated with Dentist or the MA Plan will review and approve the credentialing process and will audit the credentialing process on an ongoing basis. • Dentist must maintain individual liability insurance in the amounts of $100,000per occurrence and $300,000 in aggregate to insure you against any claim fordamages arising by reason of personal injury or death caused directly or indirectly by Dentist. • Dentist must maintain appointment hours which are sufficient and convenient to service members; and at all times, at your expense, provide or arrange for twenty-four (24) hour-a-day emergency on-call service. • Dentist must maintain all appropriate records concerning the provision of and payment for Covered Services rendered to Members. Such records are to bemaintained in accordance with customary industry record-keeping standards, Dental Manual requirements, and Applicable Laws. • Dentist must maintain dental, financial, and administrative records concerning the provision of services to Members for at least ten (10) years from the date those services were rendered. Dentist must agree that FCL or its authorized designees, regulators or accreditation agencies; have the right to inspect and make copies of records related to the provision of services to Members, given reasonable notice, during the Dentist's regular business hours. Neither FCL nor its designees shall be required to pay for copies of records necessary to complete or evaluate claim or encounter data. You agree to obtain any releases required by Applicable Laws to provide access to Member's records. • Dentist must comply with the Required Terms of the Amendment to the FCL Participating Provider Agreement which apply to services rendered to MA Members and QHP Member and will, to the extent inconsistent with any other terms of the Agreement, supersede such inconsistent terms solely as they relate to services rendered to MA Members and QHP Members.

Standards and Requirements	• If a party received Confidential Information from another party, the receiving party would not disclose the Confidential Information to third parties, in whole or in part, except with prior written consent of the disclosing party, as required by Applicable Laws or as permitted by the FCL Participating Provider Agreement. The receiving party and its representatives shall utilize confidential information disclosed pursuant to the Agreement as is reasonably necessary to accomplish the objectives of the Agreement and in accordance with Applicable Laws, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations and the Heath Information Technology for Economic and Clinical Health Act and its implementing regulation. The receiving party and its representative shall not utilize Confidential Information for any other purpose including, without limitation, using that confidential Information for its own benefit or for the benefit of thirdparties, except with the prior written consent of the disclosing party. The Dentist acknowledges and agrees that LSV may disclose Confidential Information received from or on behalf of the Dentist, including fee, claims and encounter information, to affiliates, reciprocity plans, regulators, accreditation agencies, Administrators, and auditors after informing those third parties of the confidential nature of the disclosed information.
Contractual Conditions	• Dentist shall notify FCL of Dentist intent to terminate or alter Dentist participation in writing no less than ninety (90) days prior to your requested date of change or termination. Furthermore, any individual provider wishing to join an existing group practice shall notify FCL. • To the extent that services that otherwise meet the requirement of the FCL Participating Provider Agreement are rendered by a dentist not located in Florida, the statutory and regulatory requirements of that state that are equivalent to these Contractual Conditions shall be complied with to the satisfaction of FCL. • Dentist shall comply and shall contractually obligate its Downstream Entitiesto comply with all applicable laws and regulations including, but not limited to, the provisions of 45 C.F.R. Parts 155 and 156 and MA Plan's relevant written policies and procedures, including policies and procedures for the control of fraud, waste, and abuse in the MA Programs. Dentist shall complywith the provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and all other applicable laws and regulations pertaining to recipients of federal funds. • Dentist shall perform Covered Services and shall ensure that Downstream Entities perform Covered Services in a manner that complies and is consistent with FCL's obligations to MA Plan and MA Plan's obligations to CMS set forth in the MA Contract. Additionally, you shall perform Covered Services and shall ensure that Downstream Entities perform Covered Services in a manner that complies and is consistent with FCL's obligationsto CMS set forth in the QHP Issuer Agreement.

Examples of Acceptable IRS Documents

For verification, FCL will accept a tax coupon or letter from the Department of Treasury (IRS) CP 575C. See the following example:



IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 07-28-2021

Employer Identification Number:
12-3456789

Form: SS-4

Number of this notice: CP 575 A

Happy Smiles Dentistry
DMD
123 Dental Road
Dental City, Fl 12345

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 12-3456789. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 1120 04/15/2022

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

IMPORTANT INFORMATION FOR S CORPORATION ELECTION:

If you intend to elect to file your return as a small business corporation, an election to file a Form 1120-S must be made within certain timeframes and the corporation must meet certain tests. All of this information is included in the instructions for Form 2553, *Election by a Small Business Corporation*.

Examples of Acceptable IRS Documents

For verification, FCL will also accept an IRS form W-9.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

Section 6: National Provider Identifier (NPI)

A. NPI Overview

The National Provider Identifier (NPI) is a government-issued, 10 - digit identification number for individual healthcare providers and organizations. The numbers are randomly assigned and contain no coded information about the individual or organization. The NPI will never expire, and your individual NPI will remain the same even if you change jobs or locations. All dentists are required by federal law to obtain an NPI. HMSA requires each Network Dentist to have an NPI regardless of whether the dentist submits claims electronically. We encourage you to obtain an NPI as soon as possible; getting your NPI now will help eliminate issues with claims administration.

B. How to Apply for and Use an NPI

You can apply for an NPI at no charge through CMS' National Plan and Provider Enumeration System website at NPPES NPI Registry. You can choose to:

1. Apply online receiving your NPI via email in one (1) to five (5) business days or
2. Download a printable application and submit by mail; processing takes about twenty (20) business days.

Once you have received an NPI, fax a copy of your confirmation to our Provider Network department at **(904) 866-4846** and we will update your providerrecord. If you have questions about NPI, contact your FCL Provider Network Manager.

Practice Type	NPI Type
Sole Proprietor or Solo Practitioner	Type 1 NPI only, if claims are transmitted in the dentist's name and social security number
Individual Dentist at one practice location	Type 1 for the dentist and Type 2 for the practice, if claims are transmitted in the practice's name and Tax Identification Number (TIN)
Multiple Dentists, one practice location	Type 1 for each dentist and Type 2 for the practice, if claims are transmitted in the practice's name and TIN
Multiple Dentists, one practice location	Type 1 for each dentist and Type 2 for each practice with a separate TIN

Section 7: Filing Provider or Practice Changes

Occasionally, you may need to submit changes to us associated with relocation, adding or changing an Employer Identification Number (EIN) or Tax Identification Number (TIN), adding or terminating an associate or closing a plan panel. Forms are located on our website at Update your status | Florida Blue Dental For assistance with the forms, please contact us at dentalproviderrelations@fclife.com

Changes Requiring Notification

Changes to your status that require **immediate** written notification include:

- License to practice dentistry is suspended or revoked
- Professional liability or malpractice insurance changes, lapses or revocation
- Malpractice cases or an act of professional misconduct

Changes to your practice that require **immediate** written notification include:

- Transfer of ownership (TIN change)
- Change of practice name
- Relocation
- Adding dentists to your practice
- Additional offices
- Changes to telephone numbers
- Any material or demographic changes to your practice
- Retirement/Death of Provider

Required Notification Time Limitations

FCL requires written notification within seventy-two (72) hours if:

- You or your practice, or any of its officers or directors is indicted or convicted of a felony.
- You or your practice becomes the subject of an investigation by a state or federal government entity in which you have the potential to be subject to criminal charges or subject to any action for violationof Law.
- Within one (1) business dayif:
- You are materially sanctioned by any state or federal government entity.
- Your eligibility to participate in the Medicare or Medicaid programs islimited, restricted, or otherwise terminated.
- You receive a notice of intent to file or actual filing of any professional liability action against you (or an entity in which you have an ownershipinterest, other than a publicly traded company) that involves a member.
- Within five (5) business days if:
- You are required to pay damages in any malpractice action byway of judgment or settlement notification.
- There is any change in the nature or extent of Service rendered by you.
- Any other act, event, occurrence or the like that materially affects yourability to perform your duties and obligations or otherwise perform under the Agreement.
- You shall notify FCL when you begin or cease to accept new patients or begin or cease to provide Services at the location listed in theAgreement.
- Within thirty (30) days of any change in your ownership or Affiliates or of a contemplated merger or acquisition of your practice(s).

Submission Requirements

Type of Change	Method of Submission
General location/contact information (telephone, fax, etc.)	Complete a provider information change form located on our website at Update your status | Florida Blue Dental under the Providers tab or email dentalproviderrelations@fclife.com if you have any questions.
Employer Identification Number (EIN) or Taxpayer Identification Number (TIN)	Any changes to your (EIN) Employer Identification Number or (TIN) Taxpayer Identification Number, submit a provider information change form, W-9 and a Participating Provider Agreement for each provider. Forms are located on our website at Update your status | Florida Blue Dental.
Associate dentist/orthodontist who has leftyour practice	Send a letter of termination on the practice letterhead with the provider's signature, including the dentist's name, practice address and TIN and reason for terminating via fax (904) 866-4846 or e-mail dentalproviderrelations@fclife.com
Add a new associate or dentist to your practice	Submit a credentialing application if the provider is not credentialed with FCL, or submit an abbreviated application, W-9 and a Participating Provider Agreement for existing providers. Forms are located on our website at Update your status | Florida Blue Dental.
Terminate participation in a network Requires 90-day written notification	Send a letter of termination on your practice letterhead with the provider's signature, include the Dentist name, practice address, TIN and network you are terming with the reason you are terminating via fax **(904) 866-4846** or email to dentalproviderrelations@fclife.com
Add additional practice locations for existing Employer Taxpayer identification number (TIN) on file.	Submit an abbreviated application. Forms are located on our website at Update your status | Florida Blue Dental
Terminate FCL Contract	Contact your Dental Network Manager at dentalproviderrelations@fclife.com

Section 8: Termination

The initial term of the Dental Network Participation Agreement is one year from the effective date. The Agreement shall automatically renew at the end of the initial term andcontinue in effect until terminated in accordance with such Agreement.

Types of Termination and Effective Dates

- **Without cause**: either party may terminate the Agreement with an effective date after the initial one-year term without cause by giving at least **ninety (90) days written notice** to the other party at their addresson file. For FCL, that address is:

  Florida Combined Life
  4800 Deerwood Campus
  Parkway Building 400, Suite 600
  Jacksonville, FL 32246

  The effective date of the termination will be as of 12:01am on the first day of the month following the 90-day notice period. During this 90-day period the dentist will be responsible for sending all patients of record written notification that (s)he will no longer be an in-network provider with FCL. The parties may also terminate the Agreement at any time by written mutual consent.

- **With cause**: may occur immediately with written notice to the dentist. Causes include but are not limited to material breach, fraud, misrepresentation, and loss, limitation, or suspension of licensure. You must conspicuously post or provide members with notice that you no longer participate with the plan.

- **With cause**: may occur if you do not consent to any change(s) to the Agreement made by FCL. The "Agreement" consists of the Agreement, Dental Manual, and any Amendments to the Agreement. FCL will provide you with **ninety (90) days written notice** of any proposed change(s)to the Agreement. If you fail to reject the change(s), in writing within (30) thirty days of receiving notification of the change(s), the amendment will be deemed to have been accepted. However, if you reject the amendment, in writing during that thirty (30) day period, FCL has the right to either:

  1. Notify you that it has elected to not amend the Agreement, or

  2. Terminate the Agreement upon ninety (90) days written notification.

Changes to administrative policies, procedures, rules and regulations, conditions of participation, or the Maximum Allowable Charges (fee schedule) do not require an amendment to the Agreement. Terminations for cause are reviewed and initiated by the Dental Director(s) and VP of National Clinical Operations. Appropriate steps are taken to report any abuses, including deficiencies inquality of care to the appropriate local, state, and federal agencies by the VP, National Clinical Operations.

FCL may terminate your Participating Provider Agreement immediately, upon written notice, if you fail to satisfy the requirements set forth in the Conditions of Participation.

Section 9: Dental Plans and Benefits

Florida Combined Life Insurance Company, Inc. (FCL) is an independent licensee of the Blue Cross and Blue Shield Association. The following is an overview of the dental plans offered by or administered by FCL.

Dental Plans Offered by or Administered by FCL

Plan Name	Administration	Reimbursement	Copayments	Plan-Year Maximum	Electronic Claims Payor ID	Claim Address	Customer Service Contact Numbers
BlueDental Choice PPO Plan	Plan offered and administered by FCL	Current BlueDental Choice PPO Fee Schedule		Variable by plan. Frequency Limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
BlueDental Choice Plus PPO Plan	Plan offered and administered by FCL	BlueDental Access Max Fee Schedule **or** BlueDental Choice PPO Fee Schedule		Variable by plan. Frequency limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
BlueDental Choice Copayment PPO Plan	Plan offered and administered by FCL	Current BlueDental Choice Copayment Fee Schedule for General and Specialty Care	Copayments indicated on Fee Schedule under "MemberPays" column	Variable by plan. Frequency limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
BlueDental Choice Q and QF Plans	Plans offered and administered by FCL	Current BlueDental Choice PPO Fee Schedule		Variable by plan. Frequency limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(888) 223-4892
BlueDental Copayment Q and QF Plans	Plan offered and administered by FCL	Current BlueDental Choice Copayment FeeSchedule for General and Specialty Care		Variable by plan. Frequency limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(888) 223-4892
BlueOptions Health and Dental (an integrated PPO health and dental plan for individuals and families)	Plan offered By Florida Blue and administered by FCL	Current BlueDental Choice PPO Fee Schedule		$750 Frequency limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148

Plan Name	Administration	Reimbursement	Copayments	Plan-Year Maximum	Electronic Claims Payor ID	Claim Address	Customer Service Contact Numbers
Federal Employee Program (FEP)	Program offered by the Federal Government and administered by Florida Blue	Current FEP Dental Fee Schedule	Copayments are listed for Standard Option under column titled: "Member Pays Provider." Basic Option members only pay a $35 copayment for all covered services rendered during any one evaluation	Frequency limitations apply to some services	00590	FEP Dental PO Box 1798 Jacksonville, FL 32231-0014	(800) 333-2227
FEP Dental	Program offered by the Federal Government and administered by FEP Dental	Current BlueDental Choice Fee Schedule		Program offeredby the Federal Government and administered by The Blue Cross Blue Shield Association partnered with the GRID Dental Corporation		See members ID cardfor address information	(855) 504-2583
GRID/GRID+	Program offeredby the Federal Government and administered by the national GRID	Current BlueDental Choice Fee Schedule		Program offered by the Federal Government and administered by The Blue Cross Blue Shield Association partnered with the GRID Dental Corporation		See members ID card foraddress information	(855) 504-2583
BlueOptions	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations applyto some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148 (866) 445-5148
BlueSelect	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations applyto some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	
BlueCare HMO	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
Blue Options Hospital Surgical Plus	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule or maximum of $50/visit	Current BlueDental Choice fee schedule less payment by FCL	Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
Miami-DadeBlue	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule or maximum of $50/visit	Current BlueDental Choice fee schedule less payment by FCL	Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
FHCP Pediatric Essential Dental Plan	Plan offered by Florida Health Care Plans and administered by FCL	Current Blue Dental Choice Fee Schedule		Frequency limitationsapplyto some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148

Plan Name	Administration	Reimbursement	Copayments	Plan-Year Maximum	Electronic Claims Payor ID	Claim Address	Customer Service Contact Numbers
Florida Blue BlueSelect "P" Plans	Plans offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
Florida Blue BlueSelect "V" Plans	Plans offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
Florida Blue BlueOptions "P" Plans	Plans offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
Florida Blue BlueOptions "V" Plans	Plans offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
Florida Blue BlueCare "P" Plans	Plans offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
myBlue	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
SimplyBlue	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
Truli for Health HMO	Plan offered by Florida Blue and administered by FCL	Current BlueDental Choice Fee Schedule		Frequency limitations apply to some services	76031	FCL-Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148
BlueDental Care Prepaid Plans*	Plans offered by FCL and administered by Comp Benefits	Current Fee Schedules for: P210, P220, PI210, PS220, FI315, FS295, FS305, FD305, FD310	Copayments are listed on the BlueDental Care Fee Schedules	These plans are non-claim based plans administered by Comp Benefits	N/A	N/A	(877)325-3979
BlueMedicare Classic HMO **BlueMedicare Classic PLUS HMO** **BlueMedicare Saver HMO** **BlueMedicare Premier HMO** **BlueMedicare Select PPO** **BlueMedicare Value PPO** **BlueMedicare Patriot** **Blue Medicare HMO Complete DSNP**	Plan offered by Florida Blue, FHCP and administered by FCL	Limited Benefits Current Medicare Advantage Fee Schedule for General Dentists or Specialists	Copayments apply to some covered services	Frequency limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866)445-5148

Plan Name	Administration	Reimbursement	Copayments	Plan-Year Maximum	Electronic Claims Payor ID	Claim Address	Customer Service Contact Numbers
Blue Medicare Group PPO (EGWP) **BlueMedicare PPO Employer** **FHCP Medicare Premier Plus (HMO)** **FHCP Medicare Flagler Advantage (HMO)** **FHCP Medicare Premier Advantage (HMO)**	Plan offered by Florida Blue, FHCP and administered by FCL	Limited Benefits Current Medicare Advantage Fee Schedule for General Dentists or Specialists	Copayments apply to some covered services	Frequency limitations apply to some services	76031	FCL- Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866)445-5148

FCL Preferred Provider Organization (PPO) BlueDental Choice Plans

BlueDental Choice PPO plans provide access to a large network of general dentists and specialists who have agreed to provide services at negotiated rates. The PPO plans also offer routinecleanings and other preventive services at little or no cost to the member, in addition to a wide range of basic and major services for which the member's out-of-pocket expense is limited to an annual deductible and affordable coinsurance up to the Benefit year maximum. Members also have the option of using non-participating providers at a higher level of out-of-pocket cost.

Annual Maximum: Your patient's coverage is limited to an annual maximum selectedby his or her employer. When patients exhaust their annual maximum, as well as any additional maximum rollover benefit that may have been accumulated, they are responsible for payment up to the maximum allowable charge (contracted fee) for anycovered service. Annual maximums vary by plan; however, there are a select few thathave no maximum.

Benefits and Service Exclusions*:* Services, procedures or supplies not Necessary and Appropriate; services or procedures not prescribed or rendered by a dentist; services or supplies collectible under Workers' Compensation or any law providing benefits for dependents of military personnel; services for conditions for which treatment is provided by federal or state government or are provided without cost; intentional self-inflicted injuries; accidental injuries; injuries or diseases caused by war; cosmetic services; prescription drugs; local or block anesthesia when billed separately; experimental or investigational services; services provided by an immediate relative. Any services not covered by the Member's benefit plan.

Calendar Year Rollover*:* Benefits for calendar year rollover are available in some plans.This benefit rewards members who practice good dental care by allowing them to roll over a portion of their unused benefits from year to year. To be eligible, members must:

- Have received at least one covered service during the benefit period,
- Have been an active member of the plan on the last day of the benefit period, and
- Have not exceeded the claims payment threshold, determined by theirbenefit plan, in the calendar year.

