The Blue Book℠
Dental e-Manual

A guide for dental care providers

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BlueCross BlueShield of North Carolina

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July 2012

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Nothing in this *e*-manual is intended or should be understood to modify the requirements, limitations and/or exclusions in the BCBSNC member's policy.

Note: In the event of any inconsistency between information contained in this *e*-manual and the Dental Network Participation Agreement between your dental care practice and Blue Cross and Blue Shield of North Carolina (BCBSNC) the terms of such agreement shall govern. Also, please note that BCBSNC and other Blue Cross and/or Blue Shield Plans may provide available information concerning an individual's status, eligibility for benefits and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, an individual's possession of a BCBSNC identification card in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. For the purposes of this *e*-manual: insured, policyholder, participant, patient, member, enrollee, subscriber and covered person are terms used to refer to a person who is entitled to receive benefits underwritten or administered by BCBSNC, however such person may be referred to or described in said policy.

Introduction

1.1 About The Blue Book℠ Dental e-Manual

Blue Cross and Blue Shield of North Carolina (BCBSNC) is pleased to provide you with The Blue Book℠ Dental *e*-Manual (*e*-manual) for dental care providers. This *e*-manual has been designed to make sure that you and your office staff have the information necessary to effectively administer BCBSNC dental products. This *e*-manual contains information that dental providers need in order to administer BCBSNC dental care programs efficiently and understand policies and procedures used in the management of the BCBSNC member's dental benefits.

The *e*-manual is intended as a supplement to the Dental Network Participation Agreement "agreement" between you the dental provider and Blue Cross and Blue Shield of North Carolina (BCBSNC). The agreement is the primary document controlling the relationship between participating dental providers and BCBSNC. Nothing contained in this *e*-manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the agreement. BCBSNC policies and procedures will change periodically and dental providers will receive notification of relevant changes as they occur, as contained within the terms of the agreement.

We thank you for your participation in the BCBSNC dental network, as we continue our efforts to help our members improve the quality of their health and dental care.

1.2 The Blue Book℠ Dental e-Manual available online

To access the *e*-manual online, please visit us on the Web at ***bcbsnc.com***, click on the "providers" page, and then click on the hyperlink for the *e*-manual. You must have Acrobat Reader on your computer to download the *e*-manual. If you are unable to download The Blue Book℠ Dental *e*-Manual and you would like a copy, please contact your BCBSNC regional network management representative.

1.3 ACS Benefit Services Inc. (ACS)

BCBSNC utilizes the services of our wholly owned subsidiary ACS Benefit Services Inc. (ACS), for the administration of customer service and claims processing for BCBSNC dental products. ACS is a third party administrator of self-funded medical and dental benefit plans. ACS has developed an advanced claims system for servicing the BCBSNC dental products, which allows ACS to process claims extremely accurately because benefits processing can be tailored for each employer group. ACS as our administrator for BCBSNC dental products maintains procedures, policies and guidelines for dental providers transacting dental business. This *e*-manual acts as a supplement to those procedures, policies and guidelines as determined by BCBSNC, and in the case of any discrepancy, BCBSNC rules and guidelines administered by ACS will supersede this *e*-manual. Participating dental providers are encouraged to access the BCBSNC Web site ***bcbsnc-dental.com*** to obtain copies of the procedures, policies and guidelines maintained through ACS.

1.4 Additional references

This *e*-manual is your main source of information for how to administer BCBSNC dental products. If you cannot find specific information in this *e*-manual, the following additional resources are available to assist:

- Your Dental Network Participation Agreement
- BCBSNC's dental Web site (for dental providers) at: ***bcbsnc-dental.com***
- BCBSNC's Web site for providers (not exclusively dental) at ***bcbsnc.com/content/providers/***
- ***Blue e***℠
- Customer service
- Your regional network management representative

Telephone numbers for contacting customer service and network management, as well as, information for accessing ***Blue e***℠ are located in chapter two of this *e*-manual.

Thank you for your participation and for providing dental care to our BCBSNC members.

Contact information and general administration

BlueCross BlueShield of North Carolina

2.1 Contact and claims submission information

Dental Blue® for Groups – group dental plan	
Dental customer service	**1-800-305-6638**
Dental claims (Dental services)	Dental Emdeon payor #**61473** (electronic claims filing)
	BCBSNC Dental Blue Claims Unit **P.O. Box 2100** **Winston Salem, NC 27102-2100**
Medical claims (Medical / accident / TMJ [or submit to patient's health care plan if other than BCBSNC])	Enrollment for electronic medical claims available through the Web at ***bcbsnc.com/content/providers/edi/***
	BCBSNC Claims **P.O. Box 35** **Durham, NC 27702-0035**
Medical customer service	**1-800-214-4844**
Web sites	***bcbsnc-dental.com*** ***bcbsnc.com/plans/smallgrp/dentalblue/***

Dental Blue® Select℠ – group dental plan	
Dental customer service	**1-888-471-2738**
Dental claims (Dental services)	Dental Emdeon payor #**61474** (electronic claims filing)
	BCBSNC Dental Blue Select Claims Unit **P.O. Box 2400** **Winston Salem, NC 27102-2400**
Medical claims (Medical / accident / TMJ [or submit to patient's health care plan if other than BCBSNC])	Enrollment for electronic medical claims available through the Web at ***bcbsnc.com/content/providers/edi/***
	BCBSNC Claims **P.O. Box 35** **Durham, NC 27702-0035**
Medical customer service	**1-800-214-4844**
Web sites	***bcbsnc-dental.com*** ***bcbsnc.com/plans/largegrp/voluntarydental/***

Dental Blue for Individuals℠

Dental customer service	**1-800-305-6638**
Dental claims (Dental services)	Dental Emdeon payor #**61473** (electronic claims filing)
	BCBSNC Dental Blue Claims Unit **P.O. Box 2100** **Winston Salem, NC 27102-2100**
Medical claims (Medical / accident / TMJ [or submit to patient's health care plan if other than BCBSNC])	Enrollment for electronic medical claims available through the Web at ***bcbsnc.com/content/providers/edi/***
	BCBSNC Claims **P.O. Box 35** **Durham, NC 27702-0035**
Medical customer service	**1-800-214-4844**
Web sites	***bcbsnc-dental.com*** ***bcbsnc.com/plans/dentalblue/***

Federal Employee Health Benefit Plan (BCBS medical coverage includes some dental benefits)

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

Dental Blue for Federal Employees	
Dental customer service	**1-800-305-6638**
Dental claims (Dental services)	Dental Emdeon payor **#61473** (electronic claims filing)
	BCBSNC Dental Blue Claims Unit P.O. Box 2100 Winston-Salem, NC 27102-2100
Web sites	***FEPDentalBlueNC.com***

2.2 Member eligibility, benefits and claim status verification

Dental providers can easily verify member's eligibility and benefits on the Web at ***bcbsnc-dental.com***. Access is provided at no charge and is available 24 hours a day, 7 days a week, which allows dental providers the convenience of verifying information in real-time.

Eligibility and benefits may also be verified by calling customer service at:

- **1-800-305-6638** (for members enrolled in Dental Blue® for Groups, Dental Blue for Individuals℠, and Dental Blue® for Federal Employees)
- **1-888-471-2738** (for members enrolled in Dental Blue Select® [for groups])

Dental providers can also check a BCBSNC member's dental care eligibility and benefits by use of ***Blue e***℠. ***Blue e***℠ is a secure, Internet-based application, for verification of membership and eligibility from the convenience of your Internet browser. BCBSNC offers this service free-of-charge to BCBSNC participating dental providers. Providers not already enrolled for ***Blue e***℠ access can do so, on line, by visiting BCBSNC on the Web at ***bcbsnc.com/providers/edi/bluee.htm*** or by calling ***Blue e***℠ customer support at **1-888-333-8594**.

Benefits verification online

bcbsnc-dental.com offers added advantage

Dental providers and their staff can review eligibility and benefits for BCBSNC members online, using either ***Blue e***℠ or our Web site for providers – ***bcbsnc-dental.com***.

However, ***bcbsnc-dental.com*** offers an added advantage not currently available with ***Blue e***℠. Both online applications provide needed benefit plan information, but only ***bcbsnc-dental.com*** includes the added feature of displaying benefit accumulator amounts, helping dental providers to see what amounts have been applied to a patient's deductible and coinsurance during the course of a benefit plan year.

