CareFirst

Family of health care plans

DENTAL

PROVIDER MANUAL

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Family of health care plans

Chapter 2: Product Descriptions

Overview

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) offer a comprehensive portfolio of health insurance products and administrative services to 3.3 million individuals and groups in Maryland, Washington, D.C. and Northern Virginia. This section explains the various types of healthcare plans our members may have.

Dental Traditional (Indemnity)

The Participating Provider Network provides a benefit for covered services based on the CareFirst Traditional Allowed Benefit. This level of reimbursement applies to members covered under our Traditional Dental Plans.

Traditional Dental members may seek treatment from any participating provider in the network. Reimbursement is based on a percentage of the Traditional Allowed Benefit with applicable deductibles and co-insurance. Your contracted Traditional or Participating (PAR) fee schedule with CareFirst can be accessed on CareFirst Direct. Members seeking treatment from non-participating providers receive 100% of the Allowed Benefit for covered services, subject to deductibles, co-insurance and balance billing.

Dental Preferred Provider Organization

The Preferred Provider Network (PPO) provides a benefit for covered services based on the CareFirst Preferred Allowed Benefit. This level of reimbursement applies to members covered under our Preferred Dental Plans.

Preferred Dental members may seek treatment from any Preferred Dental provider in the network. Reimbursement is based at 100% of the Preferred Allowed Benefit with applicable deductibles and coinsurance. Members seeking treatment from a participating (not a preferred) provider may receive benefits at a reduced rate and are subject to billing up to the Traditional Allowed Benefit. Your contracted PPO fee schedule with CareFirst can be accessed on CareFirst Direct. Members seeking treatment from non-participating providers receive benefits at a reduced rate and are subject to deductibles, coinsurance and balance billing.

Dental Exclusive Provider Organization

Exclusive Provider Organization (EPO) works much like the PPO. However, the member does not have out-of-network benefits. Dental EPO plans operate as a PPO hybrid. CareFirst and BlueDental EPO members will share the cost for dental treatment – BlueDental EPO plans will have member copayments instead of coinsurance.

Reimbursement is determined by your contracted fee arrangement with CareFirst, less the member's copayments. All BlueDental EPO plans will have the same member copayments by procedure for services included in the plan benefits, but accumulations like annual maximums and deductibles may vary among our BlueDental EPO plans. Your office can access these EPO member copayment schedules via CareFirst Direct.

Dental Health Maintenance Organization

A Dental Health Maintenance Organization (DHMO) plan is a structured plan where dentists who participate receive a monthly, fixed fee (capitation), based on the number of members assigned to their practice. These plans have no waiting period, calendar year maximums, or deductibles. Most work that isn't preventative will be subject to copayments.

The plan's Copayment Schedule of Benefits is a document that defines all of the procedures covered by that plan, and the amount of money the member will owe to your office for each procedure. Members who enroll in the DHMO networks must assign a Primary General Dentist (PGD) to their plan. You can find and confirm the member's PGD assignment on CareFirst Direct, the member's identification card, and on a monthly eligibility report that gets mailed to your office. Your office can access these DHMO member copayment schedules via CareFirst Direct.

Referrals

Unless otherwise stated, all office services not rendered by a PGD require a written referral. A written referral is valid for a maximum of 120 days and limited to three visits except for standing referral situations.

Decisions to issue additional referrals rest solely with the PGD.

Federal Employees Health Benefit Plan/Federal Employee Program

All federal government employees and qualified retirees are entitled to health insurance benefits under the Federal Employees Health Benefits (FEHB) Program.

Federal employees are given a wide range of insurance options, from catastrophic coverage plans with high deductibles to HMOs. Some plans are offered nationwide while others offer coverage regionally.

The Federal Employee Program (FEP), also known as the Service Benefit Plan (SBP), has been part of the FEHB Program since its inception in 1960. For Maryland, Washington, D.C. and Northern Virginia, this fee-for-service plan is administered by CareFirst. More than 50 percent of all federal employees and retirees nationwide have chosen to receive their healthcare benefits through FEP. These members and their families receive health coverage through the local Blue Plan where they reside.