Deductible Amount: Your patient's plan may include an annual deductible.Deductibles are limited to each individual patient, not to exceed the overall family deductible if applicable.

Dependent Care Coverage*:* Dependent children are covered through the end of the calendar year in which they turn age twenty-six (26) or thirty (30) - may vary by group. Dependents aging off a policy may continue their coverage by completing a new FCL application within thirty (30) days of becoming ineligible for coverage under their existing policy. At that time, the policy holder will be credited for any satisfied waiting periods and will begin a new benefit year; however, credit will not be given for a satisfied deductible.

Implant Coverage: Benefits for endosteal dental implants, abutments and implant/abutment-supported crowns are available in some plans.

Lifetime Maximum: Orthodontic coverage typically has a lifetime maximum. Services for orthodontics are excluded from the basic annual maximum (see the CDT Dental Procedure Guidelines and Submission Requirements for more information about orthodontic claim submission).

Waiting Periods: Some FCL plans contain waiting periods prior to certain services being covered. Once the waiting period is satisfied, those services are payable, subject to all other terms, conditions, exclusions, and limitations of the policy.

We recommend that you submit a predetermination of benefits for FCL members to determine if they have this benefit, as it may change the remaining total amount of members' annual maximums and reduce their out-of-pocket expenses.

Coverage for these benefits is subject to our dental policy, which includes limitations and guidelines related to; Time (frequency of performance), Age (specified age qualifications), Utilization guideline policies and Requirements for consultant review for necessity and appropriateness of care.

Benefits, policies, and conditions may not apply to the Federal Employee Program (FEP).

Benefits, policies, and conditions may not apply when dental services are embedded into FloridaBlue (Florida Blue) health plans.

Section 10: Member Identification (ID)

Every member is issued a Member Identification Card (ID card). Some may have a card specific to dental services with a dental claim mailing address and Dental Customer Service number on the back of the card. Others may present a medical ID card for a plan that may or may not have embedded dental benefits.

Key Steps to Member Identification`

We recommend following these key steps:

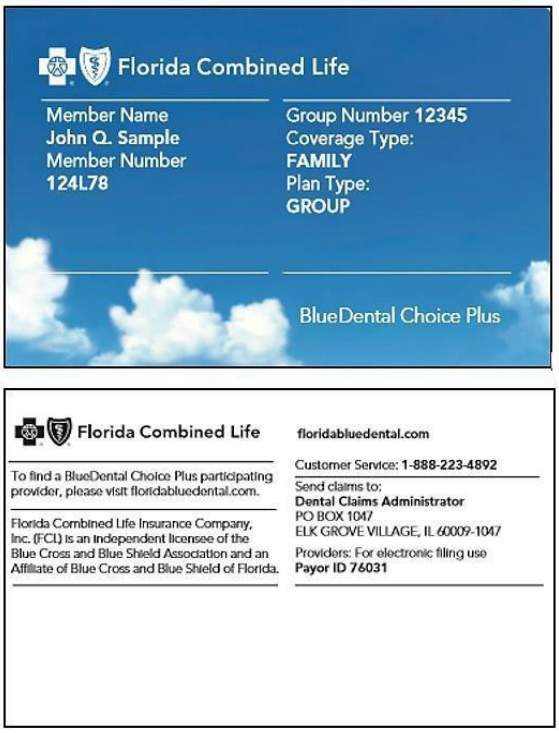
- Check the ID card for pertinent information.
- Verify the member number, group number, etc.
- Refer to the back of the card to find where to submit dental claims (to ensure timely claims processing, be sure to send your dental claims to the correct address).
- Contact Customer Service on the back of the card if the member presents with a medical card to ensure dental benefits are available and to verify the dental claim mailing address.

If a member does not have their card, it is best to ask them to contact their employerfor group insurance information; or the agent who sold them the plan for individual insurance information.

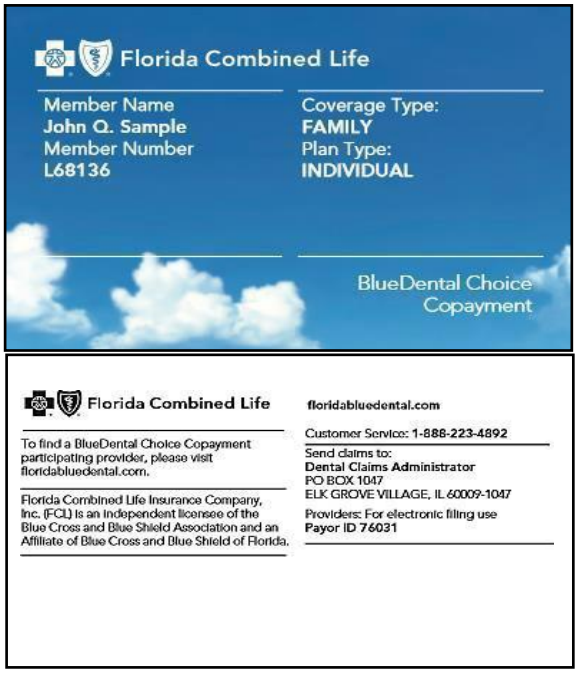
Examples of Member ID card

BlueDental Choice PPO

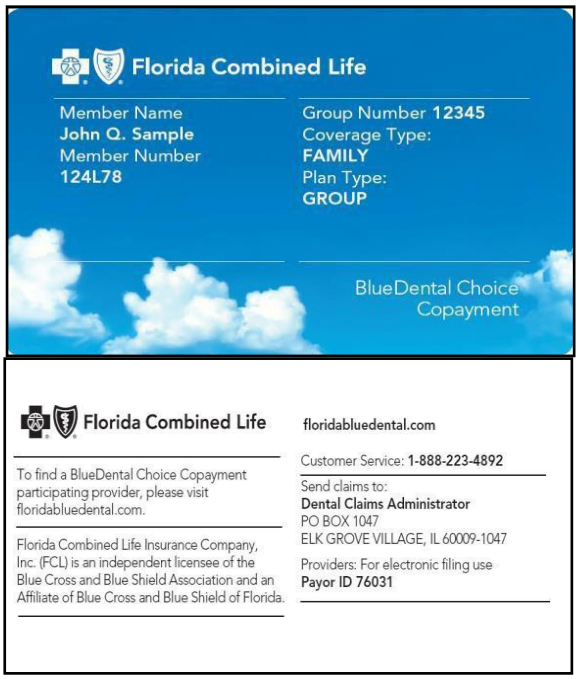
BlueDental Choice Plus PPO



BlueDental Choice Copayment Individual



BlueDental Choice Copayment Group



BlueOptions – Integrated Health and Dental

Section 11: Health Care Reform Plans Offered by FCL and Florida Blue

Under the Patient Protection and Affordable Care Act (ACA), certain plans must cover "essential health benefits" (EHBs). Each state is required to use an existing health plan as a benchmark for the benefits that must be included in the ACA-compliant plans that are sold on the Marketplace. The Federal employee Dental Vision Insurance Plan (FEDVIP) is the benchmark plan in Florida. The pediatric dental benefits that are included in that plan are considered EHBs in Florida. Beginning January 1, 2014, Florida Combined Life (FCL) will be offering new ACA-compliant dental plans. In addition, we will be administering the dental component of the health plans with embedded dental benefits that are being offered by our affiliate, Florida Blue. The level of benefits is different for each plan and the plans do not all cover the same procedures/codes. The dental benefits offered and administered by FCL are available for purchase by individuals and small group employers both on the Marketplace, and off the Marketplace as stand- alone dental plans.

Stand-Alone Dental Plans offered and administered by Florida Combined Life:

BlueDental Choice Q Plans: Members choosing these plans will utilize FCL's BlueDental Choice Network of providers (PPO) Preferred Provider Organization.

- **BlueDental Choice Q Plans** are available as stand-alone plans with pediatric benefits only.
- **BlueDental Choice Q Plans** claims will be paid according to the BlueDental Choice schedule of allowances for in-network providers.
- **BlueDental Choice Q Plans** members have access to a national network of participating providers.

BlueDental Choice QF Plans: Members choosing these plans will utilize FCL's BlueDental Choice network of providers, (PPO) Preferred Provider Organization.

- **BlueDental Choice QF Plans** are available as stand-alone plans with pediatric and adult benefits.
- **BlueDental Choice QF Plans** claims will be paid according to the BlueDentalChoice schedule of allowances for in-network providers.
- **BlueDental Choice QF Plans** members have access to a national network of participatingproviders.

BlueDental Copayment Q Plans: Members choosing these plans will utilize FCL's BlueDental Copayment network of providers, (PPO) Preferred Provider Organization.

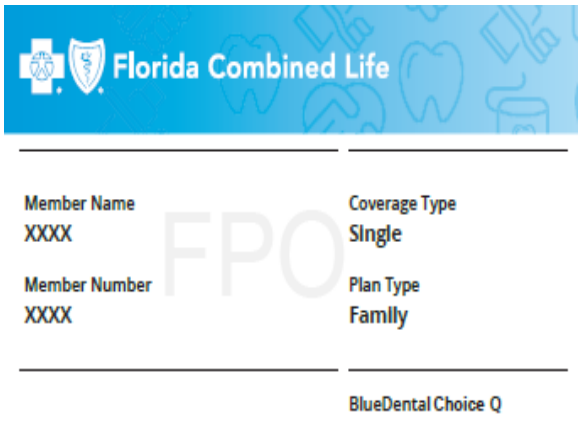
- **BlueDental Copayment Q Plans** are available as stand-alone plans with pediatric benefits only.
- **BlueDental Copayment Q Plans** claims will be paid according to the BlueDentalCopayment schedule of allowances for in-network providers.
- **BlueDental Copayment Q Plans** members must utilize a participating FCL providerwithin the state of Florida.

BlueDental Copayment QF Plans: Members choosing these plans will utilize FCL'sBlueDental Copayment network of providers, (PPO) Preferred Provider Organization.

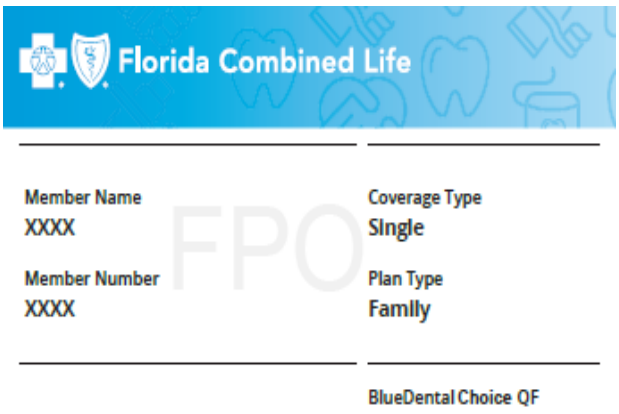
- **BlueDental Copayment QF Plans** are available as stand-alone plans with pediatricand adult benefits.
- **BlueDental Copayment QF Plans** claims will be paid according to the BlueDentalCopayment schedule of allowances for in-network providers.
- **BlueDental Copayment QF Plans** members must utilize a participating FCL provider within the state of Florida.

Examples of Stand-Alone Dental Plans Member ID cards

BlueDental Choice Q Plans

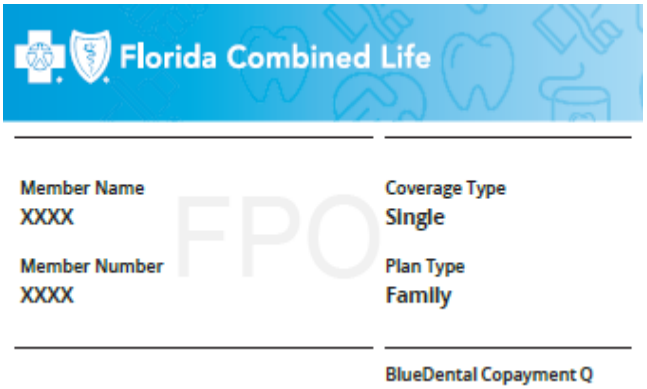


BlueDental Choice QF Plans

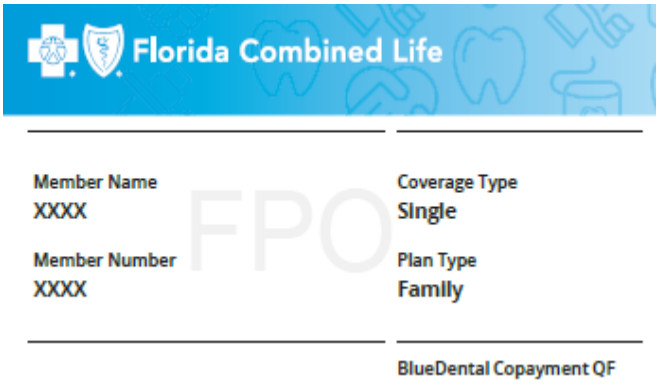


Examples of Stand-Alone Dental Plans Member ID cards cont.

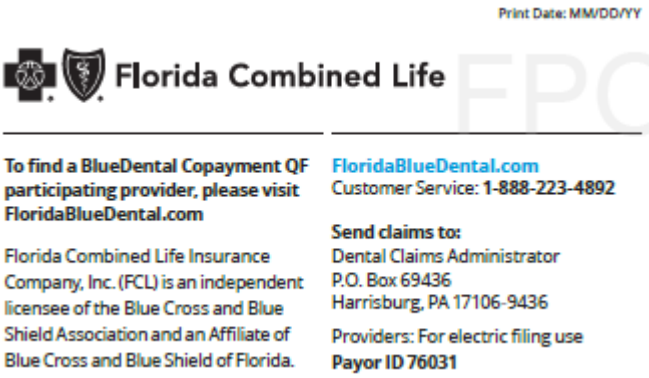
BlueDental Copayment Q Plans



BlueDental Copayment QF Plans



Back of ID cards



Plans with embedded dental benefits that are offered by Florida Blue and administered by Florida Combined Life:

BlueOptions Plans: Florida Blue Medical plans (**BlueOptions, myBlue and SimplyBlue**) with embedded dental benefits. Members choosing these plans will utilize FCL's BlueDental Choice network of providers. Benefits are available only when care is rendered by participating dental providers, (EPO) Exclusive Provider Organization.

- **BlueOptions** has plans with embedded pediatric benefits only and plans with embedded pediatric and adult benefits.
- **BlueOptions** claim payments are based on the BlueDental Choice schedule of allowances.
- **BlueOptions** is marketed statewide.
- **BlueOptions** allows out-of-state coverage for emergency treatment only if the member is more than a 100-mile radius from an EPO provider. Maximum payment for emergency treatment is $100.00.

BlueSelect Plans: Florida Blue Medical plans with embedded dental benefits. Members choosing these plans will utilize FCL's BlueDental Choice network of providers. Benefits are available only when care is rendered by participating dental providers, (EPO) Exclusive Provider Organization.

- **BlueSelect** has plans with embedded pediatric benefits only and plans with embedded pediatric and adult benefits.
- **BlueSelect** claim payments are based on the BlueDental Choice schedule of allowances.
- **BlueSelect** allows out-of-state coverage for emergency treatment only if the member is more than a 100-mile radius from an EPO provider. Maximum payment for emergency treatment is $100.00.

BlueCare Plans: Florida Blue Medical plans with embedded *pediatric* dental benefits. Members choosing these plans will utilize FCL's BlueDental Choice network of providers. Benefits are available only when care is rendered by participating dental providers, (EPO) Exclusive Provider Organization.

- **BlueCare** has plans with embedded pediatric benefits only and is available to pediatric Members ages 0 through the end of the month in which they attain age nineteen (19).
- **BlueCare** is not available for adults.
- **BlueCare** claim payments are based on the BlueDental Choice schedule of allowances.
- **BlueCare** allows out-of-state coverage for emergency treatment only if the member is more than a one hundred (100) mile radius from an EPO provider. Maximum payment for emergency treatment is $100.00.

Truli for Health Plans: Florida Blue HMO Medical plans with embedded *pediatric* dental benefits. Members choosing these plans will utilize FCL's BlueDental Choice network of providers. Benefits are available only when care is rendered by participating dental providers, (EPO) Exclusive Provider Organization.

- **Truli for Health** has plans with embedded pediatric benefits only and is available to pediatric members' ages 0 through the end of the month in which they attain age nineteen (19).
- **Truli for Health** claim payments are based on the BlueDental Choice schedule of allowances.

- **Truli for Health** is available in the following counties: Broward, Palm Beach, Martin, SaintLucie, Indian River, Orange, Osceola, and Seminole.

Pediatric Essential Dental Plan: Florida Health Care Medical Plan with embedded pediatric dental benefits. Members choosing this plan will utilize FCL's BlueDental Choice network of providers. Benefits are available only when care is rendered by participating dental providers.

- **Pediatric Essential Dental Plan** has plans with embedded pediatric benefits only and is available to pediatric members' ages 0 through the end of the month in which they attain age nineteen (19).
- **Pediatric Essential Dental Plan** is not available for adults.
- **Pediatric Essential Dental Plan** claim payments are based on the BlueDental Choice schedule of allowances.
- **Pediatric Essential Dental Plan** allows emergency coverage limited to palliative care only if the member is more than a one hundred (100) mile radius from a participating provider. Maximum payment for emergency treatment is $100.00.

Please note:

Not all procedure codes are covered under all plans. The HCR plans will allow coverage for some codes that the standard plans will not and vice versa. As a result of these varying plan designs, we strongly recommend that you verify the member's eligibility and benefits prior to rendering services. Orthodontic and implant services for the HCR plans will be covered only when medically necessary as determined by FCL and require preauthorization. Maximum payment for emergency treatment is $100.00.

Medically necessary Orthodontic services: This benefit is available to pediatric patients only. To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip.Treatment must be rendered by an orthodontist and prior authorization and approval is required beforeservices are rendered. Claim review is conducted by a licensed dentist who will review the clinical documentation submitted by the treating dentist.

Medically necessary Implant services: This benefit is available to pediatric patients only. To qualifyfor medically necessary implant services, it must be demonstrated that the patient's arch cannot be restored with a standard prosthesis or restoration, removable or fixed; or that the patient is unable tofunction in speech and mastication without a prosthesis or restoration. Prior authorization and approval are required before services are rendered. Claim review is conducted by a licensed dentist who will review the clinical documentation submitted by the treating dentist.

In addition to the traditional CDT Guide, FCL has developed a separate *HCR CDT Guide* to assist dental practices in understanding procedural and claim submission requirements for these plans. This guide will clarify which codes are covered for each plan, and outline the limitations, exclusions, and integral considerations for each procedure. Please visit Providers | Florida Blue Dental, to access online services 24/7. Eligibility and benefits for all members of these HCR plans can be verified online or by contacting Dental Customer Service at **(866) 445-5148.**

Pediatric Dental Benefits Administered by FCL Through its BlueDental Provider Network

Essential health benefits include pediatric dental benefits for children ages 0 through the end of the month in which they attain age nineteen (19), with a maximum out-of-pocket cost share of $375 for a family with one (1) child and $750 for families with two (2) or more children. Pediatric dental benefits include:

Service Type	Includes These Services	Coverage Percentage
Preventive and diagnostic services	Oral exams, radiographic images, and routine dental care	100%
Basic restorative services	Fillings, root canals, crowns, periodontal care, oralsurgery, and dental prosthetic maintenance	80%
Major restorative services	Tooth replacement	50%

Check Eligibility and Benefits

These benefits became available only to individuals and small group plan participants beginning Jan 1, 2014, and for existing accounts, upon renewal based upon the account's anniversary date. Therefore, it is important to verify eligibility and benefits before delivering services. To check eligibility and benefits:

Access MyDentalCoverage 24/7 at Providers | Florida Blue Dental, then "Access Online Services" or call Dental Customer Service at **(866) 445-5148** or the Customer Service number on the back of themember's ID card.