2.3 ACS Benefit Services Inc. (ACS)

BCBSNC utilizes the services of ACS Benefit Services Inc. (ACS), for the administration of customer service and claims processing for the BCBSNC dental products. ACS claims system allows ACS to process claims efficiently and accurately because their processing systems are customized for each dental plan's benefit structure, down to the code and tooth number level. Most claims are processed as EDI (electronic data interchange) claims for increased speed.

ACS acts on behalf of BCBSNC to administer dental claims processing and customer service. ACS also provides the following services:

- Utilization management
- Eligibility and benefit verification
- Reconsideration first level appeals for UM and dental necessity denials
- Reconsideration first level appeals for claim denials

Note: ACS accepts and routes electronically filed claims to BCBSNC for processing, when submitted by dental providers for services provided to membership enrolled in the Federal Employees Program (FEP). However, ACS does not act in the administration of dental claims processing for services provided to these members (ACS provides a routing service only).

2.4 BCBSNC dental customer service

The BCBSNC dental customer service office can be reached toll-free during the hours of operation, Monday through Friday from 8:00 a.m. to 6:00 p.m., Eastern Standard Time. Calls received outside these hours are handled by the BCBSNC integrated voice response (IVR) system. The IVR allows callers with a touch-tone phone to access benefit plan information via a series of voice prompts. When calling dental customer service, please use the customer service phone number assigned to the patient's dental coverage plan type. Customer service numbers are printed on the back of BCBSNC member's identification cards and are additionally located at the start of this chapter (chapter two, page one).

2.5 BCBSNC enhanced Web-based services

BCBSNC offers Web-based services* to assist dental providers with the many administrative functions associated with arranging patient care and subsequent claim submission and account reconciliation. These services are available by accessing ***bcbsnc-dental.com***.

- Standard services include:
  - ‡ Member/eligibility check
  - ‡ Member claim history (claim history for dental services provided by your practice to your patients)
  - ‡ Claim submission (on-line claim entry [bypassing Emdeon EDI and/or paper claim submission])
  - ‡ Pre-treatment/authorization submission
  - ‡ Review pre-treatment/authorization service requirements (if x-rays and/or treatment plans are required these requirements will be noted)
  - ‡ Upload required documents using National Electronic Attachment (NEA) (e.g. x-ray images, perio-charting, ortho contracts, etc.)
  - ‡ Check claim status
  - ‡ Check pre-treatment status
- Advanced services:
  - ‡ Load member information for easy claim entry
  - ‡ Create personalized fee schedules to avoid re-keying frequently submitted amounts for routine services
  - ‡ Access detailed office procedural manuals specific to your patient's BCBSNC dental plan

* Web-based services are not available by use of ***bcbsnc-dental.com*** for members enrolled in the Federal employees medical plan or children enrolled in the NC Health Choice program.

Web site access requires registration. To register please call BCBSNC dental customer service at **1-800-305-6638** or **1-888-471-2738**, and request to speak with provider Web services, or contact via e-mail at ***providerWebServices@bcbsnc-dental.com***. If requesting access by e-mail, please attach a completed Provider Registration Package to your request. If requesting by phone, please be ready to provide your fax number so that a registration package can be faxed to your office.

The Provider Registration Package is available for download from the BCBSNC Dental Blue provider's page located at ***bcbsnc-dental.com***. If submitting a completed registration packet by e-mail, please send to ***providerWebServices@bcbsnc-dental.com***.

Providers with questions about Web-based transaction registration or providers experiencing Web site difficulty can contact provider Web services by calling **1-800-305-6638** or by e-mailing to ***providerWebServices@bcbsnc-dental.com***.

2.6 NEA FastAttach™ and *Fast*Look

Dental providers can send electronic attachments using the NEA (National Electronic Attachment Inc.) offered services of FastAttach™. FastAttach™ enables dental providers to transmit attachments (i.e. X-rays, lab reports, perio-charts) in support of electronic claims to dental insurance payors using the Internet. Attachments can also be stored for providers who request storage services. Dental providers can receive additional information about FastAttach™ services and may sign up for FastAttach™ use, by calling **1-877-425-9334** or by visiting NEA on the Web at ***www.nea-fast.com***. If signing up for FastAttach™ use, enter the promotional code of BCBSNCS to receive half off the $200 registration fee, and two months of free service ($25 per month) for a savings of $150. **Please note that this is a promotional rate and subject to expiration.**

Additionally, NEA offers the *Fast*Look system, which gives providers one central site to view the attachment requirements for multiple payors (BCBSNC, as well as, other dental care payors). With *Fast*Look dental care providers can search by payor name and procedure code to determine what, or if any, attachment needs to be sent to a member's payor plan.

For more information about the *Fast*Look system, please visit *Fast*Look on the Web at ***welcometonea.com*** or call **1-800-782-5150**, ext #**2**.

Please note that costs and/or fees can be associated with the use of FastAttach™ and/or the *Fast*Look systems. Dental providers enrolling for use of the NEA offered applications assume all associated expenses.

2.7 BCBSNC Network Management

Your local Network Management field office is responsible for developing and supporting relationships with dental providers and their staff. Network Management staff is dedicated to serve as a liaison between you and BCBSNC. Network Management staff is available to assist your practice with the following issues:

- Questions regarding BCBSNC contracts, policies and procedures
- Changes to your organization including:
  - ‡ Opening/closing locations
  - ‡ Change in name or ownership
  - ‡ Change in tax ID number, address or phone number
  - ‡ Merging with another group

2.8 BCBSNC Network Management contact information

Phone / Fax / Email	Address
1-800-777-1643 **919-765-4349 (fax)** ***NMSpecialist@bcbsnc.com***	**P.O. Box 2291** **Durham, NC 27702-2291**

Network Management staff is available to assist Monday through Friday 8:00 a.m. to 5:00 p.m.

Dental provider demographics

3.1 Dental provider demographics

BCBSNC maintains an online provider directory listing addresses, phone numbers and current rosters of providers at a participating practice, so that our members can quickly locate dental care providers and health care providers to schedule appointments. Our ability to successfully direct members to you for their dental care depends on the accuracy of the information we have on file for your dental practice. We encourage you to visit the "find a doctor page" located on the BCBSNC Web site at ***www.bcbsnc.com/providers/*** to validate your dental care business information.

If you find that your dental practices information needs to be updated, please let us know by contacting a BCBSNC network management representative or complete and return a provider demographic form that can be accessed from the "Dental Providers" tab on our Web site at ***www.bcbsnc.com/providers/***.

Please note that having accurate mailing information on file for your practice also ensures you receive claims payments and other important correspondence in a timely manner from BCBSNC.

Dental benefit plans

4.1 Dental products

Blue Cross and Blue Shield of North Carolina (BCBSNC) offers a dental benefit plan for individuals and a choice of dental plan products for groups:

- Dental Blue for Individuals℠ a plan for individuals – member's checkups and cleanings are covered twice per benefit period and members pay no deductible for checkups or diagnostic and preventive services.
- Dental Blue® a plan for groups – employers have the freedom to customize a plan to meet the needs of employees, customizing plans from a choice of available benefit options.
- Dental Blue® Select℠ voluntary plans for groups – employers have a choice of three dental plans – Standard, Complete and Enhanced (optional orthodontia on Complete and Enhanced) – and whichever plan is selected the member's lifetime deductible is only $100.

4.2 Member identification cards

BCBSNC members enrolled for dental coverage receive identification cards from BCBSNC that display the name of the subscriber, as well as, the names of his or her eligible dependents. Providers are responsible for verifying that members are eligible for benefit coverage at the time services are rendered and for determining if patients have other dental insurance or coverage.

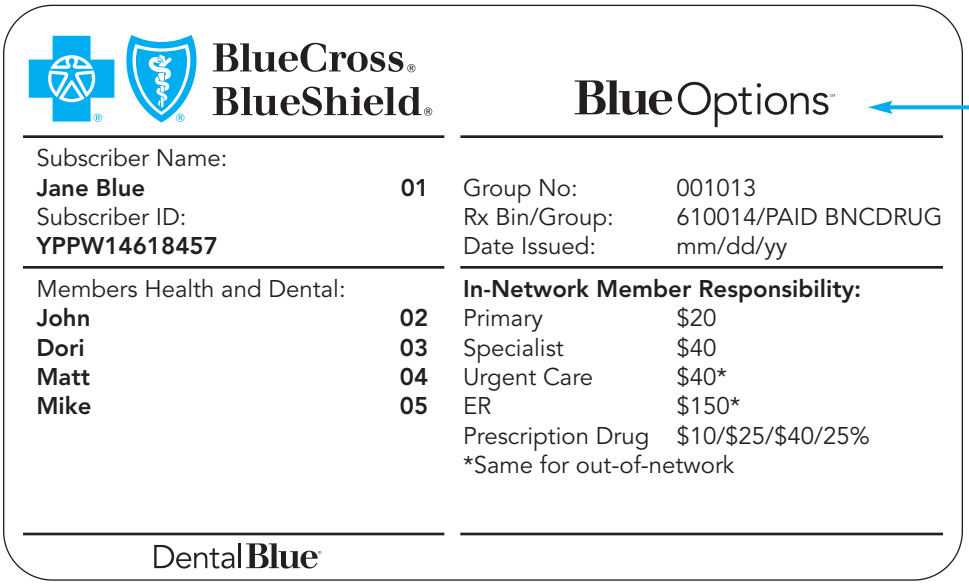
It's important to note that an identification card, in itself, does not guarantee that a person is currently enrolled in a BCBSNC dental plan. Whether from speaking with BCBSNC customer service, obtaining member information using ***Blue e***℠ or from the Web site ***bcbsnc-dental.com***, information about benefits and eligibility is accurate at the time it is given.