FEP Benefit Plan Options

The medical options with embedded dental benefits available to federal employees and retirees include:

- The Standard Option PPO which allows FEP members to seek covered services from both preferred/in-network and non-participating providers. When members use preferred PPO providers, their out-of-pocket expenses, such as coinsurance and copayment amounts, will be less.
- The Basic Option PPO has a lower premium than the Standard Option and no deductibles, but members must use participating preferred providers to receive benefits.

Learn more about the benefit plans at https://www.fepblue.org/benefit-plans.

SAMPLE: Standard Option ID card

Front of card:

Back of card:

SAMPLE: Basic Option ID card

Front of card:

Back of card:

SAMPLE: FEP Blue Focus ID card

Front of card:

Back of card:

How to Identify an FEP Policy

Members who are part of Blue Cross Blue Shield Association (BCBSA) FEP can be identified by the following:

- The letter “R” in front of their member ID number instead of a three-letter alpha prefix
- The BlueCross BlueShield (BCBS) FEP logo on their ID card.
- A thin blue border around the FEP Blue Focus ID card perimeter, which distinguishes it from the Standard Option card, which has a solid white border, and the Basic Option card, which has shaded blue font. Samples of each card are shown below.

Unlike the Standard and Basic FEHBP Options, there are no dental benefits included in the FEP BlueFocus plan.

BlueCross BlueShield FEP Dental

The BCBSA has partnered with the GRID Dental Corporation (GDC) to administer BCBS FEP Dental, formerly referred to as FEP BlueDental. BCBS FEP Dental is a supplemental dental plan offered to federal employees and utilizes the GRID+ (Traditional) network as an in-network provider source.

By participating with CareFirst, providers are considered in-network for BCBS FEP Dental members. The member’s card will be identified with the BCBS FEP Dental logo, along with the claim’s submission address and customer service number to verify benefits. Claims for members who enroll in both BCBS FEP Service

Benefit medical plan (FEHBP) and BCBS FEP Dental should always be sent to FEHBP first, for primary consideration, and are automatically routed to BCBS FEP Dental for secondary coverage consideration.

Coordination of Benefits (COB) with FEP

When BCBS FEP Dental members have the Blue Cross and Blue Shield Service Benefit Plan (also known as the Federal Employee Program® or FEP®) medical coverage, those claims should be submitted to their local Blue Cross Blue Shield (BCBS) company.

- To avoid duplicate claim submissions, do not submit dated claims to both the local BCBS company and BCBS FEP Dental.
    - Primary payment will be sent to you and then the Service Benefit Plan will forward the claim, along with the Primary payment amount, to BCBS FEP Dental.
    - BCBS FEP Dental will coordinate the benefits of the claim received from the medical carrier. Upon completion of COB, BCBS FEP Dental will send the Secondary payment to your office.
- When a member is covered by a Service Benefit Plan product with dental benefits and a separate BCBS FEP Dental plan, those two policies will coordinate to pay benefits on dental claims.
- It is recommended that the dentist not charge the patient for any copay or coinsurance associated with the medical plan benefits at the time of their dental office visit because, in most cases, these amounts will be addressed by the dental plan.

FEP BlueFocus

BCBS FEP Dental will be paid as the Primary dental benefit for those who are enrolled in FEP BlueFocus. FEP BlueFocus medical option does not have any dental embedded. All dental claims will be submitted directly to BCBS FEP Dental. FEP BlueFocus is printed on the FEHBP medical ID card.

Other Federal Employee Health Benefit Program (FEHBP) Medical Member

Submit claims to the other medical carrier. Primary payment will be sent to you. You then submit claims and Primary remittance to BCBS FEP Dental for Secondary COB payment. Please hold Secondary claim submission until you have received Primary payment and remittance from the other medical plan.

National Dental GRID

Introduction

The Dental GRID links dental provider networks, including the CareFirst Dental Provider Network and many of the nation's Blue plans.

Participating CareFirst dental providers are considered in-network for patients who are members of many Blue Cross and Blue Shield plans, and providers should check the patient's member identification card for the GRID or GRID+ indicator before considering the plan to be in network. Providers file claims directly to the Blue Cross and/or Blue Shield plan where the member's group benefits are located. Reimbursement is made to the participating provider, based on the current CareFirst provider agreement.