Member Benefits: Because some EHBs are included in the member's medical plan, those members willhave a Florida Blue medical ID card. Members who have EHB dental benefits through FCL's BlueDental plans will have a FCL BlueDental ID card.

Maximums: The member's dental benefit maximums do not apply to services processed under the member's medical benefit. The member will have a separate maximum out-of-pocket (MOOP) benefit forpediatric dental benefits. Once this is met, coverage for eligible pediatric dental services will not require a deductible, co-insurance, or copayment.

Participating Dentists: You must be a participating dentist with FCL's BlueDental Choice PPO network to provide dental EHBs under the member's Florida Blue medical plan. Some FCL EHB plans will utilize the BlueDental Copayment network. (See Plans that are Offered and Administeredby FCL).

Reimbursement: We will reimburse FCL BlueDental participating dentists for pediatric or adult dentalEHBs at the lesser of your submitted fee or the maximum allowable charge under the applicable BlueDental Choice or Copayment fee schedule, minus the member's medical deductible, copayment, or co-insurance.

Medical cost-share: When you provide services for these EHB plans, you must collect the member's cost- share (if applicable) to receive your entire reimbursement. The member's cost share may be a copayment (a fixed dollar amount), co-insurance (a percentage of the cost), or deductible (a first-dollar amount).

Eligibility and Benefits: To check eligibility and benefits, and determine the member's cost-share, please utilize the online services available through MyDentalCoverage or call the CustomerService number listed on the back of the member's ID card.

When verifying eligibility online, Exclude the First 3 letters of the patient's ID.

Medically necessary Orthodontia or Implant services: Prior authorization and approval will be required for medically necessary orthodontia (these services must be furnished by an orthodontist) and implant services. Please visit our website at HCR CDT GUIDE and access the current *HCR CDT Guide* fora listing of orthodontic and implant services that are covered only when prior authorization is requested and approved.

Claim submission: You must submit all claims for services either electronically or by paper using the most current ADA dental claim form and the member's medical/dental ID number.

Prior authorization:

To request prior authorization for orthodontia or implant services:

1. Verify that the orthodontic or implant procedure code for the service you will be performing is listed among the eligible services for your patient's plan by going to our website at Plans and documents | Florida Blue Dental.
2. Complete the most current version of the ADA Dental Claim Form as if you were submitting an actual claim for services. Do not enter a date of service on the claim.
3. Submit a narrative stating the necessity and appropriateness for orthodontia or implant services. Include any radiographic images, models, or consultant's reports. Remember to include self-addressed, postage-paid packaging if you want this information returned to you.
4. Enter an "X" in Box 1 of the claim form next to "Request for Predetermination/Preauthorization". List the services to be included in the prior authorization.
5. Send the prior authorization request electronically using our **Payor ID 76031**. Paper authorization requests can be sent to:

FCL – Dental
P.O. Box 69436
Harrisburg, PA 17106-9436

Questions?

If you have any questions, please call Dental Customer Service **(866) 445-5148** or email your FCL Provider Network Manager at For general questions, email our team at Dental Provider Relations.

Plan information for HCR plans

The following charts will provide you with an overview of plan and benefit information for these HCR plans.However, it is recommended that you verify each member's eligibility and benefits prior to rendering treatment.

Plan Name	Administration	Schedule of Benefits	Electronic Claims Payor ID	Claim Address	Customer Service Number	Network	Member Limitations
Florida Combined Life BlueDental Choice Q Plan	Plan offered and administered by Florida Combined Life	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148	BlueDental Choice PPO	Pediatric only age 0through the end of the month in which they attain age 19.
Florida Combined Life BlueDental Choice QF	Plan offered and administered by Florida Combined Life	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148	BlueDental Choice PPO	Adult and Pediatricbenefits
Florida Combined Life BlueDental Copayment Q Plan	Plan offered and administered by Florida Combined Life	BlueDental Copayment PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148	BlueDental Copayment PPO	Pediatric only age 0 Through the end of the month in which they attain age 19.
Florida Combined Life BlueDental Copayment QFPlan	Plan offered and administered by Florida Combined Life	BlueDental Copayment PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148	BlueDental Copayment PPO	Adult and Pediatricbenefits
Florida Blue BlueSelect "P" Plans	Plan offered by Florida Blue and administered by FCL	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148	BlueDental Choice PPO	Pediatric only age 0through the end of the month in which they attain age 19.
Florida Blue BlueSelect "V" Plans	Plan offered by Florida Blue and administered by FCL	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148	BlueDental Choice PPO	Adult and Pediatricbenefits
Florida Blue BlueOptions "V" Plans	Plan offered by Florida Blue and administered by FCL	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA17106-9436	(866)445-5148	BlueDental Choice PPO	Adult and Pediatricbenefits
Florida Blue BlueCare "P"Plans	Plan offered by Florida Blue and administered by FCL	BlueDental Choice PPO	76031	FCL – DentalP.O. Box1047 Harrisburg, PA17106-9436	(866)445-5148	BlueDental Choice PPO	Pediatric only age 0 through the end ofthemonth in which they attain age nineteen (19).
FHCP Pediatric Essential DentalPlan	Plan offered by Florida Health Care Plans and administered by FCL	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA17106-9436	(866)445-5148	BlueDental Choice PPO	Pediatric only age 0 through the end of themonth in which they attain nineteen (19).
myBlue	Plan offered by Florida Blue and administered by FCL	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA17106-9436	(866)445-5148	BlueDental Choice PPO	Pediatric only age 0 through the end of the month inwhich they attain nineteen (19).
SimplyBlue	Plan offered by Florida Blue and administered by FCL	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA17106-9436	(866)445-5148	BlueDental Choice PPO	Pediatric only age 0 through the end ofthemonth in which they attain nineteen (19).
Truli for Health	Plan offered by Florida Blue and administered by FCL	BlueDental Choice PPO	76031	FCL – Dental P.O. Box 69436 Harrisburg, PA17106-9436	(866)445-5148	BlueDental Choice PPO	Pediatric only age 0 through the end of themonth in which they attain nineteen (19).

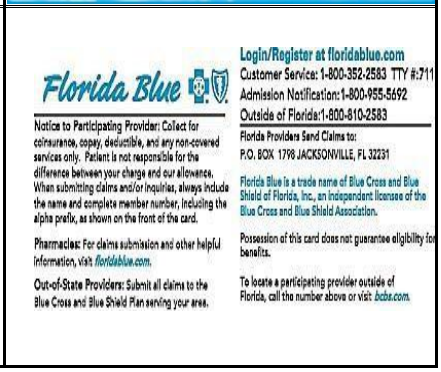
Sample Benefit information for HCR plans

Plan Name	Florida BlueSelect BlueOptionsBlueCare myBlue SimplyBlue Truli for Health	Florida BlueSelect BlueOptions		FCL BlueDental Choice Q		FCL BlueDental Choice QF		FCL BlueDental Copayment Q		FCL BlueDental Copayment QF	
Coverage	Pediatric	Pediatric	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric	Adult
Product	EPO	EPO		PPO		PPO		PPO		PPO	
Deductible	$0	$0	$50	$50 Basic	n/a	$50 Basic	$50 Basic	$50 Basic	n/a	$50 Basic	$50 Basic
Preventive	100%	100%	100%	100%	Not Covered	100%		Copay	Not Covered	Copay	
Basic	100%	100%	80%	80%	Not Covered	80%		Copay	Not Covered	Copay	
Major	100% Implants subject to Medical Necessity	100% Implants subject to Medical Necessity	50% Implants Not Covered	50% Implants Not Covered	Not Covered	Implants are covered for pediatric patients only andare subject to Medical Necessity		Implants subject to Medical Necessity	Not Covered	Implants are covered for pediatric patients only and are subject toMedicalNecessity	
Ortho	100% Medical Necessary Only	100% Medical Necessary Only	Not Covered	50% Medically Necessary Only	Not Covered	50% Medically Necessary Only	Not Covered	Copay Medically Necessary Only	Not Covered	Copay Medically Necessary Only	Not Covered
Waiting Periods	None	None	n/a	None	n/a	None	Six(6) Months Basic Six (6) Months Major	None	n/a	None	Six (6) Months Basic Six (6) Months Major
Max	None	None	$1000	one	$0	None	$1000	None	None	None	$1000
OOP Max	n/a	n/a	Unlimited	$375Child/ $750 Max	n/a	$375Child/ $750 Max	Unlimited	$375 Child/ $750 Max	n/a	$375Child/ $750 Max	Unlimited
Availability	Marketplace Only	Both on and off marketplace		Both on and off marketplace		Both on and off marketplace		Both on and off marketplace		Both on and off marketplace	
Rollover	No	No	No	No	n/a	n/a	No	No	n/a	No	Yes

Sample Cards

BlueCare

BlueOptions



BlueSelect

myBlue

Simply Blue **Truli for Health**

The Essential Health Benefit Plans FAQs

Q: How does Health Care Reform (HCR) affect dental providers?

A: Effective Jan 1, 2014, for individuals, and upon small groups' renewal dates, Florida Combined Life (FCL) and Florida Blue (FB) will offer plans that include coverage for pediatric dental benefits (Essential Health Benefits or EHBs) for children ages 0 through eighteen (18). Members may purchase stand-alone dental plans offered by FCL or health planswith these embedded dental benefits from FB.

Pediatric dental benefits for children ages 0 through eighteen (18) will include:

Type 1 services: Preventive and diagnostic services, including oral exams, x-rays, and routine dental care.

Type 2 services: Basic restorative service, including fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance.

Type 3 services: Major restorative services, including tooth replacement crowns, and occlusal guards. Medically necessary implant services that have been prior-authorized and approved for qualified members.

To qualify for medically necessary implant services, it must be demonstrated that the patient's arch cannot be restored with a standard prosthesis or restoration, removable or fixed, or that the patient is unable to function in speech and mastication without a prosthesis or restoration. Medically necessary orthodontic services that have been prior-authorized and approved for qualified members. To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip. An orthodontist must render treatment.

For pediatric dental services incurred on or after Jan 1, 2014, the member must present their dentist with the applicable dental or medical ID card.

Q: How are posterior composites handled?

A: Most FCL dental plans cover posterior composites. However, because HCR plans are modeled after the FEDVIP plan in Florida, those plans only cover amalgam restorations. Since many providers no longer use amalgam for posterior restorations, a determination was made to cover posterior composites as an alternate benefit. This enables participating providers to charge the member the difference between their UCR fee for a posterior composite and the allowance for the amalgam filling in addition to any applicable copayment or coinsurance. Claims for posterior composites should be filed using the applicable posterior composite code and the claim will process based upon the allowance for the posterior amalgam. If you choose to perform an amalgam restoration for a patient under age nineteen (19), that service is paid in full under HCR pediatric dental plans.

Q: How do pediatric dental benefits covered under a member's essential Health Benefits differ from traditional dental benefits covered under a dental insurance plan?

A: There are several significant differences between dental insurance benefits and the pediatric dental benefits covered under a member's medical plan:

1. **Maximum Out-of-Pocket.** Pediatric dental benefits covered under the member's medical plan include an annual in- network out-of-pocket maximum (the most a member could pay during the plan year for covered in- network services.) The in-network out-of-pocket maximum is $375.00 per member under age nineteen (19) and $750.00 for two (2) or more members under age nineteen (19) enrolled under the same family plan.
2. **Medically necessary Orthodontic services.** To qualify for medically necessary orthodontic services, treatment must result from congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip. Only orthodontists are allowed to perform EHB orthodontic services. A prior authorization must be requested and approved.
3. **Medically necessary Implant services.** To qualify for medically necessary implant services, it must be demonstrated that the child's arch cannot be restored with a standard prosthesis or restoration, removable or fixed; or that the child is unable to function in speech and mastication without a prosthesis or restoration. A prior authorization must be requested and approved.
4. **Participating Dentists.** The pediatric dental benefits embedded in the Florida Blue medical plans use dentists participating with Florida Combined Life through the **BlueDental Choice PPO** network. In Florida, embedded dental benefits included in the Florida Medical plans are payable only when covered services are rendered by a participating dentist.

The stand-alone dental plans offered by FCL that include pediatric dental benefits use either the **BlueDental Choice PPO** or **BlueDental Choice Copayment** networks.

Q: What will the ID cards look like for members with EHBs?

A: FCL members who have pediatric dental benefits will have an FCL dental ID card. Florida Blue members who have medical plans with embedded dental benefits will have a Florida Blue medical ID card. Copies of the ID cards are included in this manual.

Q: How can I determine whether my patient has pediatric dental Benefits?

A: There are two (2) options for checking your patient's benefits:

Verify benefits online at MyDentalCoverage once registered you can:

- Obtain fee schedules
- Verify benefits and eligibility

- Check frequency limitations, deductibles and plan maximums met to date
- Check claims status

Q: How will I be reimbursed for services to members who have EHB coverage?

A: Claims for both the stand-alone dental plans offered by FCL, and dental claims for the Florida Blue medical plans will be processed by FCL's Dental Claims Administrator. Reimbursement is based upon the lesser of the dentist's billed charges, or the applicable FCL BlueDental fee schedule.

Please continue to submit your dental claims as you do today–for example, submit claims electronically using FCL's **Payor ID 76031** or mail your dental claims to the following address:

FCL – Dental
P.O. Box 69436
Harrisburg, PA 17106-9436

Q: I am an orthodontist. What do I need to know about providing medically necessary orthodontic services?

A: To qualify for the medically necessary orthodontic services, a child must have a severe and handicapping malocclusion or misalignment of teeth. Only orthodontists are allowed to perform EHB orthodontic services. Prior authorization is required before the services are rendered.

Medically necessary orthodontic services rendered without obtaining a prior authorization approval may not be covered.

Q: What orthodontic codes require prior authorization?

A: The following codes are the only orthodontic services covered under the EHB plans and they all require prior authorization:

D8070	Comprehensive orthodontic treatment of the transitional dentition – once per lifetime
D8080	Comprehensive orthodontic treatment of the adolescent dentition – once per lifetime
D8210	Removable appliance therapy
D8660	Pre-orthodontic treatment visit
D8670	Periodic orthodontic treatment visit (as part of contract)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Q: What do I need to know about providing medically necessary implant services?

A: To qualify for medically necessary implant services, it must be demonstrated that the child's arch cannot be restored with a standard prosthesis or restoration, removable or fixed; or that the child is unable to function in speechand mastication without a prosthesis or restoration. Prior authorization is required before services are rendered. Medically necessary implant services rendered without obtaining a prior authorization approval may not be covered.

Q: What implant codes require prior authorization?

A: All implant codes, including implant bodies, abutments, crowns, etc., require prior authorization. Please refer to the current *HCR CDT Guide* located on our website at HCR CDT GUIDE for a complete listing of codes.

Q: What is the process for requesting a prior authorization for orthodontic and implant services?

A: 1. Submit the services requested on the most current version of the ADA dental claim form.

2. Include the appropriate documentation for review e.g., pre-treatment claim form, x-rays, study models, and photographs for orthodontic cases.

3. When your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization.

4. Send the prior authorization request electronically, if possible. Paper prior authorization requests should be mailed to:

   FCL – Dental
   P.O. Box 69436
   Harrisburg, PA 17106-9436

All prior authorization requests will be reviewed for appropriateness and medical necessity. Prior authorized services will not be approved for payment until they are determined to meet the guidelines for coverage. Any required priorauthorized service that does not have a prior authorization in FCL's claim system will be denied and NO insurancepayment will be made. Please provide a self-addressed, postage paid envelope or packaging if you would like your x-ray, study models or other documentation returned.

Q: Who is responsible for payment if prior authorization is not obtained?

A: The member is held liable if prior authorization is not obtained or approved.

Medical Plans with Limited Dental Benefits Offered by Florida Blue

Florida Combined Life (FCL) currently administers the dental component of the medical plans with embedded dental benefits offered by our affiliate. Your participation in the FCL BlueDental Choice PPOnetwork allows you the opportunity to provide services to members of the Florida Blue plans listed below.The maximum per visit reimbursement and level of covered services is different for each plan. Please log on to Providers | Florida Blue Dental and click Online Servicesfor eligibility and benefits for these members. If you do not have internet access, contact Dental Customer Service at **(866) 445-5148**.

Plans with embedded dental benefits offered by Florida Blue and administered by Florida Combined Life (FCL):

Miami-Dade Blue: Florida Blue Medical plans with embedded dental benefits. Allowances calculated utilizing the current FCL BlueDental Choice PPO fee schedule. Maximum reimbursement by FCL per visits $50.

BlueOptions Hospital Surgical Plus: Florida Blue Medical plans with embedded dental benefits. Allowances calculated utilizing the current FCL BlueDental Choice PPO fee schedule. Maximum reimbursement by FCL per visit is $50.

BlueSelect: **Hospital Surgical Plus**: Florida Blue Medical plans with embedded dental benefits. Allowances calculated utilizing the FCL BlueDental Choice PPO fee schedule. Maximum reimbursement by FCL per visits $50.

