BlueDental

Group Administration Guide for BlueDental Care plans

Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

Thank you for selecting a BlueDental Care product for your employees' dental care coverage needs. This guide contains information to help you administer your group dental care coverage program.

Florida Combined Life Insurance Company, Inc. (FCL), an affiliate of Blue Cross and Blue Shield of Florida (BCBSF), is committed to offering superior dental coverage to its members and cost-effective solutions to employers faced with escalating benefit costs.

This guide will explain eligibility, employee and dependent changes and more. Your agent or BCBSF/FCL representative can review any part of this guide with you and answer questions. If you have employees enrolled in an FCL BlueDental Choice[SM] product, you will receive a separate Group Administration Guide.

We're proud to provide you and your employees with the highest level of personal, professional service. Thank you for choosing FCL. We're always here to help.

Service Contacts

Customer Service

(877) 325-3979
Monday - Friday, 8 a.m. – 6 p.m

Change Forms and Applications

Fax (904) 376-8425
fclbilling@cbbcbsfl.com

Mailing address for Membership

Florida Combined Life
PO Box 769569
Roswell, GA 30076-8223

Billing

Phone: (877) 325-3979
Monday – Friday 8 a.m. – 6 p.m.
fclbilling@cbbcbsfl.com

Mailing address for Premium Payments

Florida Combined Life
PO Box 211778
Kansas City, MO 64121-1778

Overnight Mailing address for Premium Payments

UMB Bank
Attn.: Retail Lockbox 211778
Mailstop 1170105
1008 Oak St.
Kansas City, MO 64106

Note: This guide does not replace or override the information contained within the Group Policy. This guide does not cover information about health insurance coverage.

Plan Highlights

The BlueDental Care program offers a cost-saving alternative to traditional coverage and is designed to provide your employees with comprehensive care at affordable rates. Key features include:

- **No Deductibles** – There are no deductibles to be paid before a member receives benefits.
- **No Claim Forms** – Members and participating general providers are not required to submit claim forms for payment.
- **Coverage for Preventive Care** – Encourages your employees to visit the dentist on a regular schedule.
- **Savings for Major Care** – When services require copayments, BlueDental Care offers substantial savings from Usual and Customary Fees. Fixed member copayments allow your employees to predict their out-of-pockets cost.
- **Unlimited Annual Benefits** – There are no annual or lifetime dollar limits to the amount of dental care benefits members can receive.
- **No Exclusions for Pre-Existing Conditions** – No penalty is imposed for pre-existing conditions, not including congenital malformations. All other pre-existing conditions are covered with no waiting period or benefit limitations.
- **Choice of Network Dentist** – Each member on a BlueDental Care plan may select his or her own dentist.
- **Specialist Care** – Specialty care services are available through a network of participating dental specialists.

Eligibility

Adding Employees – An employee who is hired after the initial enrollment period and that meets eligibility requirements, can enroll in the plan within 31 days of becoming eligible. The employee must complete and sign an enrollment application. Please be sure all information on the application is complete and legible, including your group name, group number and the effective date of coverage for the employee. Provide the employee with a copy of the form, and retain a copy for your records.

Adding Dependents – When an employee marries, adopts or gives birth to a child, these new dependents are eligible to enroll in the member's plan within 30 days of becoming eligible. The employee must complete and sign an Employee Change Form for Group BlueDental Care (Form 50402). Please be sure all information on the form is complete and legible, and retain a copy for your records.

Removing Dependents – If a dependent must be removed (death, divorce) FCL must be notified within 30 days of the event. The employee must complete and sign an Employee Change Form for Group BlueDental Care (Form 50402).

Address Changes

Additional changes such as address or contact information should be reported to FCL. The employee must complete and sign an Employee Change Form for Group BlueDental Care (Form 50402).

Refusing Coverage

If an employee refuses dental coverage, please have him or her complete and sign an enrollment application. Be sure the appropriate boxes are checked and the Coverage Refusal section is signed. If you offer Voluntary dental coverage, this action is not required.

Terminations

When an employee terminates his or her employment with you and has dental coverage, FCL must be notified within 30 days of the date of termination to prevent your organization from being liable for any premiums due after the date of termination. Please complete an Employee Change Form for Group BlueDental Care (Form 50402).

Provider Directory

Here's how to help your employees find the dentist that best meets their needs:

1. Go to www.bcbsfl.com and click **Find a Doctor & More** found in the navigation bar along the top of the page
2. In Step 1, go to **Doctor Type** on the second line and select **Dentist**
3. Once you click Dentist, a shaded area appears listing **Type of Dentist** and **Doctor's Name**
4. From the drop-down menu under **Type of Dentist** select the dentist or specialist of choice
5. Next, go to Step 2 and choose your dental insurance plan from the drop-down menu under **Plan**. Selecting the proper plan ensures that a search will only list providers who are part of that plan's network
6. Next, go to Step 3 and narrow the selection by Zip code/Distance, Street/City or County and click **search**
7. To narrow a search even further, click **More Search Options** in Step 3. This feature will allow clients to search for a dentist based on age, gender and other attributes

Emergency Care

Within the FCL BlueDental Care Service Area

Members in need of emergency dental care must first contact their dental provider. If the provider is unavailable to see the member, FCL must be contacted at (877) 325-3979 for further instructions.