Coverage and payment decisions pertaining to eligibility are made according to the member's policy and current eligibility information when a claim is received, as of the date services were rendered. Eligibility responses provided by customer service, ***Blue e***℠ and/or the Web site ***bcbsnc-dental.com*** do not guarantee coverage, eligibility or payment.

BCBSNC recommends that a patient's chart be updated with a photocopy of the patient's most current member identification card, each time a patient is seen in your office. The updated copy of the member's card will help ensure that the needed member identifying information is accurately recorded for reporting on the next claim submission.

4.2.1 Sample member identification card – health and dental

Patients may arrive at your office and present varying types of BCBSNC member identification cards. This is because members can enroll in BCBSNC health care plans and add dental coverage as an option. Members can also select a dental plan as a stand alone coverage choice. Subsequently, a member may have an identification card for a dental coverage only plan that displays the name and logo of the dental product prominently in the upper right corner, on the front of the member's identification card. Or, if a member has health and dental coverage, the name and logo of the health care coverage plan will be displayed in the upper right corner and the dental product's name and logo will typically be printed in the lower left corner.



This card sample is of a Blue Options℠ member's identification card.

Blue Options℠ is the name of one of several health care products offered by BCBSNC. Some of the other product names include:

- Blue Advantage®
- Blue Care®
- Classic Blue®
- Blue Options℠ 123
- Blue Options℠ HRA
- Blue Options℠ HSA

- and there are more..

GRID+

Dental Blue® logo displayed on a card with a medical plan logo lets the dental care provider know that the member's identification card belongs to a member having both dental and health care benefits with BCBSNC.

Identifying that a member is part of a Blue plan that is participating in the GRID+ dental network.

Check the listed dependents for health and dental care eligibility.

Subscribers and their dependents may not always share all of the same benefits. Sometimes all dependents listed on a member's identification card will be included for dental coverage, sometimes one or only some of the dependents will be included for dental benefits, and still other times, dependents may have health benefits without coverage for dental under a subscriber's policy. It's important to always check the member's identification card and verify a patient benefits.

When reviewing a member's dependents listed on a health and dental identification card, always check that the patient is included under the dental coverage.

This card example lists all of the subscriber's dependents enrolled for dental care coverage.

BlueCross BlueShield

BlueOptions

Subscriber Name:
Jane Blue **01**
Subscriber ID:
YPPW14618457

Group No: 001013
Rx Bin/Group: 610014/PAID BNCDRUG
Date Issued: mm/dd/yy

Members Health and Dental:
John **02**
Dori **03**
Matt **04**
Mike **05**

In-Network Member Responsibility:

Primary	$20
Specialist	$40
Urgent Care	$40*
ER	$150*
Prescription Drug	$10/$25/$40/25%

*Same for out-of-network

DentalBlue

But another scenario could appear as:

Members Health and Dental:
John **02**
Matt **04**
Mike **05**

Members Health Only
Dori **03**

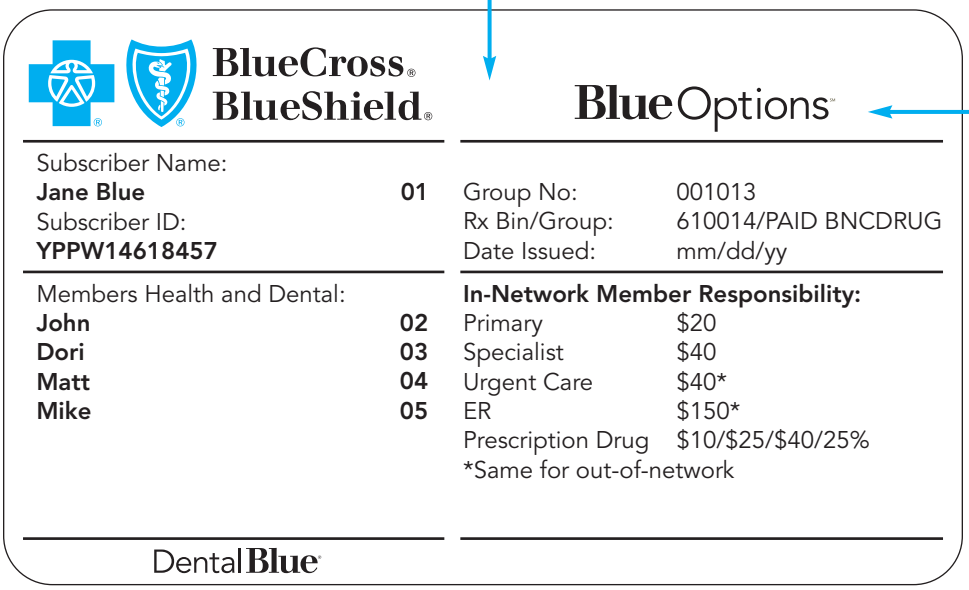
GRID+

Identifying that a member is part of a Blue plan that is participating in the GRID+ dental network.

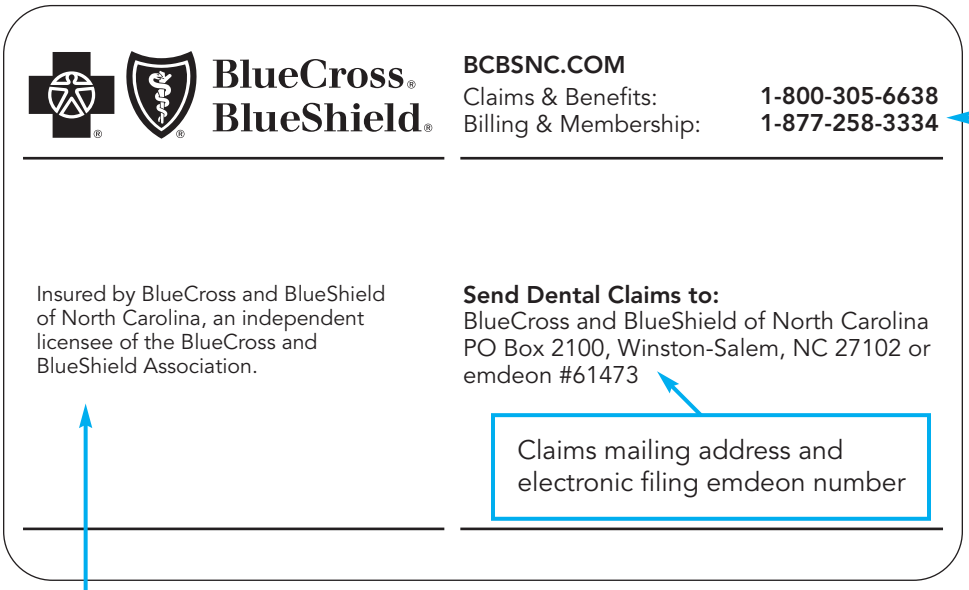
In this example Dori has health care coverage without dental coverage under the subscriber's policy.

4.2.2 Sample member identification card – dental care as a stand alone benefit

This card sample is of a Dental Blue® group plan member's identification card.
A card for a member enrolled in an individual plan would display a Dental Blue for Individuals℠ logo.



Likewise, if this card was for a Dental Blue® Select℠ member, the card would display the Dental Blue® Select℠ logo.