Limited Dental Plan Benefits

Plan	Administration	Reimbursement	Copayments	Electronic Claims Payor ID	Claim Address	Customer Service Contact Numbers
Miami-Dade Blue Blue Options Hospital Surgical Plus BlueSelect Hospital Surgical Plus	Plans offered byFlorida Blue and administered by FCL	Current BlueDental Choicefee schedule or maximum of $50/visit	Current BlueDental Choice fee schedule less payment by FCL	76031	FCL Dental P.O. Box 69436 Harrisburg, PA 17106-9436	(866) 445-5148

Service Category	CDT Code	Standard Benefits	Miami-Dade Blue BlueOptions Hospital Surgical Plus Blue Select Hospital Surgical Plus
Oral Evaluation*	D0120	Two (2) per Benefit Period	✓
Prophylaxis Adult*	D1110	Two (2) per Benefit Period	✓
Prophylaxis Child*	D1120	Two (2) per Benefit Period	✓
Topical Fluoride Varnish*	D1206	Two (2) times per Benefit Period Dependent Children under fourteen (14) years of age	✓
Topical Fluoride Treatment*	D1208	Two (2) times per Benefit Period Dependent Children under fourteen (14) years of age	✓
Intraoral Periapical radiograph	D0220	Subject to clinical necessity. Not to exceed six (6) films, total, per date of service	✓
Bitewing Two Radiographic Images*	D0272	Once per Benefit Period	✓
Bitewing Four Radiographic Images*	D0274	Once per Benefit Period	✓
Complete Full mouth radiographs or Panoramic radiographs*	D0210 D0330	Once in any thirty-six (36) consecutive month period. AdditionalCoverage of Panoramic radiograph for Removal of third molarsby different Dentist and date of service.	✓
Sealants*	D1351	Dependent Children through age 16 first and second molarsprimary teeth; bicuspids and molars permanent teeth	✓
Space Maintainer*	D1510	Dependent Children under age fourteen (14)	✓
Amalgam One (1) surface Primary/Permanent*	D2140	Payable on the same tooth surface paid once per benefit period	✓
Amalgam Two (2) surface Primary/Permanent*	D2150	Payable on the same tooth surface paid once per benefit period	✓
Amalgam Three (3) surface Primary/Permanent*	D2160	Payable on the same tooth surface paid once per benefit period	✓
Amalgam Four (4) surface Primary/Permanent*	D2161	Payable on the same tooth surface paid once per benefit period	✓
Resin One (1) surface Anterior*	D2330	Payable on the same tooth surface paid once per benefit period	✓
Resin Two (2) surface Anterior*	D2331	Payable on the same tooth surface paid once per benefit period	✓
Resin Three (3) surface Anterior*	D2332	Payable on the same tooth surface paid once per benefit period	✓
Resin Four (4) or more surfaces including Incisal angle Anterior*	D2335	Payable on the same tooth surface paid once per benefit period	✓
Resin One (1) surface Posterior primary/Permanent*	D2391	Payable on the same tooth surface paid once per benefit period	✓
Resin Two (2) surface Posterior primary/Permanent*	D2392	Payable on the same tooth surface paid once per benefit period	✓
Resin Three (3) surface Posterior primary/Permanent*	D2393	Payable on the same tooth surface paid once per benefit period	✓
Resin Four (4) or more surfaces Posterior Primary/Permanent*	D2394	Payable on the same tooth surface paid once per benefit period	✓
Denture Repair*Mandibular	D5611		✓
Denture Repair*Maxillary	D5612		✓
Tissue Conditioning Maxillary (upper)*	D5850	Two (2) times in a Benefit Period	✓
Tissue Conditioning Mandibular	D5851	Two (2) times in a Benefit Period	✓
Denture Adjustment Maxillary (upper)*	D5410	Two (2) times per Benefit Period (six [6] months after the initial insertion of the denture)	✓
Denture Adjustment Mandibular (lower)*	D5411	Two (2) times per Benefit Period (six [6] months after the initial insertion of the denture)	✓
Reline Complete Maxillary (upper) denture (laboratory)*	D5750	Limited to Immediate Dentures, not more than one relining or rebasing in any thirty-six [36] consecutive month period	✓
Reline Complete Mandibular (lower) denture (laboratory)*	D5751	Limited to Immediate Dentures, not more than one relining or rebasing in any thirty-six [36] consecutive month period	✓
Routine Extraction*	D7140	One (1) per tooth per lifetime	✓
Surgical Removal of erupted tooth*	D7210	One (1) per tooth per lifetime	✓
Alveoloplasty per quadrant*	D7310	Subject to clinical necessity, no frequency limitations, can belimited to one (1) per lifetime	✓
Surgical Removal of Maxillary (upper)or Mandibular (lower) intrabony cysts*	D7450	Not Covered	✓
Palliative (emergency) Treatment*	D9110	Subject to clinical necessity, no frequency limitations	✓
General Anesthesia*	D9223	General anesthesia and intravenous sedation are a Covered Dental Service only if given in connection with covered dentalsurgical procedures.	✓

Maximum Payment Amount of $50 per visit for covered Dental Services or the maximum allowable charge whichever is lower. Subscriber is responsible for the difference up to the allowable amount.

Reimbursement

Reimbursement for these plans is based upon the FCL BlueDental Choice fee schedule. However, depending upon the plan the member chooses payment by FCL is limited to a maximum of $50 or $75 per visit. The member is responsible for any difference between the fee schedule allowance and FCL's payment. You may bill your usual and customary charge for any non-covered service (procedure codes not listed or shown as non-covered on the previous chart). The charts below show examples of how reimbursement under these plans is impacted by the maximum payment per visit. The fee schedule examples are based upon the current FCL BlueDentalChoice area 1 fee schedule allowances.

Example 1: The Member was billed only for a periodic oral evaluation. Since the fee schedule allowance of $30 is less than the maximum allowance of $50 or $75/visit, FCL pays $30, and the Member has no additional liability.

Procedure Code	Allowed Amount	Member Co-Insurance	Amount Paid to Provider
D0120	$30	$0	$27

Example 2: The Member was billed for a periodic oral evaluation, four (4) bitewings, and a prophylaxis. Since the maximum payment allowance of $50 or $75/per visit is less than the combined total of the fee schedule allowances for these three (3) codes ($135), FCL pays $50 or $75, and the Member is responsible for balance, up to the maximum fee schedule allowance(s).

Procedure Code	Allowed Amount	Member Co-Insurance	Amount Paid to Provider
D0120	$30		
D0274	$39		
D1110	$66		
Total	**$135**	**$85 or $60**	**$50 or $75**

Sample Cards

Section 12: Blue Medicare Advantage Plans

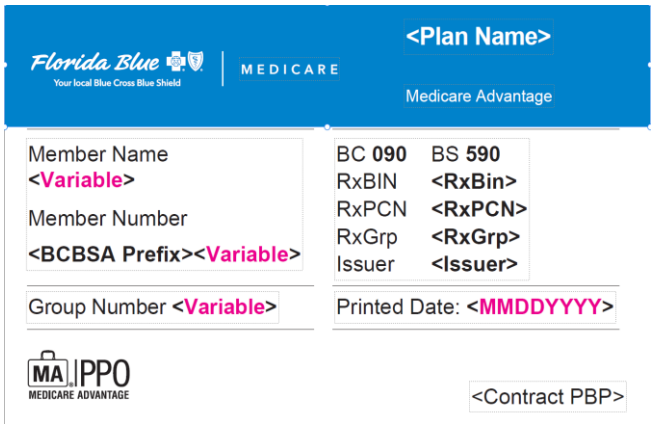
Offered By Florida Blue

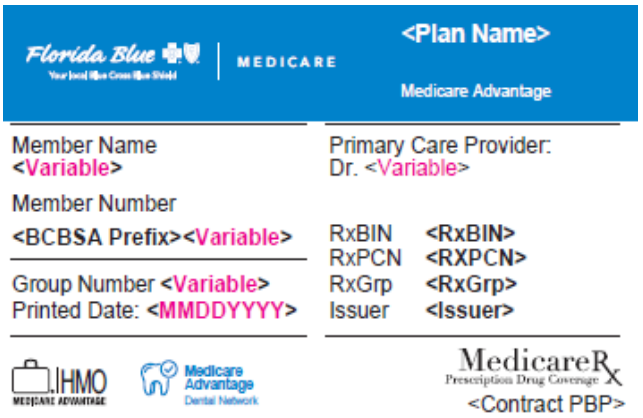
Most of these plans cover a limited number of services, but those procedures that are covered have a $0 member copayment in-network, with the balance of the allowable charge payable by FCL. Select plans have a 50% - member copayment for out-of-network benefits. Any service not covered by the member's plan may be billed at your Usual and Customary Charge. This does not include procedures that would otherwise be covered but are denied due to frequency limitations having been met. **For services not covered by the plan, please notify the members before services are rendered.**

Please be sure to verify eligibility and benefits for all members before rendering services or creating treatment plans.

The diagrams below list the Plan Id's covered procedures, copayments, and limitations for the various BlueMedicare plans. Below are samples of ID Cards.

Sample Medicare Advantage PPO/HMO Medical Member ID cards





Eligibility and Benefits, please visit the MyDentalCoverage provider portal, or contact Dental Customer Service at **(866) 445-5148**

Claims mailing address:

FCL - Dental
P.O. Box 69436
Harrisburg, PA 17106-9436

Please be sure to verify eligibility and benefits for all Medicare Advantage members before rendering services, frequencies and limitations vary plan to plan. The diagram below is an **example** of covered procedures, copayments and limitations on one of the various FloridaBlue Medicare plans.

Sample Medicare Advantage Plans

Dental Plans	HMO 10/10F PPO 10	PPO 69	HMO 67	HMO 63	HMO 62
Product & BID IDs	**Classic HMO (HMO 10):** All H1035-017 H1035-019 H1035-020 H1035-021 **FHCP (HMO 10F):** Rx Plus, Premier Advantage H1035-002 H1035-040 **Patriot PPO (PPO 10):** All H5434-038 H5434-040 H5434-041 H5434-042 H5434-044 H5434-046 **Select PPO (PPO 10)**: All H5434-002 H5434-045 **Blue Medicare Group PPO (EGWP) (PPO 10):** H5434-801 H5434-802	**Value PPO**: All H5434-023 H5434-024 H5434-025 H5434-026 H5434-030 H5434-031 H5434-034 H5434-035 H5434-036	**Premier HMO**: Brevard, Charlotte, Collier, Hernando, Lee, Manatee, Pinellas, Sarasota, St. Lucie H1035-034 H1035-045 H1035-048	**Premier HMO:** Clay, Duval, Orange, Osceola H1035-026 H1035-033	**Premier HMO:** Broward H1035-025
Member Cost	$0				
Preventive					
Exam	2 per calendar year				
Cleaning	2 per calendar year				
X-Ray	1 set per calendar year				
Comprehensive					
Fluoride Treatment	--	1 per calendar year	1 per calendar year	1 per calendar year	2 per calendar year
Extraction	1 per calendar year Simple Only	2 per calendar year Simple & Surgical	2 per calendar year Simple & Surgical	3 per calendar year Simple & Surgical	8 per calendar year Simple & Surgical
Crown	--	1 per calendar year (only in conjunction w/ a covered root canal procedure)	1 per calendar year (only in conjunction w/ a covered root canal procedure)	2 per calendar year	4 per calendar year
Filling	--	1 per calendar year	2 per calendar year	2 per calendar year	8 per calendar year
Root Canal	--	1 per calendar year	1 per calendar year	1 per calendar year	4 per calendar year
Denture *(complete or partial)*	--	1 set per 60-month period	1 set per 60-month period	1 set per 60-month period	1 set per 60-month period
Denture Adjustment	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Denture Repair		1 per calendar year	1 per calendar year	1 per calendar year	2 per calendar year
Deep Cleaning / Root Planing	--	1 per quadrant per 36-month period	1 per quadrant per 36-month period	1 per quadrant per 36-month period	1 per quadrant per 24-month period
Full Mouth Debridement	--	--	1 per 36-month period	1 per 36-month period	1 per 36-month period

Medicare Advantage Plans offered by FHCP

Effective Jan 1, 2025, Health Options, Inc., DBA FHCP Medicare will be offering the following plans for its members to choose from during the open enrollment period.

- FHCP Medicare Premier Advantage (HMO)
- FHCP Medicare Rx Plus (HMO)

These plans cover a limited number of services, but those procedures that are covered have a $0 member copayment in-network, with the balance of the allowable charge payable by FCL. Any service not covered by the member's plan may be billed at your usual and customary charge. This does not include procedures that would otherwise be covered but are denied due to frequency limitations having been met. **For services not covered by the plan, please notify the members before services are rendered.**

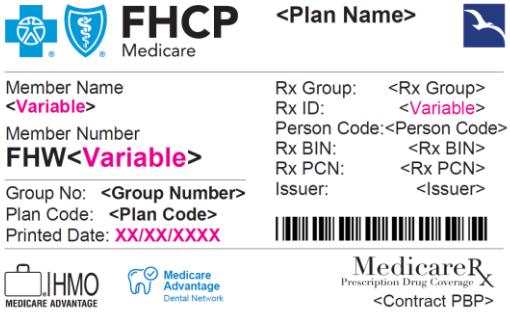
Please be sure to verify eligibility and benefits for all members before rendering services.

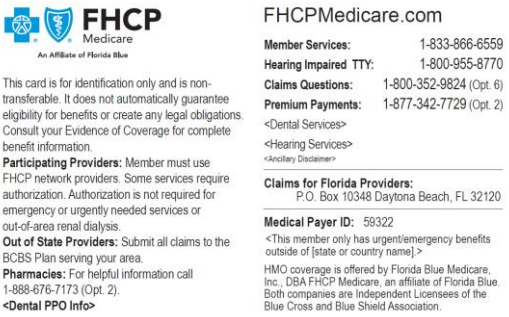
The diagrams below list the plan id's covered procedures, copayments and limitations for the Advantage plans. Below are samples of ID Cards.

For Eligibility, benefits and claims information please visit our website at Providers | Florida Blue Dental to access Online services on MyDentalCoverage or contact Dental Customer Service at **(866) 445-5148**.

Claims can be files electronically using **Payor ID 76031** or mail claims to the address listed below.

FCL - Dental
P.O. Box 69436
Harrisburg, PA 17106-9436





Section 13: Verifying Member Eligibility, Benefits and Claim Status Member Information (For FEP see Section 20)

To obtain patient eligibility, benefits, claims status, maximums, deductibles, service history, allowance information, procedure code information and orthodontic information via:

- **Dental Customer Service:** You may reach us at **(866) 445-5148**. Please have the patient's name, ID number and date of birth ready when you call.

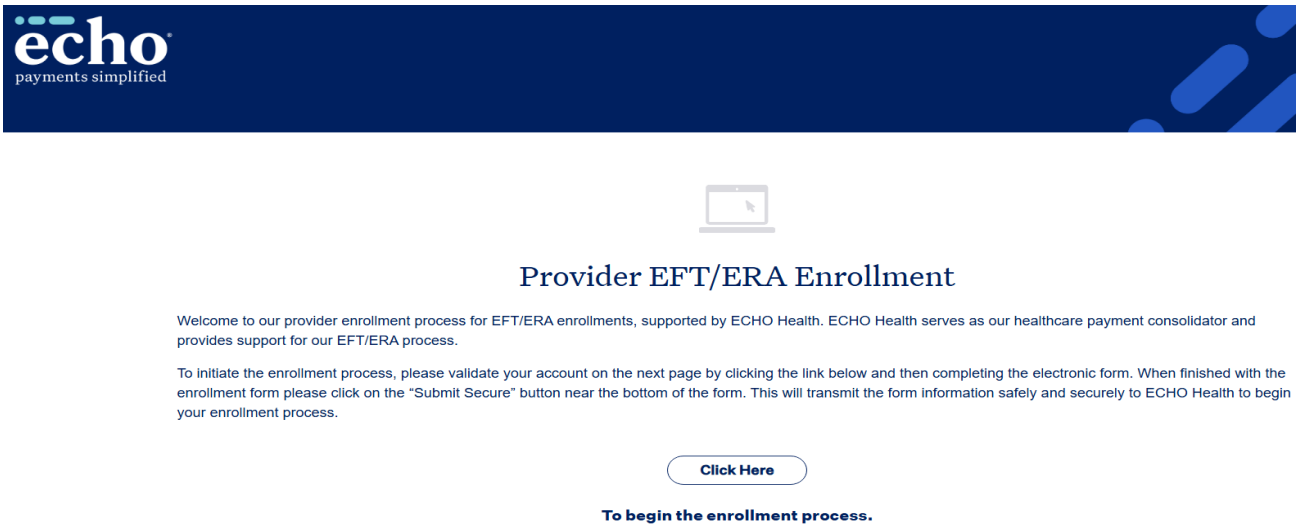
- **Interactive Voice Response (IVR) System:** Our Dental Customer Service IVR System offers dentists and most subscribers access to information stored in records and the capability of finalizing predeterminations for payment via the telephone. This automated system responds to a touch-tone telephone or voice commands and provides an immediate response. **You can choose to listen to the information or, in most instances, request the information by fax or mail**. The IVR system is available to respond to your inquiries 24/7, except when our databases are undergoing scheduled maintenance.

- **Our website:** Providers can access member information through the Providers tab on our website, Florida Blue Dental by registering for MyDentalCoverage to obtain immediate, up-to-the-minute member information 24/7. This online tool gives you the ability to check eligibility and benefits, patient history,and claims reimbursement, while easily handling pre-authorization, electronic funds transfer (EFT), and electronic claim filing.

Electronic Funds Transfer

Florida Combined Life has engaged PNC Healthcare to provide electronic payment methods via the Claim Payments & Remittances (CPR) service, powered by **ECHO Health**.

To enroll for EFT through ECHO**, please visit:** ECHO Health**.**



Confidentiality of Patient Information

The Privacy Rule enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has strengthened the protections already in place at FCL to safeguard our members' protected health information (PHI). Since the Privacy Rule applies to payors and providers, FCL shares with you the responsibility of protecting privacy.

The HIPAA Privacy Rule allows for FCL to share PHI with other parties without members authorization under certain circumstances, including when we have a business relationship with the third party and to the extent, we need to share the information to support treatment, payment, or healthcare operations, as defined bythe Privacy Rule. If you have questions about the Privacy Rule, seek advice from your attorney or business counselor.

We are sensitive to concerns about confidentiality and will take every precaution to protect the privacy of your patients' dental records, including validating your provider information when you call us. As your Agreement with FCL/LSV states,we may require access to or copies of members' dental records. Our members' subscriber certificates and benefit descriptions advise members of our right to assess and handle their records to support treatment, payment, and healthcare operations.

Section 14: FCL Predeterminations and Clean Claims

Download the most current ADA claim form at www.adacatalog.org. To order a hard copy,contact your dental office supplier or software administrator, or call the ADA at **(800)947-4746**.

Predeterminations

Overview

A predetermination is a written request by a provider for verification of benefits prior to rendering services. This request helps us determine how we will process a claim based on a member's benefits. A predetermination is not a guarantee of payment, but is designed to determine:

- If a service is covered under the member's plan
- If the procedure meets our utilization review guidelines and dental policy
- If any time limitations apply on a procedure
- The projected estimated payment for the procedure

Although not required, we recommend you submit a predetermination for prosthetics and crowns, inlay/onlay restorations and periodontal services totalingmore than $500 in allowable expenses.

We process a predetermination as if it were an actual claim and respond via apre- treatment estimate. You and the member will be notified of all approvals and denials.

How to Submit a Predetermination

Complete the most current version of the ADA Dental Claim Form as if you were submitting an actual claim for services. **Do not enter a date of service on the claim.** Remember to:

- Enter an X in Box 1 of the claim form next to "Request forPredetermination /Preauthorization."
- List only the services to be included in the predetermination.
- Send the predetermination electronically, if possible, to **Payor ID 76031**

FCL – Dental
P.O. Box 69436
Harrisburg, PA 17106-9436

Completing a Dental Claim Form

How to submit a Clean Claim

Please follow the instructions below to complete the most current *ADA DentalClaim Form*, which can be found on the ADA website. A sample form follows these instructions.

Header Information (blocks 1 and 2)

1: Enter an X in the appropriate box to indicate if this claim is a pre- treatment estimate or a claim for actual services rendered.

2: Predetermination/Preauthorization Number is not required.

