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℠ 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

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 FloridaBlueDental.com**
   - Click **Find a Dentist**, found in the navigation bar along the top of the page.
   - Go to **Dentist Information** on the second line and choose **Type of Dentist** and enter the Dentist's name.

2. **Choose your dental insurance plan**
   - Choose your dental insurance plan from the drop-down menu under **Insurance Plan Information** (this information is available on your BlueDental ID card.) Selecting your plan ensures that your search will only list providers who are part of your plan's network.

3. **Choose your location**
   - Narrow your search by Zip Code/Distance, Address or County and click **Search**.
   - If you'd like to narrow your search even further, click **within** and enter a distance. This feature will allow you to narrow your search for a dentist based on the nearest location to you.

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 760560
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

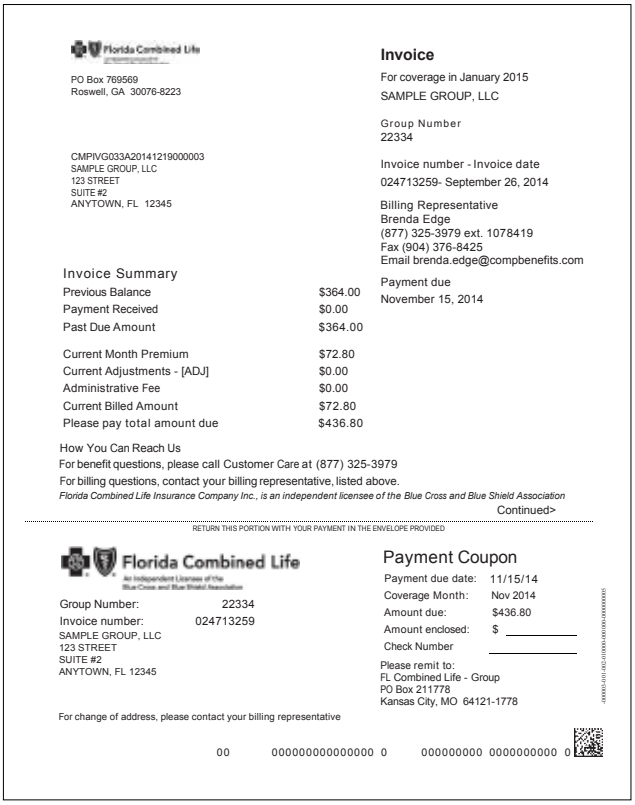
Please contact your local FCL or BCBSF representative for additional forms.

Billing

Invoice Statement

Your premium payment is due on the 15th of the month. 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.



Florida Combined Life

PO Box 769569
Roswell, GA 30076-8223

CMPIVG033A20141219000003
SAMPLE GROUP, LLC
123 STREET
SUITE #2
ANYTOWN, FL 12345

Invoice

For coverage in January 2015
SAMPLE GROUP, LLC

Group Number
22334

Invoice number - Invoice date
024713259- September 26, 2014

Billing Representative
Brenda Edge
(877) 325-3979 ext. 1078419
Fax (904) 376-8425
Email brenda.edge@compbenefits.com

Payment due
November 15, 2014

Invoice Summary

Previous Balance	$364.00
Payment Received	$0.00
Past Due Amount	$364.00
Current Month Premium	$72.80
Current Adjustments - [ADJ]	$0.00
Administrative Fee	$0.00
Current Billed Amount	$72.80
Please pay total amount due	$436.80

How You Can Reach Us
For benefit questions, please call Customer Care at (877) 325-3979
For billing questions, contact your billing representative, listed above.
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Continued>

RETURN THIS PORTION WITH YOUR PAYMENT IN THE ENVELOPE PROVIDED

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Payment Coupon

Group Number: 22334
Invoice number: 024713259
SAMPLE GROUP, LLC
123 STREET
SUITE #2
ANYTOWN, FL 12345

Payment due date:	11/15/14
Coverage Month:	Nov 2014
Amount due:	$436.80
Amount enclosed:	$ _____
Check Number	_____

Please remit to:
FL Combined Life - Group
PO Box 211778
Kansas City, MO 64121-1778