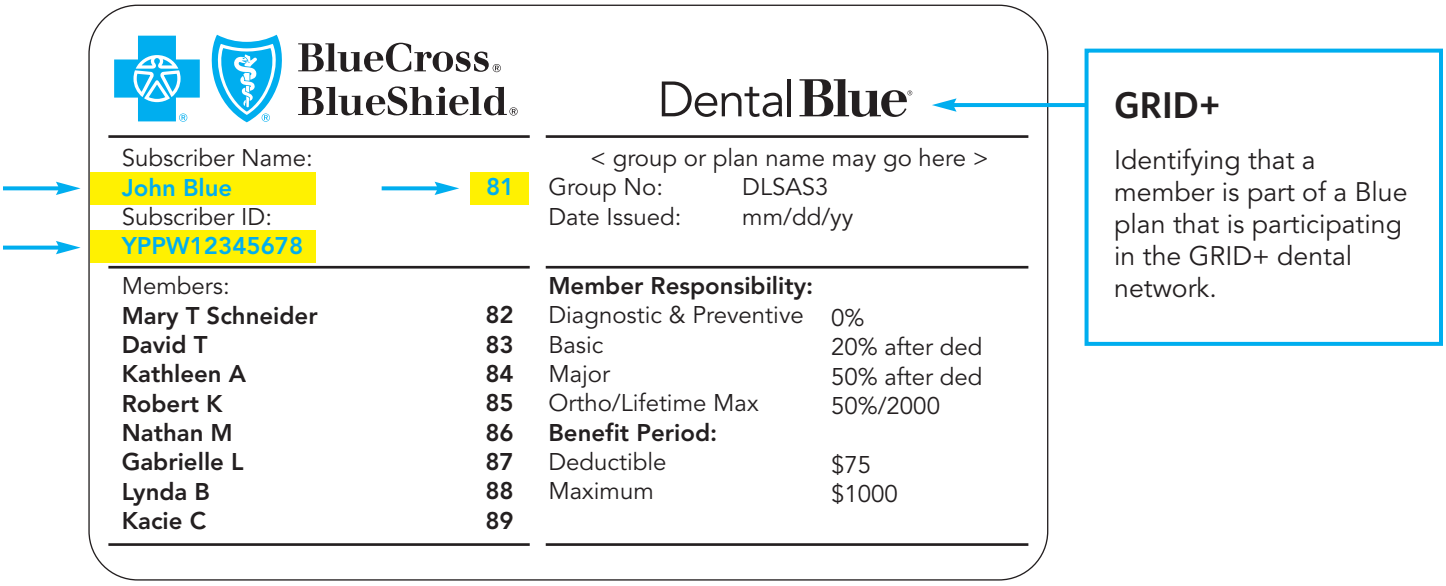
Customer service phone number

Listed on the back of a member's identification card is important contact information

Claims mailing address and electronic filing emdeon number

Lets a dental provider know that the coverage is with Blue Cross and Blue Shield of North Carolina (BCBSNC) and not another BC and/or BS Plan from another State.

4.2.3 Member identification cards – information needed for filing claims



Whether the patient is carrying a dental only identification card or a health and dental identification card, the patient information needed is the same. Always file claims for services that include the patient's complete identification number, which includes both numbers and letters.

Using the card image above as example, if filing a claim for **John Blue** the complete identification number would read **YPPW1234567881** (alpha prefix **YPPW** + the subscriber number **12345678** + the member number **81**). Including the member's complete identification number will help ensure fast and accurate processing of a dental claim.

Dental providers are encouraged to always verify a member's dental benefits, limitations and exclusions, in advance of providing services.

Dental Blue®

4.3 Dental Blue® for groups

Dental Blue® for groups is a group dental plan available to employees through their employer. Employers may contribute any amount towards the premium costs. Dental Blue® for groups is underwritten by Blue Cross and Blue Shield of North Carolina (BCBSNC). All membership and billing administrative services are provided by BCBSNC. All claims administration is provided by ACS Benefits Services, Inc.

Dental Blue® for groups offers employer groups a choice of standard and non-standard plans that include a choice of deductibles and annual maximums.

IMPORTANT: BCBSNC also offers a voluntary dental product called Dental Blue® Select℠. Please refer to the BCBSNC Dental Blue® Select℠ benefits information contained on the following pages of this ***e***-manual for benefits information about the BCBSNC voluntary group dental plan.

4.3.1 Benefit period

The 12-month benefit period is for a contract year, beginning with the group's effective date.

4.3.2 Waiting period

The following waiting period time limits only apply to those members who have waiting periods. This information does not apply to groups and/or members who do not have waiting periods.

Category	Standard plan	Late enrollments	Non-standard plans
Preventive	None	None	Non-standard plans may offer varying waiting periods for member's eligibility for services. Dental providers are encouraged to verify a member's benefits and eligibility in advance of providing services.
Basic	None	12 months	
Major	none or 12 months	12 or 24 months	
Orthodontia	none or 12 months	12 or 24 months	

Please note that depending on employer groups, waiting periods may be waived or extended for late enrollees.

4.3.3 Benefit categories

There are four benefit categories of dental services:

1) Diagnostic and preventive
2) Basic
3) Major
4) Orthodontia (available as a separate rider)

4.3.4 Benefit overview

The following overview of benefits is offered as an example of group dental benefit options; however, this is not a guarantee of member's benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

Dental Blue® for groups	Standard plan benefits*
Coinsurance	
Preventive services	80% - 100%
Basic services	80% - 100%
Major services	50%
Ortho	50%
Deductibles and maximums	
Individual deductible (applies to basic and major services)	$25 - $50 - $75
Family deductible options (applies to basic and major services)	3 times individual
Individual annual maximum options (applies to diagnostic and preventive, basic and major services)	$750 - $2,500
Lifetime maximum for orthodontia	$1,000 or $2,500
Prior coverage credit	Credit given for continuous prior dental coverage
Available benefits	
Preventive and diagnostic	Oral exams, teeth cleanings and scaling (2 per benefit period) Bitewing X-ray (2 per benefit period) Full mouth X-ray (1 every 3 yrs) Fluoride treatment (2 per period) Sealants (age 5-15) Space maintainers
Basic	Simple restorative services (fillings) Simple teeth removal Oral surgery Endodontics and periodontics** Stainless steel crowns

Continued on the following page.

Available benefits	
Major	Endodontics and periodontics** Crowns, inlays, onlays Bridges Dentures
Orthodontics	Children under 19*** No deductible

* Non-standard plans may offer varying benefits as selected by employers. Dental providers are encouraged to verify a member's benefits and eligibility in advance of providing services.

** Endodontics and periodontics may be considered either basic services or major services, depending on benefit categorization as elected by an employer group.

*** Standard plans may cover orthodontics on adults for medium or large groups.

Dental Blue Select℠

4.4 Dental Blue® Select℠ for groups (a voluntary group product)

Dental Blue® Select℠ for groups is a competitive voluntary dental plan underwritten by Blue Cross and Blue Shield of North Carolina (BCBSNC). All claims and administrative services including enrollment, billing, and customer service is provided by ACS Benefits Services, Inc.

Dental Blue® Select℠ offers employer groups a choice of three benefit plans:

1) Dental Blue® Select℠ standard – basic services at a low cost
2) Dental Blue® Select℠ complete – covers all dental needs at a reasonable price, orthodontia optional
3) Dental Blue® Select℠ enhanced – premium services at great value, orthodontia optional

4.4.1 Benefit period

The 12-month benefit period is for a contract year, beginning with the group's effective date.

4.4.2 Waiting period

The following waiting period time limits only apply to those members who have waiting periods. This information does not apply to groups and/or members who do not have waiting periods.

Category	Dental Blue® Select℠ standard	Dental Blue® Select℠ complete	Dental Blue® Select℠ enhanced
Preventive	None	None	None
Basic	6 months	6 months	None
Major	12 months	12 months	12 months (optional)
Orthodontia (optional)	NA	12 months when benefits apply	12 months when benefits apply

4.4.3 Benefit categories

There are four benefit categories of dental services:

1) Diagnostic and preventive
2) Basic
3) Major
4) Orthodontia (available as a complete or enhanced option)

4.4.4 Benefit overview

The following overview of benefits is offered as an example of a group's dental benefit options; however, this is not a guarantee of member's benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

	Dental Blue® Select℠ standard	Dental Blue® Select℠ complete	Dental Blue® Select℠ enhanced
Coinsurance			
Preventive services	100%	100%	100%
Basic services	80%	80%	80%
Major services	50%	50%	50%
Ortho	NA	50% (optional)	50% (optional)
Deductibles and maximums			
Individual deductible (applies to basic and major services)	$100 lifetime per member	$100 lifetime per member	$100 lifetime per member
Family deductible	NA - each family member satisfies an individual deductible	NA - each family member satisfies an individual deductible	NA - each family member satisfies an individual deductible
Individual annual maximum options (applies to diagnostic and preventive, basic and major services)	$1,000	$1,000 or $1,500	$1,000 or $1,500
Lifetime maximum for orthodontia	NA	$1,000 or $1,500 (optional coverage)	$1,000 or $1,500 (optional coverage)
Prior coverage credit	No	Yes	Yes

Continued on the following page.