Insurance Company/Dental Benefit Plan Information (block 3)

FCL – Dental P.O. Box 69436 Harrisburg, PA 17106-9436	Federal Employee Program FEP Dental P.O. Box 1798 Jacksonville, FL 32231-0014

Other Coverage (blocks 4-11) refers to the possible existence of other medical or dental insurance policies, relevant for coordination of benefits

Policyholder/Subscriber Information (blocks 12-17) documents information about the insured person (subscriber), who may or may notbe the patient

Patient Information (blocks 18-23) refers to the patient receiving services or treatment

Record of Services provided (blocks 24-35) regards the treatment performed or proposed. For a predetermination of benefits, complete this area in the same way as for an actual service, but omit the date of service.Ten lines are available for reporting.

Authorizations (blocks 36 and 37) where the patient or subscriber signs to provide consent for treatment and authorization for direct payment

Ancillary Claim/Treatment Information (blocks 38-47) asks for additional information regarding the claim and the member's prior dental history. Some of these questions may be left blank if the service is not orthodontic or prosthetic.

Please be sure to check the appropriate blocks if treatment is renderedas the result of an accident.

Billing Dentist or Dental Entity (blocks 48-52A) provides information on the dentist or group/corporation responsible for billing and receiving payment, which may or may not be the treating dentist. Block 49 is specific to reporting the associated National Provider Identifier (NPI).

Treating Dentist and Treatment Location Information (blocks 53-58) asks for information specific to the provider. Block 54 asks for the treatingdentist's NPI. To obtain an NPI, visit the Centers for Medicare & Medicaid Services' National Plan and Provider Enumeration System (NPPES) website at NPPES NPI Registry. **All claims must be submitted with your NPI information.**

Billing with a National Provider Identifier (NPI) See Section 6 of this manual for more details.
• If you have a Type 1 NPI (Sole Proprietor), submit your claim using the Type 1 NPI in block 49 and block 54. • If you have a Type 2 NPI (Professional Corporation, Limited Liability Corporation or Incorporated–PA, PC, LLC or INC), submit your claim using the Type 2 NPI in block 49 and the rendering provider's NPI Type 1 in block 54.

Sample ADA Dental Claim Form

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐M ☐F ☐U
8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐M ☐F ☐U
15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐M ☐F ☐U
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( )
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code
57. Phone Number ( )
58. Additional Provider ID

Type 2 NPI of Group/Corporation or Type 1 NPI of Sole Proprietor

Type 1 NPI of Treating Dentist

Section 15: Coordination of Benefits (COB)

Determining the Primary Payor

The first of the following rules applicable shall be used by FCL todetermine the primary Payor.

1. The plan that covers the person as an employee or member, other thanas a dependent, is determined to be primary before the dental plan thatcovers the person as a dependent.

However, if the person is also a Medicare beneficiary, Medicare is secondary to the dental plan covering the person as a dependent of an active employee. The order in which dental benefits are payable will be determined asfollows:

- Dental benefits of a plan that covers a person as an employee, member, or subscriber
- Dental benefits of a plan of an active employee that covers a person as a dependent
- Medicare benefits

2. When two (2) or more dental plans cover the same child as a dependent of different parents:

- The dental benefits of the plan of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the dental plan of the parent whose birthday, excluding the year of birth, falls later in the year; but
- If both parents have the same birthday, the dental benefits of the planthat has covered the parent for the longest are determined before those of the plan that has covered the parent for the shorter period of time.

However, if one of the plans does not have a provision that is based on the birthday of the parent, but instead on the gender and this results in each plandetermining its benefits before the other, the plan that does not have a provision based on a birthday will determine the order of dental benefits.

3. Divorced or separated parents, dental benefits for the childare determined in this order: If two or more dental plans cover a dependent child of

- The plan of the parent with custody of the child
- The plan of the spouse of the parent with custody of the child
- The plan of the parent not having custody of the child

However, if the specific terms of a court decree make one parent financially responsible for the dental care expenses of the child, and if the entity obliged to payor provide the dental benefits of the dental plan of that parent has actual knowledge of those terms, the dental benefits of that plan are determined first. This does not apply with respect to any claim determination period or dental plan year during which any dental benefits are actually paid or provided before that entity has the actual knowledge.

4. The dental benefits of a dental plan that covers a person as an employee other than as a laid-off or retired employee, or as a dependent of such a person, are determined before those of a dental plan that covers that person as a laid-off or retired employee or as a dependent of such a person.If the other dental plan is not subject to this rule, and if, as a result, the dental plans do not agree on the order of dental benefits, this paragraph shall not apply.

5. If an individual is covered under a COBRA continuation plan and also under another group dental plan, the following order ofbenefits applies:

    - The dental plan which covers the person as anemployee or as the employee's dependent
    - The coverage purchased under the dental plan covering theperson as a former employee, or as the former employee'sdependent provided according to the provisions of COBRA

If none of the above rules determines the order of dental benefits, the dental benefits of the plan that has covered the employee, member or insured the longest period of time are determined before those of the other dental plan.

Coordination of Benefits shall not be permitted against the following types of policies:

- Indemnity
- Excess insurance
- Specified illness or accident
- Medicare supplement

Determining Your Patient's Liability in a COB Situation

1. If the FCL Plan is the Secondary Plan in accordance with the order of benefits determination rules outlined above, the benefits of the Plan will bereduced when the sum of:
    - The benefits that would be payable for the allowable expense under the FCL Plan in the absence of this COB provision; and

    - The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like thatof this COB provision, whether a claim is made, exceeds those Allowable Expenses in a claim determination period. In that case, the benefits of the FCL plan will be reduced so that its benefits and the benefits payable under the other plans do not total more than those Allowable Expenses.

2. When the benefits of the FCL Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the FCL Plan.

Helpful Tips

In situations where you believe your patient may be covered by more than one payor, the following hints may help you manage the claim more efficiently:

- Determine your patient's primary payor and submit the claim to that payor first.
- Submit the primary payor's Explanation of Benefits (EOB) to the secondary payor (even if both payors are FCL Plans.)
- Always calculate your patient's liability by claim line rather than by using the total claim payment amount, waiting until all insurance payments have been made.
- Remember that the secondary payor's EOB may not correctly reflect the patient's balance and that your patient's liability may be affected by contracts that you hold with the primary carrier.

Section 16: Reimbursement Overview

FCL will always reimburse claim payments for covered members directly to the participating provider. If an unassigned claim is submitted on behalf of the member, we will still pay the claim directly to the participating dentist. Please verify the member's eligibility and benefits prior to rendering services as a waiting period may be applicable.

In accordance with the FCL Dental PPO Fee Schedule, participating dentistsagree to accept as payment in full, the lesser of either their regular charges or the Maximum Allowable Charge for dental services provided under the applicable dental program, less any applicable member cost-share, such as a deductible, co- insurance, or copayments. **You may not bill your patient for the difference between our Maximum Allowable Charge amount and your actual charge.**

Services That Are Not Covered

Some services are not covered regardless of whether the procedure is listed as a covered benefit. These are considered contractual limitations and are outlined in the Subscriber Certificate or Guide to Benefits under "Limitations and Exclusions." Examples include a service performed for cosmetic purposes rather than for tooth decay or fracture, or an exploratory service.

Prior to rendering Non-Covered Service(s) you need to inform the Member and obtain the Member's written acknowledgment that he or she has been informed of thenature of the service, why it is not a covered benefit, and that the Member is personally and financially liable for payment of the Non-Covered Service(s). Amounts due for the Non-Covered Service(s) may then be billed to theMember at the Dentist's usual and customary charge(s).

Here is an **example** of how we calculate the member's cost-share for a non-covered service:

Procedure Code	Your Charge	Coverage Level	Allowed Amount	Member Cost-share
D0460	$50	0%	$0	$50

Co-insurance is a type of member cost-share representing a percentage of theallowed amount for covered services. If the member's dental plan covers a procedure at less than 100%, the member is responsible for the difference between what we pay and the Maximum Allowable Charge, as shown in this example:

Procedure Code	Benefit Type	Coverage Level	Allowed Amount	Member's Co-insurance
D2150	Basic	80%	$100	$100 x 20% = $20

The member's Co-insurance is based on a percentage of your FCL Maximum Allowable Charge Schedule and the member's benefit structure. The member is responsible for all Non-Covered Services. You can collect the member's Co-insurance at the time of the visit or bill the member after you receive payment from us.

Deductibles

The deductible applies to only Basic and Major services and does not apply to Preventive and Orthodontic services. The deductibles restart each benefit year and there are no carry overs of the amounts of the deductibles from the prior year to satisfy the deductible requirement in the new benefit year. The claims filing process will be the same. The only difference will be that when Basic and Major services are incurred, the patient will be responsible for the first $25 (or $75 Family Maximum Deductible) of eligible charges before benefits begin.

The following chart contains example eligible charges; they are for illustrationpurposes only and may not be the exact dollar amounts.

Patient	Type of Service	Eligible Charge	Deductible Amount	Net Eligible Charge	Plan Benefit (70% of Net Eligible Charge)	Member Coinsurance (30%)	Member Pays
Subscriber	Crown D2750	$807	$25	$782	$574.40	$207.60	$232.25
Spouse	Crown D2750	$807	$25	$782	$574.40	$207.60	$232.25
Child 1	Crown D2750	$807	$25	$782	$574.40	$207.60	$232.25
Child 2	Filling D2393	$174	$0	$174	$121.80	$52.20	$52.20

- Deductible amounts may vary by plan. In the **example** above Child 2 is not subject to the $25 deductible because the Family Maximum Deductible of $75 has been met. This illustration is based upon services being rendered by a participating provider.

Common Reasons for Non-Payment

To familiarize yourself with FCL reimbursement requirements, please refer to the list below of messages commonly found on dental remittances to explain non-payment (See example of remittance on next page):

- No payment can be made. The reported procedure is covered once in a three (3) year period. Benefits have been provided previously for a similar service within this time period.
- No payment can be made. The patient's coverage does not provide for this service.
- No payment can be made. The reported service is covered twice in a contract year period.
- No payment can be made. The maximum benefit amount available under thepatient's coverage has been paid.
- No payment can be made. An incomplete dental claim has been received in our office.Please submit a dental claim form with the tooth number(s) for the procedure(s) reported, include x-ray(s), periodontal charting and any narrative if required.
- This patient cannot be identified from the identification number reported above.Please verify the name and number shown on the ID card. If the patient is covered, please resubmit the claim.
- No payment can be made. This service is subject to a waiting period as requiredunder the patient's coverage.
- The maximum allowance for bitewing radiographic images has been paid.
- No payment can be made. The patient's coverage has a missing tooth clause.

If you have questions about your remittance, please call Dental Customer Service at **(866) 445-5148**
Monday through Friday from 8:00 a.m. to 8:00 p.m. EST.

Retroactive Claim Denials

FCL does not request claim payment refunds for claims paid when an enrollee's termination date is adjusted retroactively unless the enrollee is terminating coveragewith FCL and enrolling in a dental plan with a new issuer. In all other circumstances,once a termination date is placed on an enrollee's membership record, claims are processed or denied based on that date moving forward.

However, if an enrollee terminates coverage with FCL and enrolls with a new dental plan issueron the Marketplace, FCL will request a refund from the provider for any claims paid after the retroactive termination date. The provider is responsible for refunding the member for payment of any cost shares.

Providers are responsible for billing the new issuer for any covered services incurred and paid after the retroactive enrollment date, and FCL instructs providers that they only collect the cost sharing for the covered service to reflect the enrollee's cost-sharing obligation for the service under the new issuer.

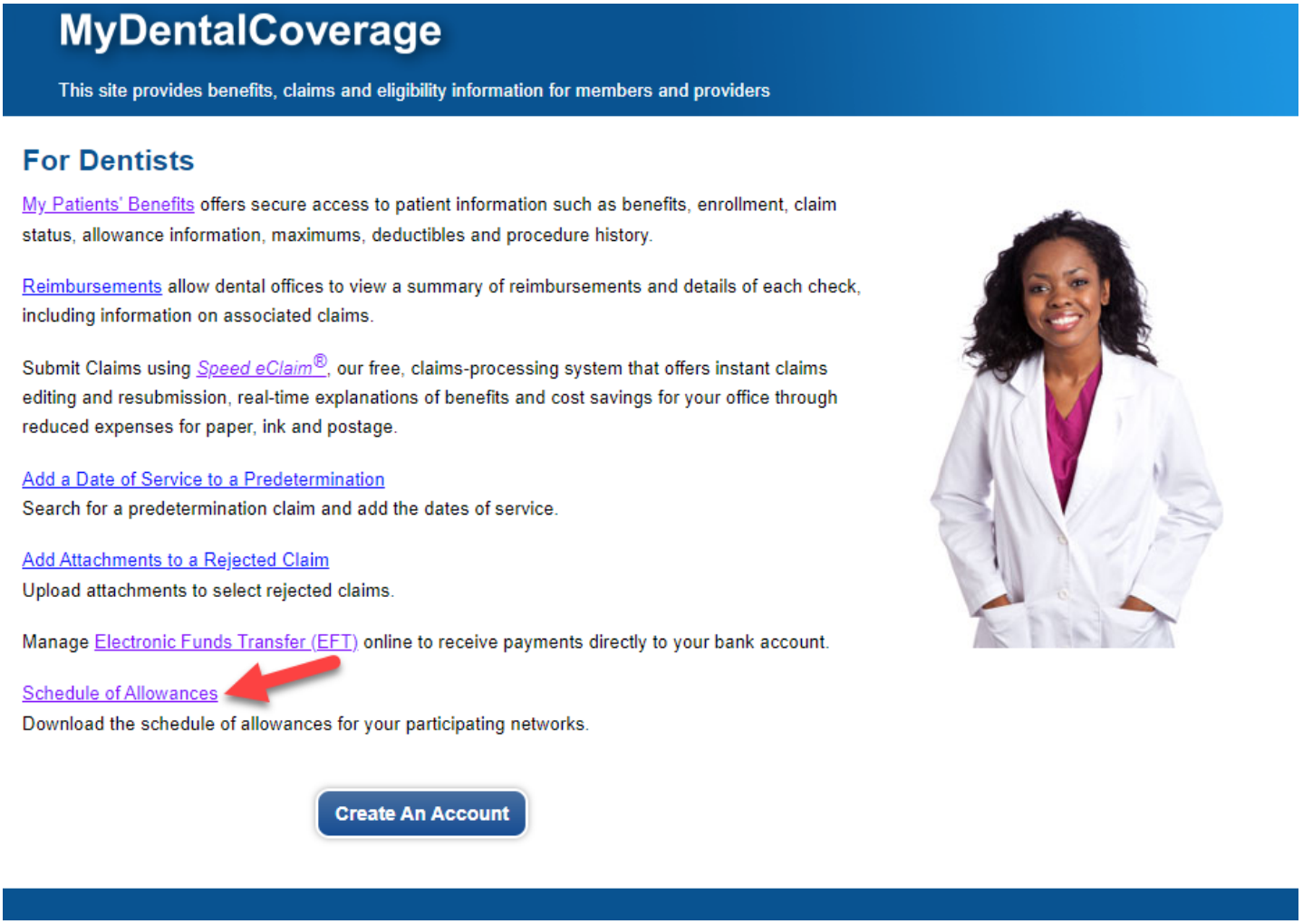
Such an adjustment may result in the enrollee owing the provider additional funds, dependingon the cost sharing and benefit structure of the new plan. FCL advises providers that any refund or credit for any excess cost sharing must be provided (or begin to be provided in the case of a credit) within **forty-five (45) calendar days** of the date of discovery of the excess cost sharing.

In the case of premium paid for or on behalf of the individual, any refund or credit for any premium paid for or on behalf of the individual will be provided (or begin to be provided in the case of a credit) by FCL within **forty-five 45 calendar days** of the date of discovery of the excess premium paid.

How to Obtain a Fee Schedule

Current-year fee schedules can be found at MyDentalCoverage. To access the fee schedules:

1. Select Schedule of Allowances
2. Login with username and password
3. Select desired network Fee Schedule
4. For FEP and FEP Dental/GRID+ fee Schedules, please email your Provider Network Manager at dentalproviderrealations@fclife.com



Disclaimer:
Some codes may be listed on the fee schedules that are not covered under a particular member's benefit plan. Verification of benefits is recommended to ensure coverage. You may bill your usual And customary charge for any service not covered by the member's plan; you will not be held to the scheduled allowance for those services.

If a service is covered by the member's plan but is denied due to waiting periods, or when frequency or plan maximums have been met, you will be held to the scheduled allowance for that service.

Sample Dental EOB

PROVIDER: Dr. Tooth DMD PA **TIN:XXXXX1232** **EPC Draft #: 199999999** **Provider ID:0012345678** **Date: 01/01/2054** **Page:1 of 1**

DATE(S) OF SVC	NUM OF SVCS	PL OF SVC	PROCEDURE CODE/ TOOTH NUMBERS/ SURFACES	PROVIDER CHARGE	ALLOWANCE	NON-CHARGE ABLE AMOUNT	NON-CHG CODE	SUBSCRIBER LIABILITY AMOUNT	SUB LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODE(S)
Claim Number: 24211111111			**Patient: JANE DOE**							**ID Number: M61111111**			
Patient Acct #: DNT1234567890										**Appl/Sub Name: JANE DOE**			
01/01/24	1	O	D0140	110.00	49.00	61.00	N01				49.00		J9751
01/01/24	1	O	D0220	42.00	20.00	22.00	N01				20.00		J9751
01/01/24	1	O	D0270	42.00	19.00	23.00	N01				19.00		J9751
01/01/24	1	O	D2940 18	182.00				182.00	H1				U9301 J9751
01/01/24	1	O	D4910	189.00				189.00	H1				A8282 J9751
			Claim Totals:			106.00		371.00		.00	88.00	.00	

Section 17: Handling Overpayment Requests

Occasionally, FCL may overpay a dental claim. Some reasons for overpayment include:

- Processing under an incorrect procedure code
- Paying a claim for a member who is not a patient of record with the provider's office
- Paying a claim without coordinating benefits

In these circumstances, we are required to correct the action and issue a Request for Refund (invoice) to you, which include information needed for you to refund to the Payor the overpayment.

This section does not apply to FEP overpayments. If you discover an **FEP overpayment**, please call Customer Service at **800-333-2227** Monday through Friday from 8:00 a.m. to 5:00p.m. EST

If You Receive a Request for Refund

If you receive a letter requesting a refund, please:

- Make a copy of the letter and include it with your refund.
- Make the check payable to Florida Combined Life
- To ensure prompt and accurate posting, send your payment within fifteen (15) days of receipt to:

  Cashier
  Customer Collection Services
  P.O. Box 69402
  Harrisburg, PA17106-9436

Please note: If payment is not received by the invoice due date, the Payor will collect the money by deducting the overpaid amount from future payments made to you by the Payor. This is called an offset. These payments may be deducted from different claims for claimants other than those who incurred the overpayment.