For change of address, please contact your billing representative

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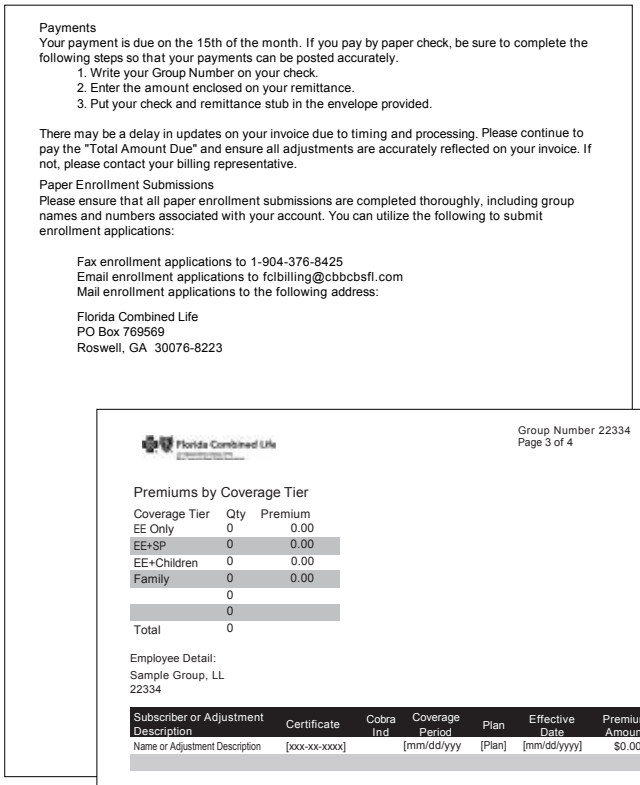


Payments
Your payment is due on the 15th of the month. If you pay by paper check, be sure to complete the following steps so that your payments can be posted accurately.

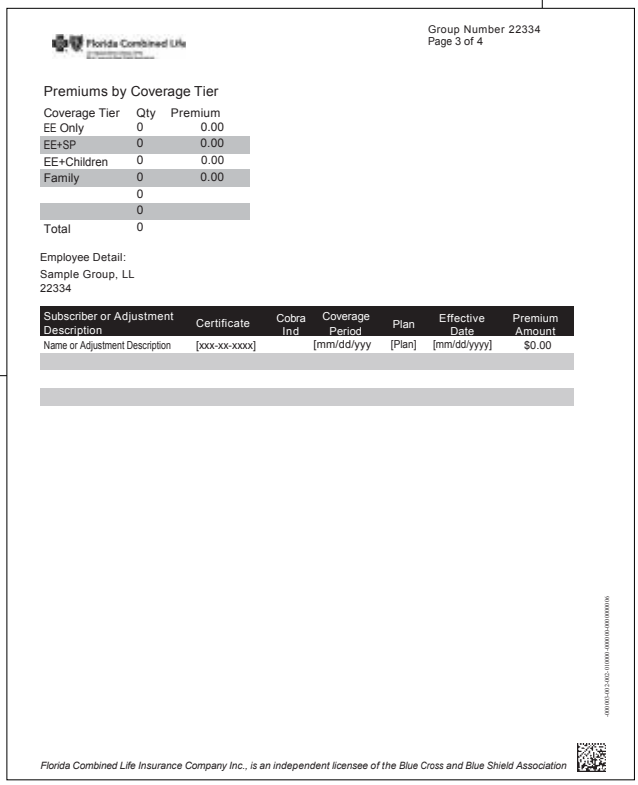
1. Write your Group Number on your check.
2. Enter the amount enclosed on your remittance.
3. Put your check and remittance stub in the envelope provided.

There may be a delay in updates on your invoice due to timing and processing. Please continue to pay the "Total Amount Due" and ensure all adjustments are accurately reflected on your invoice. If not, please contact your billing representative.

Paper Enrollment Submissions
Please ensure that all paper enrollment submissions are completed thoroughly, including group names and numbers associated with your account. You can utilize the following to submit enrollment applications:

Fax enrollment applications to 1-904-376-8425
Email enrollment applications to fclbilling@cbbcbsfl.com
Mail enrollment applications to the following address:

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



Florida Combined Life

Group Number 22334
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Premiums by Coverage Tier

Coverage Tier	Qty	Premium
EE Only	0	0.00
EE+SP	0	0.00
EE+Children	0	0.00
Family	0	0.00
	0	
	0	
Total	0	

Employee Detail:
Sample Group, LL
22334

Subscriber or Adjustment Description	Certificate	Cobra Ind	Coverage Period	Plan	Effective Date	Premium Amount
Name or Adjustment Description	[xxx-xx-xxxx]		[mm/dd/yyy	[Plan]	[mm/dd/yyyy]	$0.00

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