This section describes the advantages of the program and provides information to make filing claims easy. This section offers helpful information about:

- Identifying members
- Verifying eligibility
- Filing claims

What is the National Dental GRID?

Definition

CareFirst has partnered with other Blues plans nationally and the GDC to provide BlueCross and BlueShield card holding members with seamless access to in-network dental care, regardless of where they reside or travel within the United States. The National Dental GRID links the dental networks of BlueCross and BlueShield plans and utilizes two networks (GRID and GRID+).

Advantages to Providers

The National Dental GRID gives your practice national directory presence. Participating CareFirst Traditional or PPO Dental providers will be listed in the National Dental GRID and Dental GRID+ directory. The program offers providers access to more patients who hold the Cross and Shield insurance.

There is no disruption to your contracted compensation, as reimbursement for claims rendered under the National Dental GRID are calculated using your current contracted allowances with CareFirst. You can access your contracted allowances on CareFirst Direct.

Products included in the National Dental GRID

If you participate with our Traditional (Indemnity insurance), PPO, and EPO plans, your office is included in the national Dental GRID and GRID+ provider directory. A GRID+ indicator on your patient's ID card corresponds to your Traditional, or PAR reimbursement with CareFirst, and similarly, a GRID indicator on your patient's ID card corresponds to your Preferred, or PPO reimbursement with CareFirst. Participating providers verify members benefits and eligibility and submit claims directly to the member's plan. Providers will also be paid by the member's plan, according to the provider's current CareFirst reimbursement agreement.

Third Party Administrators (TPA)

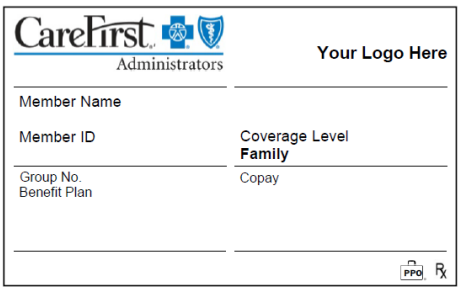
CareFirst jointly administers, with third-party administrators (TPAs), self-insured employers, and health and welfare funds, a TPA claims product. This product enables employers to utilize the CareFirst network of providers while still being able to design and administer their health benefits. CareFirst is actively involved and responsible for collecting and pricing claims, training and maintenance of the provider networks. The TPAs are responsible for issuing ID cards, handling claims adjudication, benefit and claims inquiries, correspondence, appeals, etc. Participating providers agree to accept the CareFirst allowance as payment in full for services rendered, less any deductibles and coinsurance amounts.

Member identification

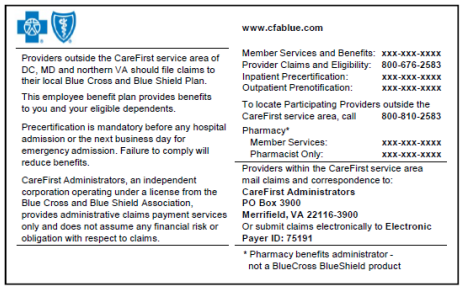
The member will have a unique ID card with the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund). The prefix on the ID card begins with an "A" followed by two numeric characters. Notice of Payments (NOPs), Explanation of Benefits (EOBs), checks and vouchers will

usually have the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund).