If You Discover an Overpayment

If you discover that FCL has overpaid you, please call Dental Customer Service at **(866) 445-5148** and provide the amount of the claim, the claim number, and the patient ID number. The representative will confirm the overpayment and, ifnecessary, have a Request for Refund mailed to your office. After that, you may do one of the following:

- Cash the check and wait for the Request for Refund letter, then follow the steps above for "If You Receive a Request for Refund."
- Return the check. To ensure we credit the refund to the appropriate account, we recommend that you wait for the Request for Refund letter to arrive and attach it to the check you are returning.

Section 18: Orthodontic Services

FCL offers orthodontic benefits through its PPO plans, to small and large group employers who elected to include orthodontic coverage in their benefit packages. Orthodontic treatment is covered under the orthodontic portion ofthe Member's benefit plan. Please refer to the current orthodontic case fees.

The health care reform pediatric benefits also include medically necessary orthodontics. These benefits require prior authorization, and approval is required before services are rendered. Please refer to the current orthodontic case fees.

Through its Value-Added Benefits, FCL also offers an Orthodontic Discount Program to members who utilize FCL's dental PPO networks but whose plansdo not include orthodontic coverage. This enables those members to receive a 20% discount off the provider's usual and customary case fees when utilizing an orthodontist who participates in this program.

Orthodontic Treatment Types

Review of the Members Orthodontic Benefits and TreatmentPlanning are essential to the timely and accurate payment ofclaims for Orthodontic Treatment.

Limited Orthodontic Treatment: Treatment with a limited objective, not involving the entire dentition. The following orthodontic treatment codes D8000-D8999 may be used more than once for the treatment of a particular patient depending on the particular circumstance. A patient may require more than one limited or comprehensive procedure due to their particular problems.

Example: Treatment in one arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge, implant, and partial treatment for closure of space(s).

Comprehensive Orthodontic Treatment: Multiple phases of treatment provided at various stages of dentofacial development.

Example: The use of an activator is generally staging one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two- stage treatment. Both should be listed as comprehensivetreatment modified by the appropriate stage of dental development.

FCL BlueDental Choice Plans with Orthodontic Benefits – Orthodontic Claim Submission Guidelines

Orthodontic treatment is covered under the orthodontic portion of the Member's benefit plan when all of the following conditions exist:

1. The patient has orthodontic coverage (and qualifies based upon eligibility at time of treatment).
2. The orthodontic treatment is for the correction of a malocclusion.
3. The orthodontic treatment involves appliance therapy.

Review of the Member's orthodontic benefits and treatment planning are essential to the timely and accurate payment of claims for Orthodontic treatment. Orthodontic treatment plans are based upon the type of dentition involved – transitional, adolescent or adult; as well as the treatment of a particular patient depending on circumstance:

Limited Orthodontic Treatment- treatment with a limited objective, not involving the entire dentition	
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
Comprehensive Orthodontic Treatment Phase II - multiple phases of treatment provided at various stages of dentofacial development	
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8091	Comprehensive orthodontic treatment associated with orthognathic surgery when additional surgical intervention is planned
Minor - treatment to control harmful habits	
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
Other Orthodontics Services	
D8660	Pre-orthodontic treatment visit
D8670	Periodic orthodontic treatment visit (as part of contract)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)

FCL BlueDental Choice Plans Claim Submission Guidelines and Payments for Orthodontic Services:

If you are billing:	Please include the following on your claim:	We will reimburse you:
Limited or Minor Treatment	Itemized claim for services rendered	One-time payment deducted frompatient's overall lifetime orthodontic maximum
Comprehensive Treatment (when patient's orthodontic benefits are in effect when treatment begins)	• Appropriate CDT procedure codes • Treatment start date/banding date • Total case fee • Length of treatment plan orestimated end date	An initial installment of 25% of the treatment liability. Prorated payments continue monthly until thetreatment has ended or benefits areexhausted. One lump sum for all new cases inwhich the total allowable charge is $750 or less.
Comprehensive Treatment (when patient's orthodontic benefits become effective after treatment begins, orthere is a change inproviders mid treatment)	• Appropriate CDT procedure codes • Treatment start date/banding dateTotal case fee • Length of treatment plan or estimated end date	A prorated payment will be calculated by comparing the banding date to the effective date ofcoverage and remaining length of treatment. Benefit dollars provided by a prior carrier will be considered in determining the patient's availablebenefit. Payments will be generated monthly.

Policies and Limitations for Orthodontic Procedures

- Initial payment for orthodontic services will not be made until a banding date has been submitted to FCL.
- Payment for diagnostic services performed in conjunction with orthodontics isapplied to the member's annual/lifetime orthodontic maximum.
- All retention and case finishing procedures are integral to the total case fee.
- Observations and adjustments are integral to the payment for retention appliances.
- The replacement of a lost or missing appliance is not a covered benefit.
- Periodic orthodontic treatment visits are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service.
- Recommendation of an orthodontic appliance is not covered by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient. However, re- cementation by a different dentist will be considered for payment as a palliative emergency treatment.

Orthodontic Claim Submission Guidelines - Pediatric Essential Health Benefits under Healthcare Reform Plans

Orthodontic treatment is limited to medical necessity for all Healthcare Reform Plans. Members under age nineteen (19) who have a severe and handicapping malocclusion may qualify for orthodontic care under the Essential Health Benefit mandate if the member belongs to a plan that includes these benefits.

To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed as a result of cleft palate,with or without cleft lip. Treatment must be rendered by an orthodontist and **prior authorization and approval is required** before services are rendered. Claim review is conducted by a licensed dentist who will review the clinical documentation submitted by the treating dentist.

Review of the Member's orthodontic benefits and treatment planning are essential to the timely and accurate payment of claims for Orthodontic treatment. Orthodontic treatment plans are based upon the type of dentition involved – transitional, adolescent or adult; as wellas the treatment of a particular patient depending on circumstance:

Limited Orthodontic Treatment- treatment with a limited objective, not involving the entire dentition	
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
Comprehensive Orthodontic Treatment Phase II - multiple phases of treatment provided at various stages of dentofacial development	
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8091	Comprehensive orthodontic treatment associated with orthognathic surgery when additional surgical intervention is planned
Minor - treatment to control harmful habits	
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
Other Orthodontics Services	
D8660	Pre-orthodontic treatment visit
D8670	Periodic orthodontic treatment visit (as part of contract)
D8671	Periodic orthodontic treatment visit with orthognathic surgery
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)

Guidelines and Payments for Orthodontic Service - Pediatric Essential Health Benefits under Healthcare Reform Plans

If you are billing:	Please include the following on your claim:	We Will Reimburse you:
Limited or Minor Treatment	Itemized claim for services rendered	One-time payment deducted frompatient's overall lifetime orthodontic maximum
Comprehensive Treatment (when patient's orthodonticbenefits are in effectwhen treatment begins)	• Appropriate CDT procedure codes • Treatment start date/banding dateTotal case fee • Length of treatment plan or estimated end date	An initial installment of 25% of the treatment liability. Prorated paymentscontinue monthly until the treatment has ended or benefits are exhausted. One lump sum for all new cases inwhich the total allowable charge is $750 or less.
Comprehensive Treatment (when patient's orthodonticbenefits become effective after treatment begins, orthere is a change inproviders mid treatment)	• Appropriate CDT procedure codes • Treatment start date/banding dateTotal case fee • Length of treatment plan or estimated end date	A prorated payment will be calculated by comparing the bandingdate to the effective date of coverage and remaining length of treatment. Benefit dollars provided by a prior carrier will be considered in determining the patient's availablebenefit. Payments will be generated monthly.

Policies and Limitations for Orthodontic Procedures HCR Plans

- Initial payment for orthodontic services will not be made until a banding date has been submitted to FCL.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the member's annual/lifetime orthodontic maximum.
- All retention and case finishing procedures are integral to the total case fee.
- Observations and adjustments are integral to the payment for retention appliances.
- The replacement of a lost or missing appliance is not a covered benefit.
- Periodic orthodontic treatment visits are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separateservice.
- Re-cementation of an orthodontic appliance is not covered by the same dentist whoplaced the appliance and/or who is responsible for the ongoing care of the patient. However, re-cementation by a different dentist will be considered for payment as a palliative emergency treatment.

How to Submit Claims for Pediatric Essential Health Benefitsunder Healthcare Reform Plans

Please follow these guidelines when submitting claims for orthodontic treatment:

- **Limited and Minor Treatment.** Submit a claim with the appropriateCDT procedure code, including the total treatment fee and the placement date of the appliance. We will make payment after receipt of initial claim fortreatment.

- **Comprehensive Treatment.** One (1) installment equal to 25% of the lifetime maximum; pro-rated payments continue monthly until the treatment has ended or a new treatment plan including complete treatment plan information is submitted. For patients whose comprehensive treatment started after their orthodontic benefits became effective, submit the claim with the appropriate CDT procedure code, including the treatment charge and the date treatment began. Payment will be prorated by comparing the banding date to the effective date of coverage and remaining length of treatment. (Accumulation transfers will be considered if provided by prior carrier.) If comprehensive treatment began before the patient's orthodontic benefits became effective, submit the monthly visits and your monthly fee using the appropriate CDT procedure code. When submitting claims for the services included in orthodontic records, itemize the appropriate CDT procedure code for each service (e.g., radiographs, evaluation, study models) with your usual fee. If you have questions regarding a patient's coverage, effective dates, or benefits, call our Dental Customer Service at **(866) 445-5148.**

  Diagnosis, banding date and estimated length of treatment must be submitted with the claim.

Section 19: General Policies and Procedures

Quality and Utilization Review

While we continue to conduct utilization review on submitted claims, as a participating dentist, you are no longer required to submit radiographs or periodontal charting, except in specific cases or unless requested by the Plan.

From time to time, we may require that your practice participate in FCL's Quality Assurance and Utilization Management programs that may include, an on-site review offacilities, on-site review of dental records, providing copies of member dental records, audit of dental records, dental care evaluation studies, practice pattern studies and/or analysis based on claims data.

Necessary and Appropriate Care

Our members' Subscriber Certificates or Guide to Benefits specify that all dental care including services, procedures, supplies and appliances–must be "necessary and appropriate to diagnose or treat [the] dental condition." Necessary and appropriate care must meet these criteria:

Care must be:

- Rendered consistent with the prevention and treatment of oral disease or with thediagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases)
- Furnished in accordance with standards of good dental practice
- Provided in the most appropriate site and at the most appropriate level of servicesbased upon the member's condition
- Not provided solely to improve a member's condition beyond normal variation inindividual development and aging, including improving physical appearance thatis within normal individual variation
- As beneficial as any established alternative; and
- Not rendered solely for Dentist's, Member's, or a Third-party's convenience.

Information Needed to Review a Procedure

Please refer to the CDT Guide for information you must submit for procedures requiring review. In cases where we request a detailed narrative, please supply details about the patient's condition that will help us evaluate your claim and reimburse you appropriately. The narrative must be legible.

Please refer to the CDT Guide for any specific requirements needed when submitting claim for treatment. Any radiographic images you submit must be:

- Preoperative radiographic images that are current and dated
- Labeled – left or right side – if duplicates
- Mounted, if they are a full series
- Of diagnostic quality
- Labeled with the patient's name and ID number
- Labeled with the dentist's name and address

Return of Radiographic Images

Radiographic images orattachments will not bereturned unless specifically requested by the dental office and accompanied by a pre- addressed, stamped envelope

Advisory Committee

FCL has a Dental Advisory Committee that provides valuable guidance and counsel to FCL regarding various dental issues related to operations and programs. FCL will consider recommendations for new committee members from individual dentists anddental organizations in the community.

Compliance and Anti-Fraud Program

The Dentist will maintain throughout the term of their Agreement, a compliance and anti-fraud program to detect and prevent the incidence of fraud and abuse relating to the provision of Services, including without limitation, maintaining andcomplying with internal controls, policies and procedures that are designed to prevent, detect and report known or suspected fraud and abuse activities.

Appeals and Grievances Process

A member, a provider, a third-party representative acting on behalf of the memberor a provider acting on behalf of the member, may file an Appeal or Grievance if they are dissatisfied with their service or there is a benefit or service eligibility discrepancy that resulted in a denial, reduction of payment or termination of or failure to make payment (in whole or in part). If a third-party representative is filing an Appeal on behalf of a member, HIPAA Authorization is required.

1. **Florida Combined Life (FCL)** receives an inquiry request regarding an Appeal or Grievance via a phone call. The Customer Service Representative will ask the caller to put their request in writing and forward to:

FCL Appeals
P.O. Box 69437
Harrisburg, PA 17106-9437

The request may also be faxed to **(888) 667-8388**

2. FCL receives an inquiry request regarding a Member regarding an Appeal or Grievance via a phone call. The Customer Service Representative will ask the caller to put their request in writing, providing the caller with a required PPO Appeals form.The completed form must be mailed to:

   Blue Cross Blue Shield of Florida – BlueOptions PPO Appeals
   P.O. Box 44197
   Jacksonville, Florida 32231-4197

3. If the inquiry is regarding **Quality of Care or Quality of Service**, it must be in writing and is handled by the Quality Assurance Area of FCL's Dental Administrator. (Referto Grievance Processing – Quality of Care & Quality of Service document). A Customer Service Representative will ask the caller to put their request in writing and forward to:

   FCL Appeals
   P.O. Box 69437
   Harrisburg, PA 17106-9437

   The request may also be faxed to **(888) 667-8388**

4. Our Dental Claims Administrator will determine if a group has a specificAppeal or Grievance process. If so, the group's Appeal or Grievance process is followed.

5. If there is not a group specific Appeal or Grievance process, our Dental Claims Administrator will determine if there is a State Appeal or Grievance process that needs to be followed. The Appeal or Grievance process will be followed based uponthe State where the Group is located.

6. If there is no State Appeal or Grievance process:

   - Our Dental Claims Administrator will follow the FCL Appeals process. All FCL Appeals and Grievances resulting in a financial or clinical adverse determination will be forwarded to the LSV Dental Director for final determination.

- An **expedited appeal** may be filed via a telephone call. Our Dental Claims Administrator will notify the member or third-party representative of their appeal decision in written or electronic form. The appeal decision will be provided no later than seventy-two (72) hours after all sufficient information is received to make a final determination regarding the appeal.

- For **Fully Insured Business** – the member or third-party representative has one hundred eighty (180) days from the date of the EOB to file an Appeal. Our Dental Claims Administrator will review the request and complete the Appeal within sixty-five (65) days. The Appeal decision letter will include the following verbiage:

- If you disagree with FCL's Appeal decision, you have further rights. Your options will include one or more of the following:

    - Request arbitration within one year of the appeal decision.
    - Request a review by an Independent Review Organization (IRO) Within one hundred-thirty (130) days of the Appeal decision if you are appealing an issue of medical necessity, appropriateness, or effectiveness. File suit against FCL under section 502(a) of the Employee Retirement Income Security Act (ERISA)

- For Self-Insured Business – the member or third-party representative has sixty-five (65) days from the date of the EOB to file an Appeal. Our Dental Claims Administrator will review the request and complete the Appeal within sixty-five (65) days. The Appeal decision letter will include the following verbiage:
    - If you disagree with FCL's Appeal decision, you have further rights. Your options will include one or more of the following
    - Request arbitration within one year of the Appeal decision.
    - Request a review by an Independent Review Organization (IRO) within 130 days of the Appeal decision if you are appealing an issue of medical necessity, appropriateness, or effectiveness.
    - File suit against FCL under section 502(a) of the Employee Retirement Income Security Act (ERISA).

7. Our Dental Claims Administrator's Customer Service How-To guidelines willinclude specific verbiage that is to be used in Group, State, or FCL Appeal responses for both a denial that is upheld as well as a denial that was overturned.

Section 20: Federal Employee Program (FEP)

Overview

The Federal Employee Program (FEP) is a nationwide Federal Employee program. Claims and customer service functions are administered through the local Blue Cross and Blue Shield Association. The FEP membership card is identified by coverage codes104,105 and 106 for the Standard Option and 111, 112 and 113 for the Basic Option.

Providers should always verify member eligibility by calling the FEP Customer Service Center at **(800) 333-2227**.

FCL is responsible for servicing and recruiting the Participating Dentist Network for FEP and for ensuring the accuracy of the online provider directory and the provider file used for claims processing.

Dentists who participate in FEP must provide care to members of both the FEP Basic and Standard Option plans. You can determine which plan a member has by looking at the ID card. (See samples on the following page.) The card will have a unique ID number beginning with an "R" to indicate FEP, as well as one of these enrollment codes

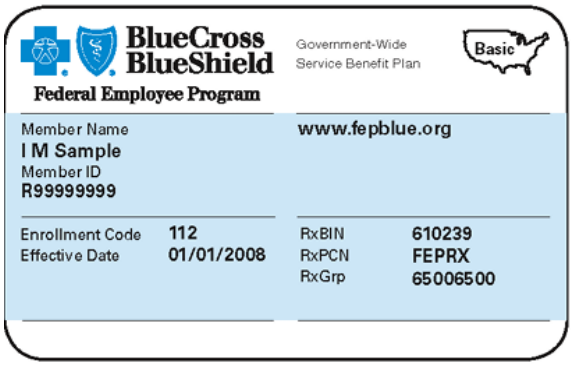
ID Card	Member's PlanEnrollment Code
104	Standard Option Individual Policy
105	Standard Option Family Policy
106	Standard Option Plus 1
111	Basic Option Individual Policy
112	Basic Option Family Policy
113	Basic Option Plus 1

Highlights of Basic and Standard Options

Features of Basic and Standard Options
• The Basic and Standard Options have separate lists of covered services. • For procedures on both lists, the MAC is the same. • For procedures not covered under either option, you may charge your Usual and Customary Charge. • If a procedure is not covered under FEP, do not bill FEP (unless you require a rejection for coordination of benefits). • Neither plan requires payment of a deductible. • The Customer Service number for both options is **(800) 333-2227**

Note: FEP refers nationally to the established allowance for a procedure (the amount you agree to accept as payment in full) as the maximum allowable charge (MAC).

Basic Option Plan



Basic Option Features

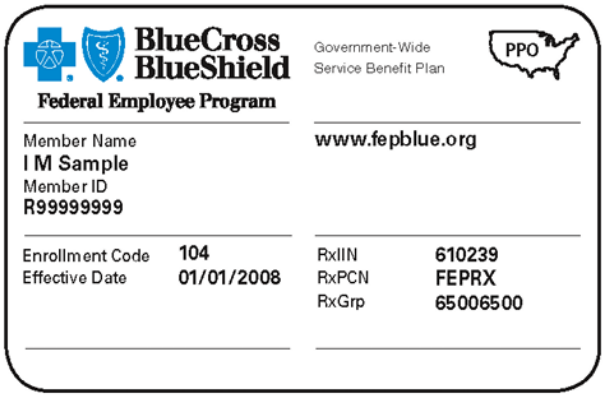
Benefits

- Benefits are available only when services are performed by in-network providers.
- Coverage is limited to basic and preventive services (covered codes are listed on the FEP fee schedule).
- Each covered procedure has a fixed MAC.
- A fixed copayment of $35 is applicable when an evaluation is billed (ADA codes: D0120, D0140, D0150) and is payable by the member at the time of service. When the MAC is lower than the copayment, the member is only responsible for the MAC.
- Members may not be billed in excess of the $35 copayment, or the MAC for covered services.
- Sealants (ADA Code D1351) are covered for children up to age sixteen (16).