	Dental Blue® Select℠ standard	Dental Blue® Select℠ complete	Dental Blue® Select℠ enhanced
Available benefits			
Preventive and diagnostic	Oral exams, teeth cleanings and scaling (1 per benefit period) Bitewing X-ray (maximum of 4 films per benefit period) Fluoride treatment (2 per period) Sealants (age 6-15)	Oral exams, teeth cleanings and scaling (2 per benefit period) Bitewing X-ray (maximum of 4 films per benefit period) Fluoride treatment (2 per period) Sealants (age 6-15)	Oral exams, teeth cleanings and scaling (2 per benefit period) Bitewing X-ray (maximum of 4 films per benefit period) Fluoride treatment (2 per period) Sealants (age 6-15)
Basic	Simple restorative services (fillings) Simple teeth removal	Simple restorative services (fillings) Simple teeth removal	Simple restorative services (fillings) Simple teeth removal Root of teeth X-ray Panorex or full mouth X-ray (1 per 36 months) Endodontics Periodontics
Major	Endodontics Periodontics Oral surgery Space maintainers Root of teeth X-ray Panorex or full mouth X-ray (1 per 36 months)	Root of teeth X-ray Panorex or full mouth X-ray (1 per 36 months) Endodontics Periodontics Oral surgery Space maintainers Crowns, inlays, onlays	Oral Surgery Space maintainers Crowns, inlays, onlays Dental implants Prosthodontics (bridges, dentures)
Orthodontics	Not available	Children under 19** No deductible	Children under 19** No deductible

* Enhanced with Orthodontia plan has all the same benefits as the Enhanced plan, plus orthodontia coverage.

** Standard plans may cover orthodontics on adults for medium or large groups.

Dental Blue
for Individuals℠

4.5 Dental Blue for Individuals℠

Dental Blue for Individuals℠ is a consumer dental product for individuals and their eligible dependents, underwritten by Blue Cross and Blue Shield of North Carolina (BCBSNC). All membership and billing administration is provided by BCBSNC. ACS Benefits Services, Inc. is responsible for all claims and customer service administration.

4.5.1 Eligibility

North Carolina residents and their dependents are eligible. An eligible dependent is defined as a spouse or an unmarried child until age 26. A child who is a North Carolina resident may have an individual policy in their name. A person is ineligible for Dental Blue for Individuals℠ if they have cancelled a previous Dental Blue for Individuals℠ policy within the past 12 months.

4.5.2 Waiting period

The following waiting period time limits only apply to those members who have waiting periods. This information does not apply to groups and/or members who do not have waiting periods.

Category	Standard plan	Non-standard plans
Preventive	None	Members who can demonstrate prior proof of dental coverage may have waiting periods waived if they have a statement from another carrier showing consecutive dental coverage. However, waiting periods will not be waived if more than 63 days have passed between the termination of the prior coverage and the effective date of the current coverage.
Basic	6 months	
Major	12 months	
Orthodontia	NA	

4.5.3 Benefit categories

There are three benefit categories of dental services:

1) Diagnostic and preventive
2) Basic
3) Major

(Orthodontic coverage is not available on the Dental Blue for Individuals℠ plan)

4.5.4 Benefit overview

The following overview of benefits is offered as an example of a member's dental benefit options; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

Dental Blue for Individuals℠	Plan benefits
Coinsurance	
Preventive services	100%, not subject to deductible or waiting period limitations
Basic services	60%, subject to deductible and 6 month waiting period
Major services	50%, subject to deductible and 12 month waiting period
Ortho	NA
Deductibles and maximums	
Individual deductible (applies to basic and major services)	$75 per member annual
Individual annual maximum (applies to all services)	$1000
Prior coverage credit	Yes, waived or reduced by number of months of prior coverage
Available benefits	
Preventive and diagnostic	Oral exams, teeth cleanings and scaling (2 per benefit period) Bitewing X-ray (2 per benefit period) Full mouth X-ray (1 every 3 yrs) Fluoride treatment (2 per period) Sealants (age 5-15) Space maintainers
Basic	Simple restorative services (fillings) Simple teeth removal Oral surgery Endodontics Stainless steel crowns

Continued on the following page.

Available benefits	
Major	Periodontics Crowns, inlays, onlays Bridges Dentures
Orthodontics	NA

4.6 Benefit exclusions and limitations

The following services, supplies and drugs are typically not covered under a member's dental benefit coverage unless written into a policy by an employer group:

- Not clinically necessary
- Investigational in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment
- Procedures that are considered to be experimental, including pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics
- Drugs or medications, obtainable with or without a prescription unless they are dispensed and utilized in the dental office during the patient visit
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
- Not prescribed or performed by or upon the direction of a dentist or other provider.
- For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement.
- Received prior to the member's effective date.
- Received on or after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining dental records, and late payment charges.
- Incurred more than 18 months prior to the member's submission of a claim to BCBSNC, except in the absence of legal capacity of the member.
- For any services that would not be necessary if a non-covered service had not been received, except for emergency services in the case of an emergency.
- For benefits that are provided by any governmental unit except as required by law.
- For services that are ordered by a court that are otherwise excluded from benefits under this dental benefit plan.
- For care that the provider cannot legally provide or legally charge or is outside the scope of license or certification.
- Provided and billed by a licensed dental care professional who is in training.
- Available to a member without charge.
- For care given to a member by a provider who is in a member's immediate family.
- For any condition suffered as a result of any act of war or while on active or reserve military duty.
- In excess of the allowed amount.
- For oral orthotic devices, palatal expanders and orthodontics except as specifically covered by a member's dental benefit plan.
- Dental services provided in a hospital, except when a hazardous condition exists at the same time or covered oral surgery services are required at the same time as a result of a bodily injury.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- Hypnosis except when used for control of acute or chronic pain.

- Acupuncture and acupressure.
- Surgery for psychological or emotional reasons.
- Travel, whether or not recommended or prescribed by a doctor or other licensed dental care professional, except as specifically covered by a member's dental benefit plan.
- Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control.
- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps.
- For services primarily for educational purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by your dental benefit plan.
- For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law.
- For conditions that federal, state or local law requires to be treated in a public facility.
- For vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind.
- Dental procedures performed solely for cosmetic or aesthetic reasons, except when dental procedures are performed in order to restore normal function to minor children with congenital defects and anomalies.
- Dental procedures not directly associated with dental disease.
- Procedures not performed in a dental setting.
- Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations or hard or soft tissue, including excision. Hard or soft tissue biopsies of neoplasms, cysts, or hard or soft tissue growth or unknown cellular makeup are not excluded.
- Replacement of complete or partial dentures, fixed bridgework or crowns within 8 years of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral.
- Expenses for dental procedures begun prior to the member's eligibility with the Plan.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct vertical dimension or occlusion (VDO).
- Denture relines for complete or partial conventional dentures are not covered for six months following the insertion of prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures are not covered for six months after insertion of the full or partial denture. After the specified waiting period, relines are covered once every 12 months.
- One hard tissue periodontal surgery and one soft tissue periodontal surgery per surgical area are covered within a 3-year period. This includes gingivectory, gingivoplasty, gingival curettage (with or without flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
- Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement, are covered once every 36 months per quadrant or surgical site.
- Clinical situations that can be effectively treated by a more cost-effective, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.
- Services for incision and drainage if the involved abscessed tooth is removed on the same date of service.
- Full mouth debridement is limited to once every 5 years.
- Occulsal guards for any purpose other than control of habitual grinding.
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
- Implants (except as specifically covered).
- Orthodontia services (except as specifically covered).
- Any dental services not specifically listed as a covered service.

Chapter 5

The Blue Book℠
Dental e-Manual

Federal employees health benefit plan Dental Blue® for Federal employees

Visit us at bcbsnc.com | bcbsnc-dental.com

BlueCross BlueShield of North Carolina

5.1 Federal Employees Health Benefit Plan (FEHBP)

The Blue Cross and Blue Shield Association (BCBSA) contracts with the United States Office of Personnel Management on behalf of the independent Blue Cross and Blue Shield Plans to provide health care coverage (including certain dental services) to federal employees, postal employees and retirees who choose to enroll in one of two service benefits plan options - standard option and basic option.