Members will be charged an additional copayment as stipulated in the Benefits and Copayment Schedule for appointments after standard business operating hours.

Outside of the FCL BlueDental Care Service Area

When members are more than 100 miles from the nearest available participating general dentist, they may obtain reimbursement for expenses for emergency care rendered by any licensed dentist - less applicable FCL copayments - up to $100 per member, per year upon presentation of an itemized statement of emergency services from the provider's office. FCL must be notified of such treatment within 90 days of the treatment being rendered.

COBRA

FCL will comply with COBRA as administered by your organization. Employees and/or their dependents that would otherwise lose coverage may choose to keep group coverage for up to 18, 29 or 36 additional months, depending on the circumstances.

When an employee chooses to continue individual and/or dependent coverage, under COBRA you must notify FCL no later than 60 days following the event that has made the employee and/or dependents eligible for this coverage. If, at the time of the qualifying event, an employee has not made a decision regarding COBRA coverage, it is best to terminate coverage pending a decision.

The employee has 60 days to make this decision. If the employee accepts the COBRA extension, coverage will be restored as of the termination date with no lapse in coverage, and your organization will be billed retroactive to the termination date.

Under COBRA, the former employee and/or his or her dependents will continue to be listed on your bill's roster of membership. You must collect premiums and send payment to us for this coverage along with the payment due for your active employees.

ID Cards

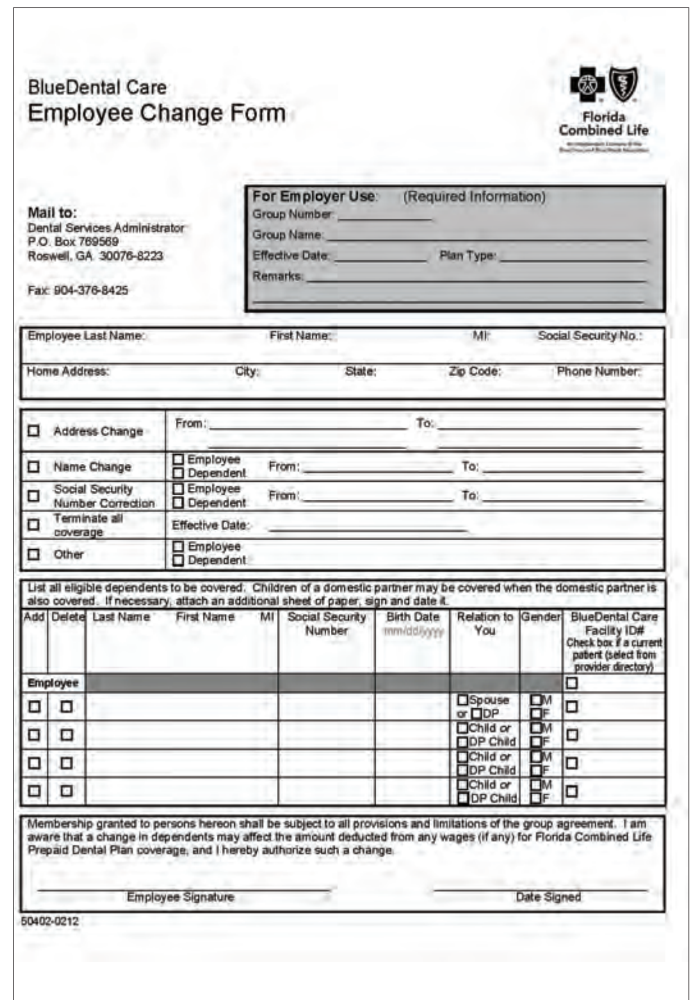
Lost ID cards may be replaced by having the employee call Customer Service at (877) 325-3979. Representatives are available from 8 a.m. to 6 p.m., Monday through Friday.

BlueDental Care Change Form

The Employee Change Form for Group BlueDental Care (Form 50402) must be completed by your employee and then submitted to you for verification for any of the following changes:

- Name or address change
- Add spouse or child(ren)
- Remove spouse or child(ren)
- Terminate coverage
- Transfer provider

See the sample Employee Change Form below for additional details.



BlueDental Care

Employee Change Form

Florida Combined Life

Mail to:
Dental Services Administrator
P.O. Box 769569
Roswell, GA 30076-8223

Fax: 904-376-8425

For Employer Use: (Required Information)
Group Number: ____________
Group Name: ____________
Effective Date: ____________ Plan Type: ____________
Remarks: ____________

Employee Last Name:	First Name:	MI:	Social Security No.:	
Home Address:	City:	State:	Zip Code:	Phone Number:

☐ Address Change	From: ____________ To: ____________
☐ Name Change	☐ Employee ☐ Dependent From: ____________ To: ____________
☐ Social Security Number Correction	☐ Employee ☐ Dependent From: ____________ To: ____________
☐ Terminate all coverage	Effective Date: ____________
☐ Other	☐ Employee ☐ Dependent

List all eligible dependents to be covered. Children of a domestic partner may be covered when the domestic partner is also covered. If necessary, attach an additional sheet of paper, sign and date it.