Limitations

- Clinical Oral Evaluations (ADA codes: D0120, D0150) Benefit limited to a combined total of two (2) evaluations per person, per calendar year.
- Radiographic Imaging: Intraoral complete series, including bitewings (ADA code: D0210) Benefit limited to one (1) complete series every three (3) years.
- Prophylaxis/Fluoride (ADA codes: D1110, D1120, D1206, D1208) Benefits limited to a combined total of two (2) prophylaxes and two (2) fluoride treatments per person, per calendar year.
- Fluoride (ADA codes D1206, D1208) Benefits up to age sixteen (16).
- Sealants (ADA Code D1351): Benefit is available for covered children up to age sixteen (16) at a limit of once per tooth for first and second molars only.

Standard Option Plan



Standard Option Features

Benefits

- There is a fixed MAC for each covered procedure.
- Member is responsible for amount between the FEP allowance and MAC allowance when services are performed by in-network providers
- Sealants (ADA Code D1351) are **NOT** covered. You may bill Standard Option members at your Usual and Customary Charge for this procedure.

Limitations

- Periodic Oral Evaluations (ADA Code: D0120) Benefit is limited to two (2) evaluations per person, per calendar year.
- Prophylaxis (ADA Codes: D1110, D1120) Benefit is limited to combined total of two (2) per person, per calendar year.
- Fluoride (ADA Codes: D1206, D1208) Benefit is limited to (2) two perperson, per calendar year.

FEP Coordination of Benefits

As explained in Section 15, coordination of benefits (COB) involves two or more payors plan identified as working together to share the cost of healthcare expenses, with one primary (this plan pays first) and the other plan as secondary (this plan pays second). COB allows payors to help manage the cost of healthcare by avoiding payment of morethan the total reasonable expenses incurred.

When FEP is the secondary payor, we will adhere to these guidelines:

- We will pay the difference between the primary Payor's payment and the lower of the MAC allowance or the dentist's charge.
- If the primary Payor's payment is equal to or greater than the Allowable Charge (MAC) allowance, FEP will not owe a Maximum payment.
- If the primary Payor's payment is less than our allowance, we will coordinate and process up to the fee schedule not to exceed the MAC. Whether FEP is the primary or secondary payor, you may not bill members for the difference between your charges and the MAC. Whenever you bill the secondary plan, always attach a copy of the primary Payor's Explanation of Benefits

How to File a FEP Claim

When filing paper claims for FEP Basic and Standard plan members, please do the following:

- Include the policy subscriber's contract ID number listed on their card it begins with R and is followed by eight digits—in block 15 of the ADA claim form. Do notuse the members Social Security number.
- Make sure the provider has signed the claim form and included their Provider Identification Number.
- Mail paper claims to the following address:

Federal Employee Plan
FEP Dental
P.O. Box 1798
Jacksonville, FL 32231-0014

Electronic Claim Submission:

- Electronic claims can be filed through your clearinghouse using **Payor ID 590**.
- Paper claims can be mailed to the address listed on the member's ID card.
- All claims must be filed with the member's "**R"** contract ID number found on the members IDcard.
- Claims for non-covered services should be filed for secondary payment purposes.

FEP Reimbursement

Please see the following tables for services covered under the Standard Option and Basic Option. For current FEP fees schedules, please email a request to Dental Provider Relations.

- The Standard Option allowances listed are those reimbursed by the Plan. You can bill Standard Option members up to your MAC less the Standard Option Fee Schedule.
- You can bill Basic Option members the $30 copayment for covered servicesand your Usual and Customary Charge for any services not covered under the Basic Option.
- Codes not covered under either option may be charged at the providers Usual and Customary Charge unless the member subscribes to secondary coverage with FEP Dental, the Allowance would be based on the FEP fee schedule.

The fee schedule **examples** below are based upon the current FEP Area 1 fee schedule allowances.

Sample Standard Benefits

	Standard Plan ONLY	AREA I - 2025				
		AGE 1 - 12		AGE 13 & OVER		
CDT	DESCRIPTION	MEMBER	FEP	MEMBER	FEP	MAC I
D0120	Perodic oral evaluation - established patient	$18	$12	$22	$8	$30
D0140	Limited oral evaluation - problem focused	$36	$14	$41	$9	$50
D0150	Comprehensive oral evaluation - new or established patient	$39	$14	$44	$9	$53
D0160	Detailed and extensive oral evaluation - problem focused, by report	$88	$14	$93	$9	$102
D0210	Intraoral - complete series of radiographic images	$51	$36	$65	$22	$87
D1110	Prophylaxis - adult	$66	$0	$50	$16	$66
D1120	Prophylaxis - child	$21	$22	$29	$14	$43
D1206	Topical application of fluoride varnish	$14	$13	$19	$8	$27
D2940	Protective restoration	$36	$24	$45	$15	$60
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$36	$24	$45	$15	$60

Sample Basic Benefits - services covered only when rendered by participating providers

	Basic Plan ONLY	AREA I - 2025				
		AGE 1 - 12		AGE 13 & OVER		
CDT	DESCRIPTION	MEMBER	FEP	MEMBER	FEP	MAC I
D0120	Perodic oral evaluation - established patient	$30*	$0	$30*	$0	$30
D0140	Limited oral evaluation - problem focused	$35*	$15	$35*	$15	$50
D0150	Comprehensive oral evaluation - new or established patient	$35*	$18	$35*	$18	$53
D0210	Intraoral - complete series of radiographic images	$35*	$52	$35*	$52	$87
D1110	Prophylaxis - adult	$35*	$31	$35*	$31	$66
D1120	Prophylaxis - child	$35*	$8	$35*	$8	$43
D1206	Topical application of fluoride varnish	$27*	$0	$27*	$0	$27
D1208	Topical application of fluoride	$26*	$0	$26*	$0	$26
D1351	Sealant - per tooth	$24*	$0	$24*	$0	$24

Reconsideration of an FEP claim

FEP Dental Claims are paid by your local Blue Cross Blue Shield Plan (hereinafter referred to as the Local Plan).
Within six (6) months of the initial claim decision, you may ask the Local Plan in writing to reconsider the claim decision. Follow Step 1 of the disputed claims process below.

Step 1: To request reconsideration of a claim decision you must:

- Write to the Local Plan within six (6) months from the date of the decision; and
- Send your request to the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim; and
- Include a narrative detailing why you believe the initial decision was wrong, based on specific benefit provisions; and
- Include copies of documents that support your claim, such as physicians' letters,operative reports, statements, dental records, and explanation of benefits (EOB) forms.

The Local Plan will provide you, in a timely manner, with any new or additional evidence considered, relied upon, or generated at its direction in connection with the claim and any new rationale for the claim decision. The Local Plan will provide you with this information sufficiently in advance of the date that it is required of the reconsideration decision to allow you a reasonable opportunity to respond before that date. However, the Local Plan's failure to provide you with new evidence or rationale in sufficient time toallow you to timely respond shall not invalidate its decision on reconsideration. You mayrespond to that new evidence or rationale at the Office of Personnel Management (OPM) review stage described in Step 3.

Step 2: In the case of a post-service claim, the Local Plan has thirty (30) days from thedate it receives your request to:

- Pay the claim or
- Write to you and maintain its denial or
- Ask you or your patient for more information.

You or your patient must send the information so that we receive it within sixty (60) days of our request. The Local Plan will then decide within thirty (30) more days.

- If the Local Plan does not receive the information within sixty (60) days, a decision will be made within thirty (30) days of the date the information was due
- The decision will be based upon the information already on file. The LocalPlan will provide a written response regarding its decision.

Step 3: If you do not agree with the decision, you may ask OPM to review it. You must write to OPM within:

- Ninety (90) days after the date of the Local Plan's letter upholding the initial decision; or
- One hundred twenty (120) days after you first wrote to OPM – if they did not answer that request in some way within thirty (30) days: or
- One hundred twenty (120) days after OPM asked for additional information – if OPM did not send you adecision within thirty (30) days after receiving the additional information.

Write to OPM at:

United States Office of Personnel Management Federal
Employee Insurance Operations, HealthInsurance
11900 E Street, NW Washington, DC 20415 3610

Section 21: FEP Dental and the Grid

Federal and postal employees who live in Florida can choose a dental plan with comprehensive coverage. Effective Jan 1, 2019, TRICARE retirees and their dependents became eligible to select FEP Dental as their primary dental coverage. The Blue Cross Blue Shield Association (BCBSA) partnered with the GRID Dental Corporation (GDC) to administer FEP Dental. These FEP Dental members can utilize the GRID+ network as an in-network provider source. By participating in the Federal Employee Dental Program provider network, you now have access to FEP Dental members. Reimbursement for this plan is based upon the current (area specific) BlueDental Choice PPO fee schedule.

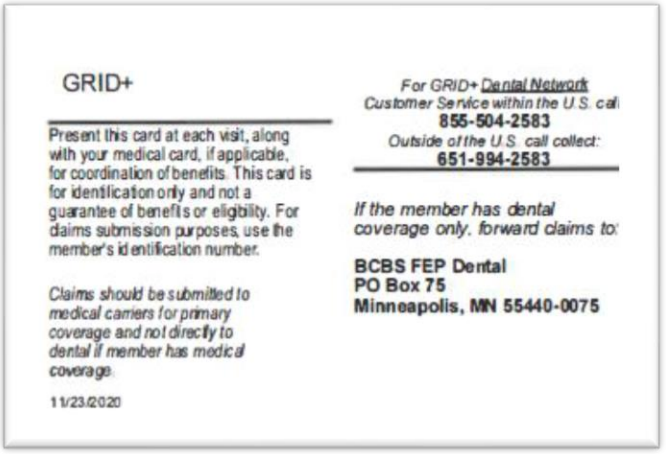
Today, we offer federal and postal employees' medical coverage that includes some dental benefits. Currently there are approximately 325,000 members in Florida enrolled in these medical plans. With FEP Dental, these employees can now choose comprehensive dental coverage to complement their existing coverage.

As an added feature of these plans, when FEP Standard and Basic Option plans are primary, you will only have to submit one (1) claim. You will first submit claims to the Local Plan, as you currently do. Primary payment will be sent to you and the claim will then be forwarded, along with the primary payment amount, to FEP Dental. The primary benefit will be coordinated on the claim received from the Local plan, and upon completion of Coordination of Benefits; FEP Dental will send the secondary payment to you.

Other Plans with the GRID network

By virtue of your participation in the Federal Employee Dental (FEP) network, you are now a participating provider in the GRID network. This means that members of BlueCross and BlueShield plans who live in, or travel to Florida will be able to receive in-network care in your office. These members carry ID cards with either GRID or GRID+ on the back of the card. When applicable, the covered dental services you provide to these members will be based upon the current area specific FEP fee schedule. Email your Provider Network Manager for FEP fee schedules at dentalproviderrelations@fclife.com

Sample Card



Frequently Asked Questions About FEP Dental and the GRID

Q. What is FEP Dental?

A. FEP Dental is a supplemental dental plan offered to federal employees.

Q. How did I become an FEP Dental and a GRID participating provider?

A. Your participation in the GRID is the result of your participation in the Federal Employee Dental (FEP) network.

Q. When a member has FEP Dental, do I only need to file the claim once?

A. Yes, if the member's primary coverage is FEP Standard or Basic Option, you would only file once to the member's Local Plan as primary. The Local Plan will automatically send the primary EOB to FEP Dental if the member has the FEP Dental supplemental coverage.

Q. Our office doesn't file secondary claims. Are we required to file when FEP Dental is secondary?

A. Yes, you are always required to accept assignment and file a claim when you participate in the member's secondary plan.

Q. In addition to FEP Dental members, am I also able to treat members of other BlueCross Blue Shield Plans as an in-network provider?

A. Yes, if those members have ID cards with GRID or GRID+ on the back of their ID card.

Q. How am I reimbursed for claims submitted on members with FEP Dental or other eligible Blue Cross Blue Shield Plans?

A. You will be reimbursed at the area-specific FEP fee schedule. Email your Provider Network Manager for FEP fee schedules at dentalproviderrelations@fclife.com

Q. Who should I contact to verify eligibility for FEP Dental?

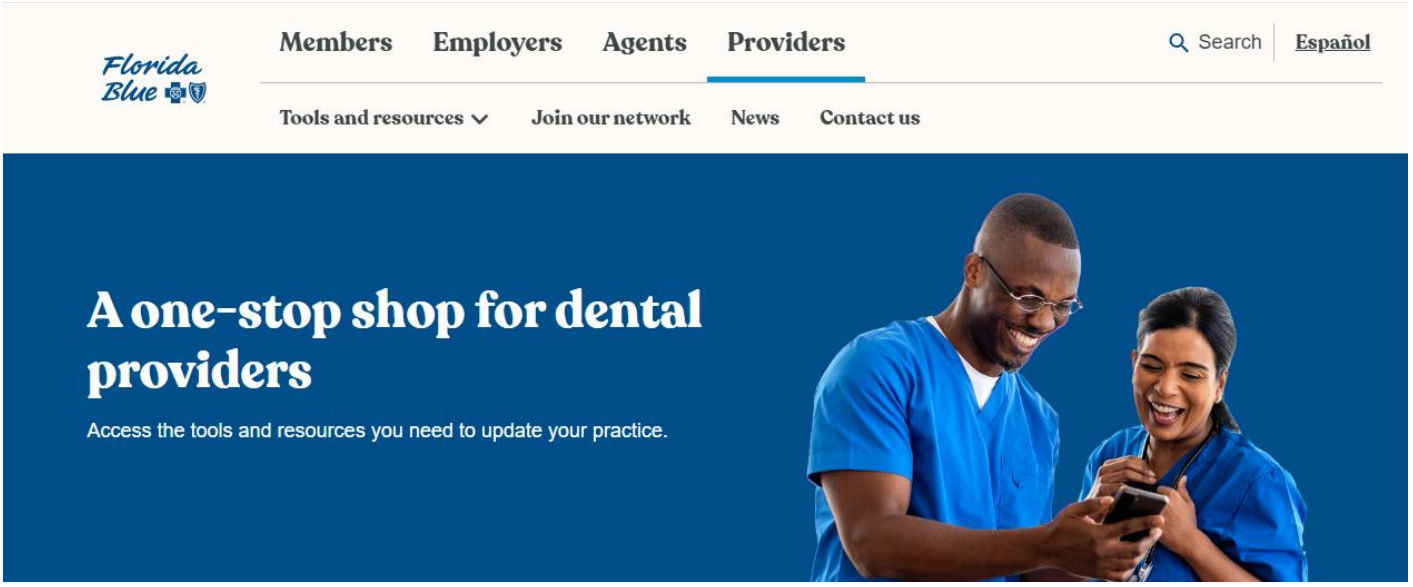
A. Contact FEP Dental at **(855) 504-2583** or on their portal FEP Dental Provider Portal.

Q. Who should I call to verify benefits for members of other eligible Blue Cross Blue Shield Plans?

A. Call the Customer Service number on the back of the member's ID card.

Section 22: Technology Solutions

Florida Blue Dental Website Information



We use our website, Providers | Florida Blue Dental for all communication with participating dental providers. Information is available at your convenience 24/7.

Secure web portals allow access to:

- Online Services for PPO member/claims information through MyDentalCoverage
- Online Services for FEP Dental member/claims information through FEP Dental and the GRID
- Online Services for FEP Basic and Standard Plans member/claims information through Availity (FEP)

Links to online resources on Florida Blue Dental include:

- Join Our Network
- Online Services
- News & Announcements
- Plans, Manuals, & CDT Guides (Dental Plans, Current Dental Manual, CDT Guides-Standard and HCR)
- Update Your Status (Provider Change Forms)
- Provider's Guide to Oral Health for Overall Health
- Provider Contacts
- Find a Dentist (for verification of provider listing)

Technology can help you spend less time on paperwork and other administrative tasks, so you can spend more time caring for your patients. FCL offers technology solutions to help you, and your staff do business with us more efficiently by:

Common Terms

The following terms are important to know when using our technology solutions.

Clearinghouse	The entity that connects your office and the insurance carrier for electronic billing
Electronic Data Interchange (EDI)	The transmission of data from one computer to another
Electronic attachment	Any clinical documentation requested by the insurer to support your claim
Practice management software	The software program that allows you to manage your practice; often includes electronic-claims capability

Electronic Claim Submission

We encourage you to submit claims electronically via Speed eClaim® to enjoy the advantages listed below. One important advantage is that your vendor automatically corrects electronic claims prior to reaching us, so they are more likely to process without delay. You will receive a report confirming that your vendor did or did not receive each claim.

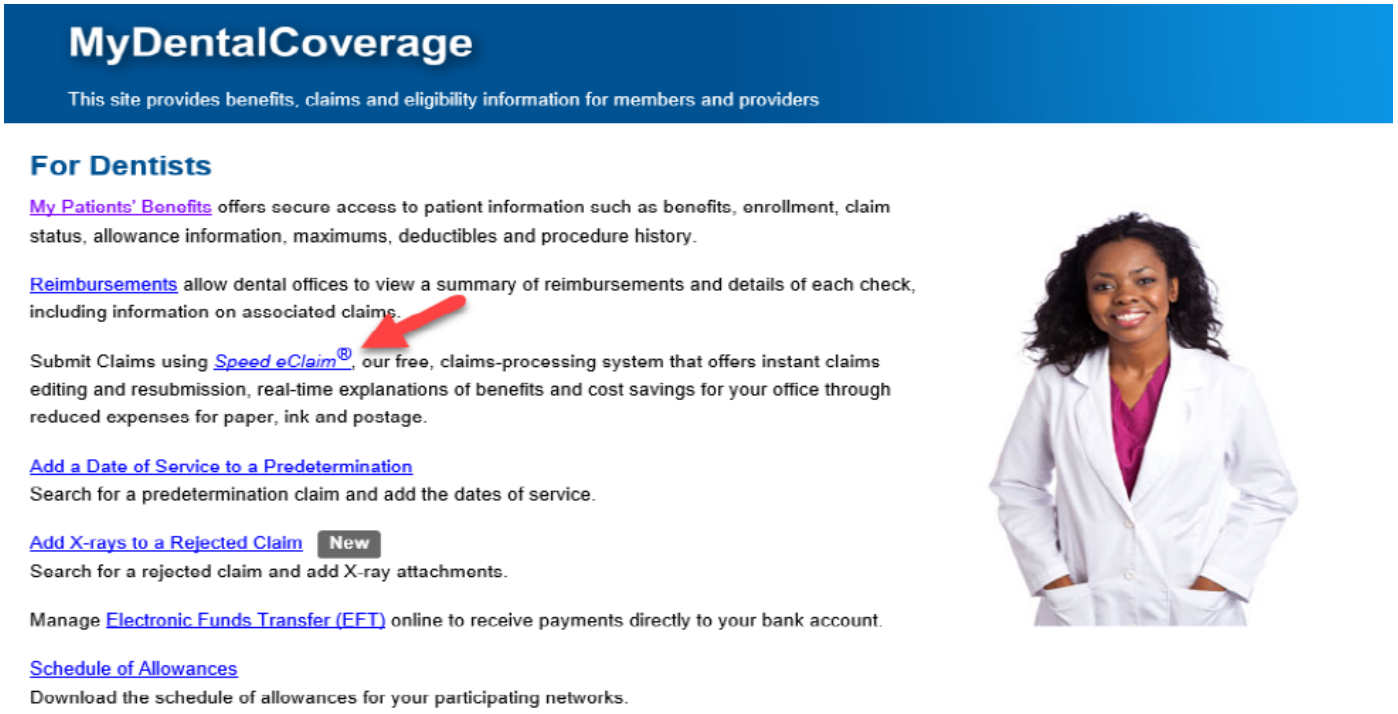
- Improving claim payment time and office profitability
- Reducing claim errors
- Increasing productivity and efficiency by reducing time spent on billing and benefit inquiries

To get started, you will need:

- A computer with a modem and a printer
- Internet access
- Practice management or EDI-enabling software
- Notification to your software vendor of your provider billing number

Electronic Claims Filing Information

Use FCL Speed eClaim® for free real-time claims, secondary claims, and pre-treatment estimates. Within moments, you will see FCL payment and patient portions when the claim or pre-treatment estimate processes.
To access electronic claims filing, login to the MyDentalCoverage portal, select Speed eClaim® and enter patient information and treatment. Claim numbers will be issued immediately.