5.2 Eligibility

Benefits are available to federal employees who have elected coverage, retirees and their surviving spouses, family members, former spouses, federal employee reservists who are on leave and certain members qualifying for temporary continuation of coverage. Please visit the United States Office of Personnel Management Web site for detailed descriptions about eligibility requirements: ***http://www.opm.gov/insure/health/eligibility/index.asp***.

5.3 Benefit overview

The following overview of benefits is offered as an example of benefits available to federal employees; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

2012 Standard option

Under the standard option plan a member's dental benefits will typically cover the billed charges for the following services, up to the amounts shown per service, as listed in the following chart. Members enrolled in the standard option have no deductibles, copayments, or coinsurance amounts. When members use preferred dentists they pay the difference between the amounts listed in the below chart and the dental provider's contractual allowance with BCBSNC.

Available benefits	Benefit to age 13	Benefit for age 13 and over
Clinical oral evaluations		
Periodic oral evaluation (limited to 2 per person per calendar year)	$12	$8
Limited oral evaluation	$14	$9
Comprehensive oral evaluation	$14	$9
Detailed and extensive oral evaluation	$14	$9
Radiographs		
Intraoral complete series	$36	$22
Intraoral periapical first film	$7	$5
Intraoral periapical each additional film	$4	$3
Intraoral occlusal film	$12	$7
Extraoral first film	$16	$10

Continued on the following page.

Available benefits	Benefit to age 13	Benefit for age 13 and over
Extraoral each additional film	$6	$4
Bitewing – 1 film	$9	$6
Bitewings – 2 films	$14	$9
Bitewings – 4 films	$19	$12
Bitewings – vertical	$12	$7
Posterior-anterior or lateral skull and facial bone survey film	$45	$28
Panoramic film	$36	$23
Tests and laboratory exams		
Pulp vitality tests	$11	$7
Palliative treatment		
Palliative (emergency) treatment of dental pain – minor procedure	$24	$15
Sedative filling	$24	$15
Preventive		
Prophylaxis – adult*	$0	$16
Prophylaxis – child*	$22	$14
Topical application of fluoride (prophylaxis not included) – child	$13	$8
Topical application of fluoride (prophylaxis not included) – adult	$0	$8

*Limited to 2 per person per calendar year

Space maintenance (passive appliances)		
Space maintainer – fixed – unilateral	$94	$59
Space maintainer – fixed – bilateral	$139	$87

Continued on the following page.

Available benefits	Benefit to age 13	Benefit for age 13 and over
Space maintainer – removable – unilateral	$94	$59
Space maintainer – removable – bilateral	$139	$87
Recementation of space maintainer	$22	$14

Amalgam restorations (including polishing)

Amalgam – 1 surface, primary or permanent	$25	$16
Amalgam – 2 surfaces, primary or permanent	$37	$23
Amalgam – 3 surfaces, primary or permanent	$50	$31
Amalgam – 4 or more surfaces, primary or permanent	$56	$35

Filled or unfilled resin restorations

Resin – 1 surface, anterior	$25	$16
Resin – 2 surfaces, anterior	$37	$23
Resin – 3 surfaces, anterior	$50	$31
Resin – 4 or more surfaces or involving incisal angle (anterior)	$56	$35
Resin-based composite – 1 surface, posterior	$25	$16
Resin-based composite – 2 surfaces, posterior	$37	$23
Resin-based composite – 1 surface, posterior	$25	$16
Resin-based composite – 3 surfaces, posterior	$50	$31
Resin-based composite – 4 or more surfaces, posterior	$50	$31

Continued on the following page.

Available benefits	Benefit to age 13	Benefit for age 13 and over
Inlay restorations		
Inlay – metallic – 1 surface	$25	$16
Inlay – metallic – 2 surfaces	$37	$23
Inlay – metallic – 3 or more surfaces	$50	$31
Inlay – porcelain/ceramic – 1 surface	$25	$16
Inlay – porcelain/ceramic – 2 surfaces	$37	$23
Inlay – porcelain/ceramic – 3 or more surfaces	$50	$31
Inlay – composite/resin – 1 surface	$25	$16
Inlay – composite/resin – 2 surfaces	$37	$23
Inlay – composite/resin – 3 or more surfaces	$50	$31
Other restorative services		
Pin retention – per tooth, in addition to restoration	$13	$8
Extractions – includes local anesthesia and routine post-operative care		
Extraction, erupted tooth or exposed root	$30	$19
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27
Surgical removal of residual tooth roots (cutting procedure)	$71	$45
General anesthesia in connection with covered extractions	$43	$27

Continued on the following page.

2012 Basic option

Under the basic option plan benefits are available for the following listed services. Members pay a $25 copayment for each evaluation; the benefit plan typically pays any remaining balance up to the dental provider's contracted allowable with BCBSNC. This is a complete list (except for accidental) of dental services and benefits covered under the basic option plan. Members must use a preferred dentist in order to receive benefits.

Available benefits	Plan pays	Member pays
Clinical oral evaluations		
Periodic oral evaluation (limited to 2 per person per calendar year)	Charges in excess of $25 copayment (up to the preferred dental provider's contractual allowable)	$25 copayment per evaluation when services received from a preferred dental provider
Limited oral evaluation		
Comprehensive oral evaluation		
Detailed and extensive oral evaluation		
Radiographs		
Intraoral - complete series including bitewings (limited to 1 complete series every 3 years)	Charges in excess of $25 copayment (up to the preferred dental provider's contractual allowable)	$25 copayment per evaluation when services received from a preferred dental provider
Bitewing – 1 film*		
Bitewings – 2 films*		
Bitewings – 4 films*		
Bitewings – vertical		
*Benefits are limited to a combined total of 4 films per person per calendar year		
Preventive		
Prophylaxis – adult*	Charges in excess of $25 copayment (up to the preferred dental provider's contractual allowable)	$25 copayment per evaluation when services received from a preferred dental provider
Prophylaxis – child*		
Topical application of fluoride (prophylaxis not included) – child (up to 2 per calendar year)		
Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only)		

Continued on the following page.

Accidental injury	Standard option	Basic option
Benefits are available for services, supplies and appliances for dental care necessary to promptly repair injury to sound natural teeth, as required as a result of, and directly related to, an accidental injury. **Notes:** An accidental injury is an injury caused by an external force or element such as a blow or fall and that requires immediate attention (injury to teeth while eating is not considered an accidental injury). A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this benefit, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Benefit pays 85% of the contractual allowance when services are provided by a preferred dental provider (calendar year deductible applies). **Note:** Benefits for accident related services are first applied based on dental benefits available. Accidental injury benefits are then applied based on any remaining balances for those services.	Member pays $100 copayment per performing surgeon **Note:** All follow-up care must be performed by a preferred provider to be eligible for benefits.

5.4 Additional online information

Additional dental benefits information is available from the 2012 Service Benefit Plan handbook, which may be accessed on the Web at:

- ***http://www.fepblue.org/benefitplans/2012-sbp/bcbs-2012-R171-005.pdf***

To learn more about the Federal Employees Program, dental providers can visit the following Web sites:

- BCBSNC Federal Employees Program: ***http://www.bcbsnc.com/content/fep/index.htm***
- Federal Employees Program: ***http://www.fepblue.org/***
- U.S. Office of Personnel Management: ***http://www.opm.gov/insure/index.aspx***

5.5 Important information about Federal Dental Blue® when accessing Web site information

Federal employees located in a few states other than North Carolina are offered an optional dental benefit program called Federal Dental Blue®, which supplements the dental benefits members already receive when enrolled in a standard or basic option plan.

Currently membership enrolled in Federal Dental Blue® resides primarily in one of the following Blue Cross and Blue Shield Plan areas; Alabama, Oklahoma, New Mexico, Texas and Illinois.

Federal employees having benefits administered through Blue Cross and Blue Shield of North Carolina (BCBSNC) are not currently eligible for Federal Dental Blue® supplemental benefits. We want to make you aware of this distinction, in case, when viewing information on the Web, Federal Dental Blue® information is accessed. Also, dental providers should be aware that BCBSNC is currently working to bring Federal Dental Blue® to North Carolina and we will update dental providers when the supplemental dental benefits become available for local federal employees.

5.6 Dental Blue® for Federal employees

Dental Blue® for Federal Employees offers flexibility and freedom: A choice of plan options (standard and basic) and the ability to choose any licensed dentist in North Carolina. Dental Blue® for Federal Employees is not part of the covered benefits of any other BCBSNC health plans. It must be purchased separately.