Front



Back



CFA, LLC dba CareFirst Administrators and NCAS

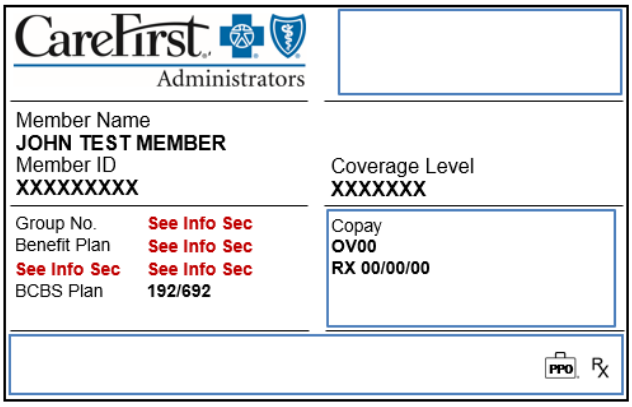
CFA, LLC dba CareFirst Administrators

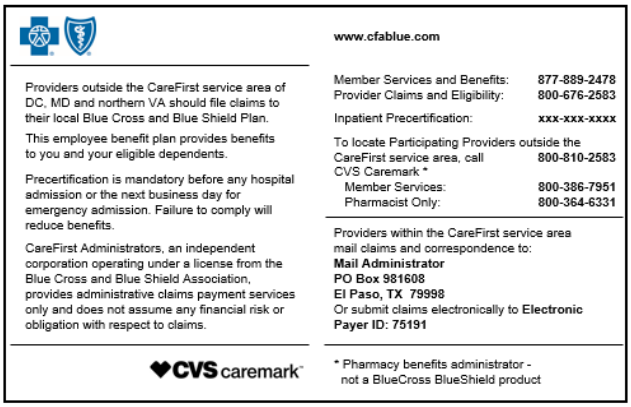
CFA, LLC dba CareFirst Administrators is a wholly owned subsidiary of CareFirst, Inc. CareFirst Administrators (CFA) is Blue-Branded and operates under an independent license from the BCBSA. CFA provides administrative services to self-funded employer groups whose plans are governed by the Employee Retirement Income Security Act of 1974. This allows members to take advantage of local plan networks for out-of-area services. Products are customized using the BCBS national network of providers.

CFA provides administrative services only and does not assume any financial risk or obligation with respect to healthcare benefit claims for the self-insured portion of the plan. Though CFA offers access to the CareFirst provider network, specific requirements of member's health benefits vary and may differ than the procedures outlined in this manual.

Though CFA membership information is not available through the CareFirst Direct portal, CFA does have an interactive voice response system (IVR), 877-889-2478 that providers can access for patient benefits, eligibility and claims information.

CFA members' identification cards carry the CFA logo. Contact information for claims and correspondence is listed on the back of the card.





Claims should be submitted electronically using payer code 75191. Correspondence and paper claims should be submitted to:

CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998

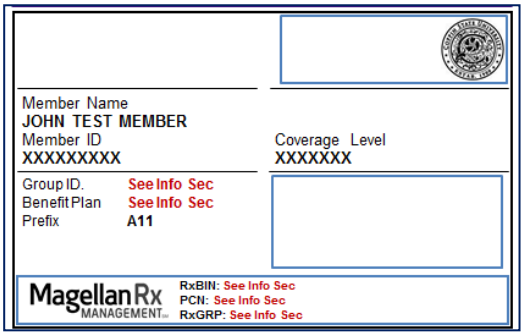
For more information, refer to www.cfablue.com.

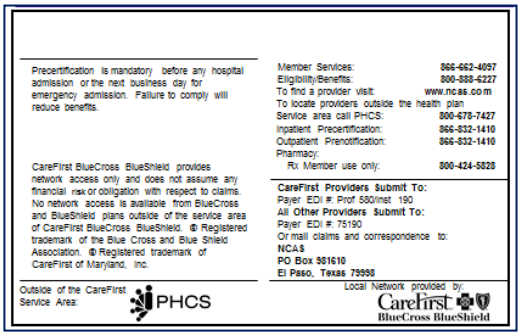
NCAS

CFA, LLC dba NCAS (NCAS) is a non-blue branded national TPA for companies headquartered throughout the United States. Members in the CareFirst service area have access to the CareFirst provider network. Members outside of the CareFirst service area are provided access to provider networks through agreements with NCAS. NCAS shares administrative duties with the employer groups or TPA.

NCAS is responsible for benefits eligibility and claims processing. NCAS has an IVR, 877-889-2479, that providers can access for patient benefits, eligibility and claims information. NCAS membership information is not available through the CareFirst Direct portal.

NCAS members' ID cards will have a dual logo and may have a CareFirst network logo if the group is located in the CareFirst service area. Otherwise, the logo of the applicable provider network will appear on the ID Card that shows both CareFirst and the TPA. Contact information and mailing addresses are listed on the back of the card.





Claims for NCAS should be submitted electronically using payer code 00580 for dental claims. Correspondence and paper claims should be mailed to:

NCAS
P.O. Box 981610
El Paso, TX 79998

For more information, visit www.NCAS.com.