FCL Payor ID Number and Technical Support

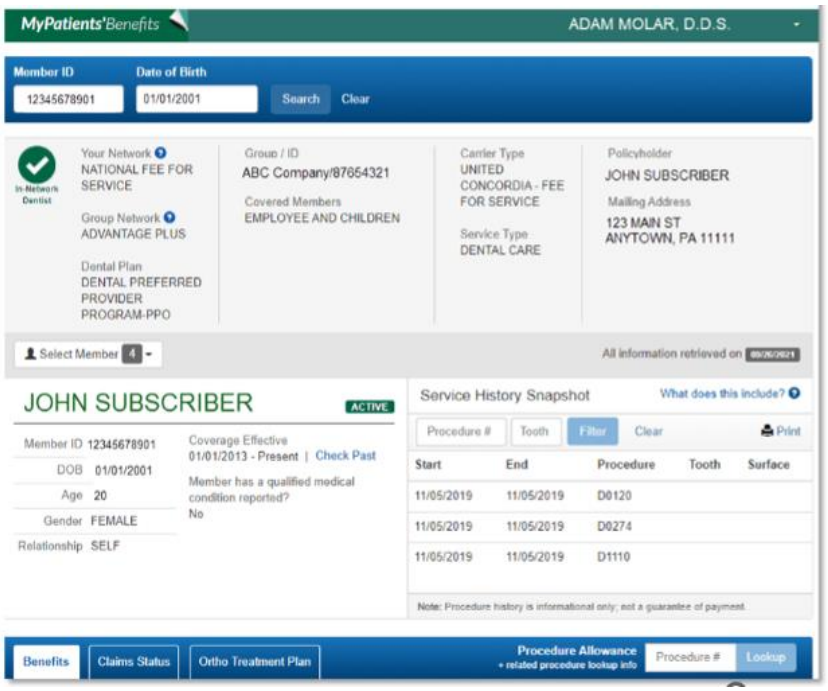
FCL **Payor ID 76031**. If you have questions about filing claims electronically, please contact technical support at **Dental Electronic Services (800) 633-5430** Monday through Friday 8:30 am and 5:00 pm EST

Self Service Tools

Services for FCL Providers are available through MyDentalCoverage website.

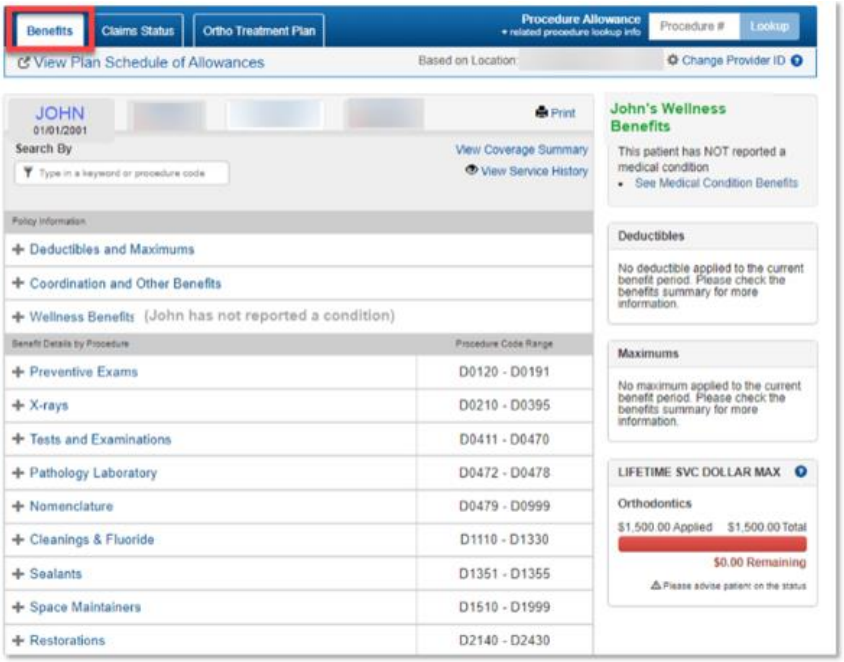
Self Service Tool	Service Available	How to Access
MyDentalCoverage	Eligibility & Benefits: up to the minute access to memberinformation and offers dental offices the ability tocheck patient eligibility, deductible, service historyand the claim status and history free of charge.	**To verify patient eligibility:** • Go to MyDentalCoverage. • Enter the required provider username and password. • Enter the Member ID and DOB.The patient record is displayed. • Click on benefits and select benefit summary in the drop down. For detailed benefits, select a benefit under Benefit Details by Category.
MyDentalCoverage	Claims Status: This online feature allows dental office staff to view a summary of reimbursements and details of each check, including information on associated claims.	**To check claim status:** Go to MyDentalCoverage. • Enter the required provider username and password. • Enter the Member ID and DOB.The patient record is displayed. • To check the **Claim Status**, simply click on **claim status**, and select **date range**.
HIPAA ELIGIBILITY AND CLAIM STATUS TRANSACTIONS USING A CLEARINGHOUSE/ VENDORS	Our Dental Administrator works with numerous clearinghouses and software vendors who can provide the ability for dental offices to perform these electronic transactions with all payors, using just one system.	Contact your software vendor to find out howyou can perform these transactions through your practice management software.

Sample of My Patients' Benefit Summary



- Confirm your network status
- Validate member enrollment dates and status
- Wellness benefits reported by the member
- Look up service history

Note: The information displayed within the tool is specific to the provider who is logged in and the patient you are researching.



- Schedule of Allowances
- Search for a specific code and related services
- Benefits are easily accessed by selecting a category or search for a specific code
- **Wellness** – You can view eligible benefits available for the member
- **Deductibles & Maximums** – amount used/remaining clearly displayed

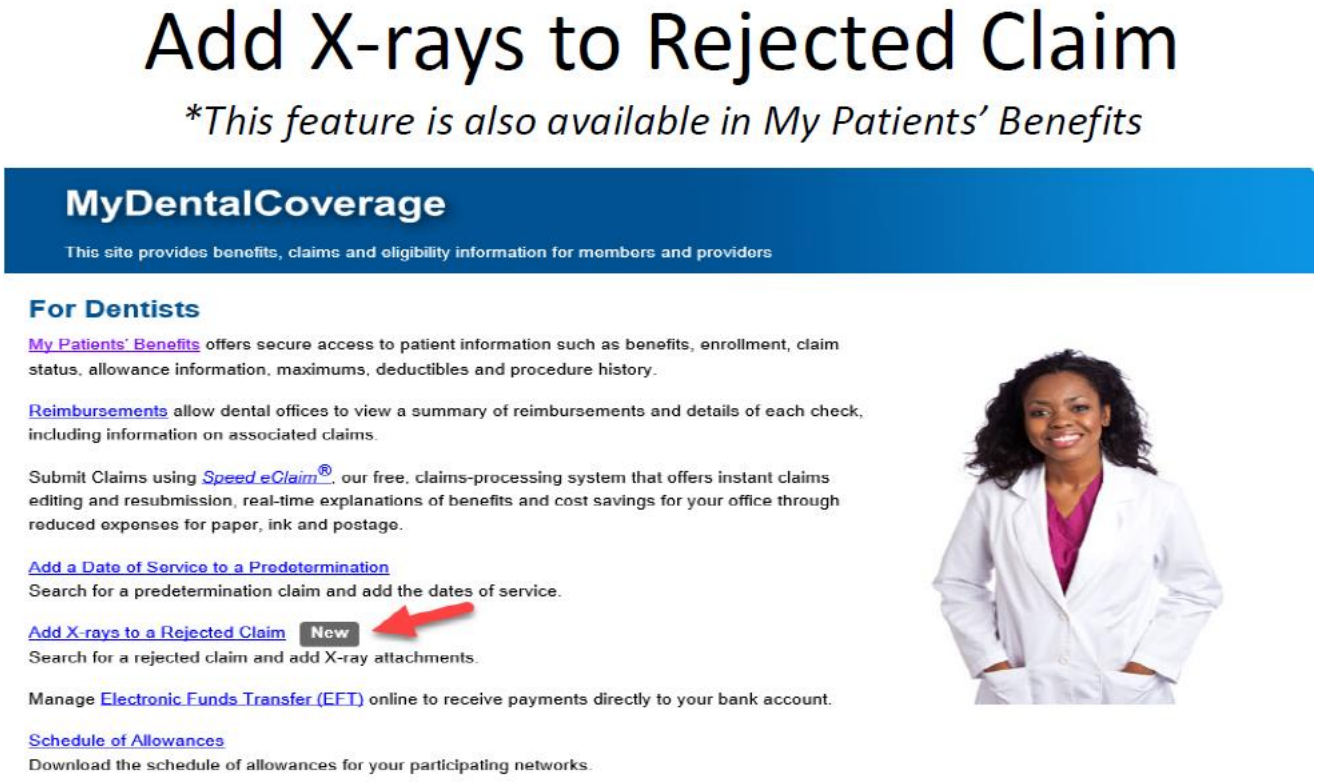
ADDING X-RAYS TO A REJECTED CLAIM

In an effort to enhance the claims processing experience, Florida Combined Life has implemented a functionality that provides dental offices the ability to upload new attachments and/or attachment control numbers (ACN's) **to claims that were rejected** due to a requested X-ray.

To utilize this feature sign into MyDentalCoverage.

FLORIDA BLUE WEBSITE PROVIDER ONLINE SERVICES

1. Under MyDentalCoverage - Click on "Add X-rays to a Rejected Claim"
2. After clicking on "Add X-rays to a Rejected Claim," you will be taken to the Account Accessscreen where you will Sign in with your Username and Password.
3. You will then enter the claim number and click Search. Please note that currently this enhancement can only be used for rejected claims with a "Rejection Code" beginning with a "C."
4. Click Browse to add an attachment. Select the attachment to be uploaded and click Open. Amaximum of five attachments can be added.
5. To add an ACN, key the ACN in the Electronic Attachment # field. A maximum of five ACN's canbe added.
6. When finished, click Review and Submit.
7. Click Submit on the summary page. A new claim number will be generated.
8. Click done to search for another claim.



This functionality is part of our commitment to making dental insurance easier for you and your patients. If you have any questions or need additional information about uploading electronic attachments, please contact technical support at **Dental Electronic Services (800) 633-5430** Monday through Friday 8:30 am and 5:00 pm EST

Interactive Voice Response (IVR) System

Our Dental Administrator's IVR System offers dental offices access to information storedin its records and the capability to finalize predeterminations for payment via the telephone. You can choose to listen to the information or, in most instances, request the information by fax or mail.

The IVR System is accessible by calling Dental Customer Service at **(866) 445-5148**. The IVR system isavailable 24/7, except when the databases are undergoing scheduled maintenance.

The IVR System connects you directly to the databases and gives you access to:

- Patient eligibility and benefits
- Claim/predetermination status information
- Orthodontic information
- Procedure history
- Maximum/deductible accumulations
- Co-payment listings
- Procedure allowances

To use the IVR, dial **(866) 445-5148**, verbally state who you are **"Dental Office"** and follow the prompts listed on the next page.

- Once connected to the IVR, navigate through the IVR system to retrieve your desired information about a particular patient.
- You many have instructions repeated by saying **"Repeat"**.
- Please note that all dates must be entered in the MM/YYYYformat. For example, March 15, 2024, would be entered as 032024.

To use the IVR, dial **(866) 445-5148**
Note: When entering the number portion of the contract ID, **include all leading zeros.**

Say "Benefits" or Press1	**Say "Claims" or Press 2**	**Say "Something Else" or Press 3**
Benefits, Enrollment and Eligibility	Status of Claims, Predeterminations and Orthodontic Information	Procedure History, Maximums andDeductibles Copayment Schedules, Coinsurance or Cost Share and Procedure Allowances
Benefit Details • Fax • E-mail • Mail	• Say or enter date of service • Listen to status of the claim	• Procedure history or Press 1 • Accumulations • Patient responsibility calculator(Allowance) or Press 2 • Add date of service or Press 3 • Hear orthodontic information or Press 4 • More Options or Press 7
Coverage • Effective date • Group name • Network Name		
Benefit Summary • Listen by procedure code • Listen by benefit category		

Section 23: Oral Health for Overall Health℠

Oral Health for Overall Health℠ - Program Overview

At Florida Blue, we deliver innovative health plans and programs to people in the communitieswe serve. Because of our commitment to the health of our members, we provide Oral Health for Overall Health℠, a program that connects medical and dental plans to improve the overall health of participating members. For members with both Florida Blue medical and dental plans, we're able to review their medical claims to identify and automatically enroll those with qualifying health conditions that would benefit from additional dental services.

While research is ongoing, the connection between oral health and overall health is well established.The enhanced dental benefits that Oral Health for Overall Health℠ provides can have a significant impact on a member's overall health and well-being.

Condition-Specific Benefits at No Additional Cost

All BlueDental PPO and Florida Blue Medicare plans include our Oral Health for Overall Health℠ program. Florida Blue members who are enrolled in Oral Health for Overall Health℠ receive condition-specific enhanced dental benefits that are valued at more than $1,000 - which is also additional revenue for your practice.

These benefits are covered 100% with no out-of-pocket expenses **when members see a participating provider**. The benefits don't count toward the calendar year maximum and there are no waiting periods. The program includes education and ties dental into Florida Blue care coordination programs.

We regularly engage enrolled members to make sure they are aware of the relationship between preventive or periodontal dental services and their overall well-being; however, the program has a greater impact when our provider partners participate in member education, so we encourage you and your staff to help your patients understand the value of these important benefits.

Since patients in the program are eligible for four visits per year, we recommend that you schedule all four visits during their first visit.

Overall Health and Well-being

Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow and make facial expressions to show feeling and emotions. However, oral disease from cavities to oral cancer causes pain and disability for many Americans.

Periodontal diseases are infections of the gum and bone that surrounds and support the teeth. In its earliest stage called gingivitis, the gums can become swollen, red and may bleed. In its more serious form, called periodontitis, the gums can pull away from the tooth, bone can be lost, and the teeth may loosen or even fall out. Periodontal disease and tooth decay are the two biggest threats to dental health and can influence many health conditions such as diabetes, coronary artery disease, stroke, oral cancer,

Sjogren's® syndrome and even impact pre-term low birth weight babies.

- Studies show that treatment of periodontal disease can result in improved control of blood sugar levels.
- Research has shown an increase in the incidence of cardiovascular disease and stroke in people with periodontal disease.
- Studies show up to a 7-fold increase in the risk of pre-term low birth weight babies in women with periodontal disease.
- Fluoride applications and more frequent cleaning appointments may help reduce the risk of cavities caused by side effects from previous oral cancer treatments and dry mouth that occurs because of Sjogren's® syndrome.
- Oral health is essential to an individual's overall health. If your patients have one of the ten (10) conditions covered by the Oral Health for Overall Health℠ program, enroll today to start getting additional condition specific support and to jump start your path toward optimum overall health and well-being.

For more information about the impact oral health has on the qualifying conditions, please visit:

Oral Health for Overall Health | Florida Blue Dental

OHOH Education

Our program education activities may focus on at risk individuals, but the benefits of understanding oral health and its association with overall health and well-being is for everyone. Information on Florida Blue® Oral Health for Overall Health℠ program can be found in brochures and oral health articles at Oral Health for Overall Health | Florida Blue Dental.

Better oral health can help individuals improve or manage the qualifying medical conditions in our program. Research has also shown improvement with oral health not only leads to better overall health but can positively impact medical cost differences.

OHOH Program Enrollment

For members with qualifying conditions, they have two (2) ways to enroll into the program.

1. Members who have a Florida Blue medical plan and dental plan will be automatically enrolled in the program if they are seeing their physician for one of the qualifying medical conditions.
2. Members who only have a dental plan can go to the Enroll OHOH link and submit their enrollment form.

Self-enrollment takes approximately 10 to 12 days to be evaluated for members to be enrolled in the program. Once a member is enrolled, they will receive a welcome letter.

OHOH Engagement & Outreach

Florida Blue has a strong commitment to members and the communities of Florida, which includes concern for oral health as well as overall health. An important part of that commitment is to not only provide additional condition specific benefits to members, but to reach out to participating program members for continued encouragement toward optimumoral health.

The Oral Health for Overall Health program includes four (4) outreach activities that are focused on keeping better oral health in the fore front of program participant's minds.

1. The first program outreach consists of a welcome letter being mailed to the enrollee advising of their qualification into the program, and that they are now eligible to use their enhanced dental benefits.

2. The second program outreach consists of reminder letters being mailed to enrolled program members reminding them of their additional condition specific benefits, encouraging them to visit their dental provider more frequently. Members are encouraged to use their additional dental benefits to maintain, manage or even improve their oral health, which is connected to improvement in their overall health.

3. The third program outreach consists of evaluating the claims of enrolled Oral Health for Overall Health℠ members to determine which members have not utilized their enhanced dental benefits.

4. Once identified, we then provider outreach to these members through letter campaigns, telephone calls, email or text messaging to actively engage with these members. Through active engagement, we hope to encourage these members to visit their dental professional and continue the path toward optimum oral healthandwell-being.

5. The third program outreach consists of evaluating the claims of enrolled Oral Health for Overall Health℠ members to determine which members have not utilized their enhanced dental benefits.

6. Once identified, we then provider outreach to these members through letter campaigns, telephone calls, email or text messaging to actively engage with these members. Through active engagement, we hope to encourage these members to visit their dental professional and continue the path toward optimum oral healthandwell-being.