Add	Delete	Last Name	First Name	MI	Social Security Number	Birth Date mm/dd/yyyy	Relation to You	Gender	BlueDental Care Facility ID# Check box if a current patient (select from provider directory)
Employee									☐
☐	☐						☐Spouse or ☐DP	☐M ☐F	☐
☐	☐						☐Child or ☐DP Child	☐M ☐F	☐
☐	☐						☐Child or ☐DP Child	☐M ☐F	☐
☐	☐						☐Child or ☐DP Child	☐M ☐F	☐

Membership granted to persons hereon shall be subject to all provisions and limitations of the group agreement. I am aware that a change in dependents may affect the amount deducted from any wages (if any) for Florida Combined Life Prepaid Dental Plan coverage, and I hereby authorize such a change.

Employee Signature ____________ Date Signed ____________

50402-0212

Forms

Please contact your local FCL or BCBSF representative for additional forms.

Billing

Invoice Statement

Premiums for your organization's BlueDental Care plan are due prior to the first day of the month for which coverage is effective. Each month, FCL will send you an Invoice Statement listing all of your subscribers that are eligible for coverage during the indicated period.

See the sample Invoice Statement below for additional details.

1771

FLORIDA COMBINED LIFE INSURANCE COMPANY
BlueDental Care (Prepaid)
P.O. Box 769569
Roswell, GA 30076-8223
877-325-3979

Invoice

Group Number	12345
Desk Code	FCL
For Month of	Oct. 2011
Invoice Number	010206526
Payment Due	10/15/11
Agent #	8417FCL
Agent Name	Insurance Congress of Florida

SAMPLE COMPANY
ATTN:
123 Street
ANY TOWN, USA 33333

Cobra Indicator	Certificate	Subscriber or Buyer	Cvrg Prd	Prem Amt	Plan	Eff Date	Adj Indicator
	***-**-2345 3	Last Name, First Name	10/11	14.60	DHMO	02/11	
	***-**-3456 3	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-4567 2	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-8765 1	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-7654 1	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-6789 2	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-5678 1	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-3322 3	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-7887 2	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-8239 2	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-7892	Last Name, First Name	10/11	42.47	DHMO	12/10	
	***-**-8923	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-6993 2	Last Name, First Name	10/11	14.60	DHMO	12/10	
	***-**-7237 1	Last Name, First Name	10/11	42.47	DHMO	12/10	
	***-**-4663	Last Name, First Name	10/11	30.01	DHMO	12/10	

Previous Balance	674.37	EE Only	14.60	12
Payment Received	.00	EE+SP	30.01	1
Past Due Amount	674.37	EE+Children	24.24	0
Current Month Premium	290.15	Family	42.47	2
Current Adjustments (AJ)	.00	Total		15
Administrative Fee	.00			
Current Billed Amount	290.15			
Total Amount Due Please Pay this amount *	964.52	<---		

HOW YOU CAN REACH US

For benefit questions, please call Member Services at (877)325-3979.
For billing questions, please call Account Services at (877)325-3979.

*This total must be adjusted if "Past Due Amount" has previously been paid.

If no changes, detach and return bottom portion of invoice with your remittance. If changes shown, adjust the total premium and mail this entire form back to FCL with your remittance. Check here if changes are shown on the back of this form. ☐

SAMPLE COMPANY
ATTN:
123 Street
ANY TOWN, USA 33333

Group Number	12345
Desk Code	FCL
For Month of	Oct. 2011
Invoice Number	010206526
Amount Due	$964.52

MAKE CHECK PAYABLE TO:

FL Combined Life-Group
PO Box 211778
Kansas City, MO 64121-1778

Check Number
Check Amount

01 FC 0000029377 G 010206526 0000096452 0

Billing (continued)

Membership Change Form

FCL uses the Membership Change form on the back of the monthly invoice Statement to reconcile your account. Therefore, it is imperative that all necessary information is provided in order to eliminate billing discrepancies. Monthly adjustments will be reflected on your next Invoice Statement, provided they are submitted to FCL **no later than the fifteenth (15th) day of the month prior to the effective month of coverage.**

See the sample Membership Change from below for additional details.

Membership Changes

Please attach this sheet with your payment.

List Terminated Subscribers		
Certificate Number	Name	Termination Date
1.		
2.		
3.		
4.		

List New Subscribers (please include applications)		
Certificate Number	Name	Effective Date
1.		
2.		
3.		
4.		

List Changes		
Certificate Number	Name	Effective Date
1.		
2.		
3.		
4.		

50450-0114