This dental product, offered by BCBSNC, is intended to complement the policy offered to federal employees and retirees by the federal government. This dental product is not approved, endorsed or accredited by the federal government, and it is in no way connected to the federal government or to the U.S. Office of Personnel Management.

5.6.1 What's covered

Type of coverage	Plan benefits	
	Standard option	Basic option
Preventive services **Standard option** Routine oral exams and cleanings Bitewing X-rays Pulp testing Fluoride treatment (for those under the age of 19) Palliative emergency treatment Emergency oral examinations Sealants and other preventive services **Standard and Basic options** Space maintainers (for those under the age of 13) and other preventive services	You pay 0% (plus applicable copayment[1]). There is no deductible and no waiting period.[2]	Routine services such as checkups, cleanings, and x-rays are not covered. You pay 0% on some Diagnostic and Preventive services such as palliative treatments, consultations, space maintainers and pulp testing.
Basic services Fillings Simple extractions Oral surgery Other basic services	You pay 35% (plus applicable copayment[1]) in Year 1 with no deductible and no waiting periods.[2] In Year 2 and after, you pay 25% (plus applicable copayment[1]).	You pay 35% in Year 1 with no deductible and no waiting periods.[2] In Year 2 and after, you pay 25%.
Major services Gingival curettage Gingivectomy and gingivoplasty Endodontics (root canals) Periodontal maintenance Inlays and onlays (once every 8 years) Crowns, bridges, dentures, implants and other major services	You pay 60% (plus applicable copayment[1]) in Year 1 with no deductible and no waiting periods.[2] In Year 2 you pay 55% (plus applicable copayment[1]) and in Year 3 and after you pay 50% (plus applicable copayment[1]).	You pay 60% in Year 1 with no deductible and no waiting periods.[2] In Year 2 you pay 55%, and in Year 3 and after you pay 50%.

Continued on the following page.

Type of coverage	Plan benefits	
	Standard option	Basic option
Orthodontic services Orthodontic services (members under age 19 only)	There is a 24-month waiting period before coverage begins. Once coverage begins you pay 50% with no deductibles and no copayment amounts. There is a $1,500 lifetime maximum per individual.	There is a 24-month waiting period before coverage begins. Once coverage begins you pay 50% with no deductibles and no copayment amounts. There is a $1,500 lifetime maximum per individual.
Annual maximum, all services (except Orthodontia)	$3,000	$2,500

5.6.2 Waiting periods

Diagnostic and Preventive services	None
Basic services	None
Major services	None
Orthodontia	24 months

GRID+

6.1 National GRID+ Dental Network, effective January 1, 2012

The GRID+ is a national dental network formed by a consortium of Blue Cross and Blue Shield plans.

The GRID+ network is one of the largest dental networks across the United States, providing broad access and discounts to our dental members.

All dental members can access the GRID + network when traveling outside the state of North Carolina.

Billing and reimbursement

7.1 BCBSNC dental claims submission

BCBSNC accepts dental claims in the following formats: EDI (electronic data interchange) submissions via the Emdeon clearing house and paper claims.

Emdeon is the preferred and most efficient method.

An interactive paper claim form is available online. Using the ***bcbsnc-dental.com*** site, register and log in as a provider. (Refer to chapter two for instructions on registration.) You will then have access to the appropriate dental claim form for each of the dental products which include the correct mailing address.

7.2 National provider identifiers

BCBSNC requires that all electronically transmitted claims include billing and rendering NPI (national provider identifier) numbers.

7.3 Emdeon clearing house

Dental providers are encouraged to submit their claims via Emdeon. Claims are received by BCBSNC through separate Emdeon payor numbers that identify product lines. Submitting claims using an incorrect payor ID number will delay processing. Always refer to the member's BCBSNC ID card to properly identify the correct plan and the correct Emdeon payor ID number:

- 61473 – BCBSNC Dental Blue for group and individual plans and Dental Blue for Federal Employees
- 61474 – BCBSNC Dental Blue Select (group enrollment only)
- 61472 – Federal employees
- 61472 – North Carolina Health Choice for Children

7.4 NEA FastAttach™ and *Fast*Look

Dental providers can send electronic attachments using FastAttach™, made available from National Electronic Attachment Inc. (NEA). FastAttach™ enables dental providers to transmit electronic attachments in support of electronic claims via the Internet. Attachments can also be stored for providers requesting the service. Attachments include: X-rays, lab reports, EOBs, narratives, OP reports, dental notes, perio-charts and most other documents required to process a claim.

Dental providers can receive additional information about FastAttach™ services and/or sign up for FastAttach™, by calling **1-877-425-9334** or by visiting NEA on the Web at ***www.nea-fast.com***. If signing up for FastAttach™ use, enter the promotional code of BBNC2M to receive half off the $200 registration fee, and two months of free service ($25 per month) for a savings of $150. Please note that this is a promotional rate and subject to expiration.

Additionally, NEA offers the *Fast*Look system, which gives providers one central site to view the attachment requirements for multiple payors (BCBSNC), as well as, other dental care payors). Using *Fast*Look dental care providers can search by payor name and procedure code to determine what, or if any, attachments need to be sent to a member's payor plan. For more information about the *Fast*Look system, please visit *Fast*Look on the Web at ***welcometonea.com*** or call **1-800-782-5150**, ext #**2**.

Please note that costs and/or fees can be associated with the use of FastAttach™ and/or the *Fast*Look systems. Dental providers enrolling for use of the NEA offered applications assume all associated expenses.

7.5 Paper claims

Claims for dental services must be submitted on the most current version of the American Dental Association (ADA) Claim Form. ADA claim forms may be purchased from a vendor or directly from the ADA by calling **1-800-947-4746** or visiting ADA on the Web at ***ada.org***. Additionally, dental providers may download copies of the current pre-addressed and approved ADA forms from ***bcbsnc-dental.com***.

7.6 Claim form completion

Dental claim forms must be submitted with all required fields complete, using acceptable data and coding sets needed to complete processing of a claim (please note that additional information may be requested). Claim submissions should report all rendered services and include procedure codes from the most current ADA Current Dental Terminology (CDT) User's Manual.

All participating dental providers must submit claims within 180 days from the date of completion of the dental treatment. Below is a summary (not all-inclusive) of what's needed to comply with claims submission requirements:

- Use the most current version of the American Dental Association (ADA) Claim Form and complete by following the ADA Claim Form instructions.

- Essential data elements must be completed (essential data elements include, but are not limited to, place of service codes and procedure codes).
- Claims must be completed using the ADA standard code set. Claims missing an essential data element or listing inappropriate code sets, or are otherwise illegible, will be returned.
- Include necessary supporting documentation (i.e. X-rays and dental provider notes).
- Claim forms must include the member's name and ID number (including alpha prefix and suffix) and patient's date of birth.
- The dental provider's identifying information and the location where service was provided must be clearly identified on the claim form.
- A date of service must be provided on the claim form for each service line submitted.
- Each separate (individual calendar date) of service must be submitted as a single claim. Individual claims may not span dates of service with the exception of certain orthodontia services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Failure to provide tooth and surface identification codes can result in the delay or denial of claims payment.

7.7 Sample ADA claim form and completion instructions

General completion guidelines along with a sample image of the current ADA claim form are available for view from the American Dental Association, located on the ADA Web site at ***ada.org***. The ADA claim form contains 58 fields for dental provider completion, to be used when submitting a claim. The following general instructions have been taken from the ADA completion guidelines that detail information needed for each of the 58 fields:

- Field 1, check all applicable if the patient is covered by EPSDT (State Medicaid's early and periodic screening, diagnosis and treatment program) for persons under age 21
- Field 2, enter the predetermined or preauthorized number provided by the payor if submitting a claim for services that have been predetermined or preauthorized
- Field 3, the payor's name, address and Web payor ID#
- Field 4, check box indicating if patient has other coverage
- Fields 5 – 11, complete other insurance information if patient has other coverage or leave blank if no other coverage
- Field 12, patient's BCBSNC member identification number including alpha prefix and suffix
- Field 13, patient's date of birth
- Field 14, check the box indicating gender
- Field 15, the subscriber's member identification number including alpha prefix and suffix
- Field 16, the subscriber's or employer group's plan or policy number (not the subscriber's identification number)
- Field 17, the subscriber's employer's name
- Field 18, check the box indicating the patients relationship to the subscriber
- Field 19 - 23, complete patient information, but only if the patient is not the primary subscriber (self is not indicated in Field 18)
- Field 19, check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank
- Field 23, enter if dentist's office assigns a unique number to identify the patient that is not the same as the subscriber identifier number assigned by the payor e.g., chart number)
- Field(s) 24, enter the date of the procedure(s)
- Field 25, designate tooth number(s) or letter(s) when procedure code directly involves a tooth (use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity')
- Field 26, enter applicable ANSI ASC X12 code list qualifier:
  - ‡ Use "JP" when designating teeth using the ADA's Universal/National Tooth Designation System
  - ‡ Use "JO" when using the ANSI/ADA/ISO Specification No. 3950
- Field 27, designate the tooth number when procedure code reported directly involves a tooth:
  - ‡ If a range of teeth is being reported use a hyphen ('-') to separate the first and last tooth in the range
  - ‡ Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported

- Field 28, designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces (enter up to five of the following codes, without spaces; B = Buccal; D = Distal; F = Facial; L = Lingual; M = Mesial; and O = Occlusal)
- Field 29, use appropriate dental procedure code from current version of Code on Dental Procedures and Nomenclature
- Field 30, provide a description of service(s)
- Field 31, list dentist's full fee for the dental procedure reported
- Field 32, used when other fees applicable to dental services provided must be recorded (fees include state taxes, where applicable, and other fees imposed by regulatory bodies)
- Field 33, the total of all fees listed on the claim form
- Field 34, report missing teeth on each claim submission
- Field 35, use the "remarks" space for placement of NEA reference numbers and additional information such as 'reports' for '999' codes or multiple supernumerary teeth
- Field 36, patient's signature – the patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental care (for matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case)
- Field 37, subscriber's signature – necessary when the patient/insured and dentist wish to have benefits paid directly to the provider (this is an authorization of payment, it does not create a contractual relationship between the dentist and the payor)
- Field 38, indicate place of treatment, office, hospital, ECF or other (ECF is the acronym for extended care facility [e.g., nursing home])
- Fields 48-52, leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber
- Field 48, the individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information (this may differ from the actual treating dentist's name and is the information that should appear on any payments or correspondence that will be remitted to the billing dentist)
- Field 49, NPI (national provider identifier) assigned to billing dentist of dental entity other than the SSN or TIN (necessary when assigned by carrier receiving the claim)
- Field 50, refers to the license number of the billing dentist (this may differ from that of the treating [rendering] dentist that appears in the treating dentist's signature block)
- Field 51, social security number or TIN
- Field 52, the Internal Revenue Service requires that either the social security number (SSN) or tax identification number (TIN) of the billing dentist or dental entity be supplied only if the provider accepts payment directly from the third-party payor (when the payment is being accepted directly report the: 1) SSN if the billing dentist in unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic)
- Field 53, the treating, or rendering, dentist's signature and date the claim form was signed (dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed)
- Field 56, full address, including city, state and zip code, where treatment performed by treating (rendering) dentist
- Field 58, enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers' section of the Healthcare Providers Taxonomy code list (the current list is posted at: ***wpc-edi.com/codes/codes.asp***)

  The available taxonomy codes, as of the first printing of the ADA claim form are as follows:

  ‡ **122300000X** Dentist – a dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.

  ‡ **1223G0001X** General practice – many dentists are general practitioners who handle a wide variety of dental needs.

  Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

  ‡ **1223D0001X** Dental public health
  ‡ **1223P0221X** Pediatric dentistry (pedodontics)
  ‡ **1223E0200X** Endodontics
  ‡ **1223P0106X** Oral & maxillofacial pathology
  ‡ **1223P0300X** Periodontics
  ‡ **1223D0008X** Oral and maxillofacial radiology
  ‡ **1223P0700X** Prosthodontics
  ‡ **1223S0112X** Oral & maxillofacial surgery
  ‡ **1223X0400X** Orthodontics

7.8 Required identifying information

- Member's name, BCBSNC identification number (including alpha prefix and suffix) and date of birth must be listed on all claims submitted. If the member's identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting provider's office, causing a delay in payment. The member's ID is located on the member's BCBSNC identification card. (Do not use "nick names" when submitting claims.)
- The rendering and billing office must be clearly identified on the claim. Please include either a typed dentist (practice) name, NPI and tax identification number for both the rendering provider and the billing entity.
- The date of service must be provided on the claim form for each service line submitted.
- Use approved ADA dental codes as published in the current CDT book.
- Claims must be submitted within 180 days of the date of service.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Failure to provide tooth and surface identification codes can result in the delay or denial of claim payment.

7.9 Documentation, treatment plans, charting and X-rays

Please send only copies of x-rays or readable images. X-rays will not be returned unless they are accompanied by a postage paid envelope.

Dental providers can send electronic attachments using FastAttach™ available on the Web at *http://edsedi.com/NEA.aspx*.

For a listing of CDT specific codes and corresponding documentation that can be accepted by NEA for transmission per BCBSNC coverage plan type, please see chapter nine of this *e*-manual.

7.10 Postage

Affix the proper postage when mailing bulk documentation to BCBSNC. BCBSNC does not accept postage due mail. This mail will be returned to the sender and will result in delay of processing and payment.

7.11 Timely filing of claims

To be eligible for payment, claims must be received no later than one hundred and eighty (180) days of the date of service. Participating dental providers may not collect, or attempt to collect payment from BCBSNC members for any claim that was not submitted within the 180 day time period.

7.12 Dental coding terminology, dental procedures and nomenclature

Dental providers should report services using codes found in the most current edition of the Current Dental Terminology (CDT) manual. The CDT manual is published by the American Dental Association (ADA) for reporting services for treatment. The existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract. The CDT manual can be purchased directly from the ADA by calling **1-800-947-4746** or by accessing their Web site at ***ada.org***.

7.13 Dental claims processing

In an effort to process claims accurately and consistently, ACS as our claims processing administrator has developed processing standards that represent current community standards of dental care and are derived through consultation with dental practices, academic communities and current scientific literature. These standards are supported by system edits designed to adjudicate claims efficiently and accurately based on the member's contract. These edits use the most cost-effective, clinically appropriate claim reimbursement, based on clinical standards and contractual limitations.

7.14 Mutually exclusive edits

Mutually exclusive edits are designed to identify the billing for two or more procedures that by dental care standards would not usually be billed for the same patient, on the same date of service.

7.15 Bundling edits

Unbundling occurs when two or more procedures are used to describe a service for which a single, more comprehensive procedure exists that more accurately describes the complete service performed. Unbundled procedures will be re-bundled to the correct CDT procedure.

7.16 Incidental and integral

Incidental and integral services are defined as procedures carried out at the same time as a primary procedure, which are clinically integral/necessary to the performance of the primary procedure. Additional reimbursement is not provided for incidental procedures, as they are included in the allowance for the primary procedure.

7.17 General criteria

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member's condition. Treatment rendered for cosmetic reasons, member convenience or services that do not meet standards of care are not eligible for benefits.

7.18 Dental (CDT) accidental procedure codes

Claims coded with (CDT) accidental procedure codes are processed under the member's medical coverage instead of their dental coverage. Oral surgical services and services rendered as a result of an accidental injury must be reported on the most current version of the American Dental Association (ADA) claim form. Services not covered under the dental plan should be submitted to the member's medical plan using a CMS-1500 Claim Form.

7.19 Dental-medical claims CPT/HCPC

Claims for "dental-medical" (dental related services that fall under a patient's medical benefit), such as accidental injury and/or TMJ services, should be filed to BCBSNC (or the patient's medical benefit carrier) using the most current version of the CMS-1500 claim form. Essential data elements must be completed.

Essential data elements include, but are not limited to, place of service codes and procedure codes (including modifiers if applicable). Claims must be completed using CPT and/or HCPC standard code sets. Claims missing an essential data element or that use an inappropriate code or are otherwise illegible will be returned.

BCBSNC accepts medical service claims when filed using the CMS-1500 paper claim form and when filed electronically. If sending a paper claim form to BCBSNC, please submit to the medical claims address listed on the member's BCBSNC identification card. Providers electing to transmit claims electronically for medical services can obtain resources and required forms on the BCBSNC electronic solutions Web site located at ***bcbsnc.com/content/providers/edi/***.

Please note that all electronic senders of claims for medical services will need to sign and submit a Blue Cross and Blue Shield of North Carolina trading partner agreement and an electronic connectivity request form or a ***Blue e***℠ interactive network agreement available from the BCBSNC Web site located at ***bcbsnc.com/content/providers/edi/***.

7.20 Accidental injuries and dental-medical for out-of-state members

BCBSNC can accept claims for Blue Cross and/or Blue Shield member's having medical benefits coverage from a Blue Cross and/or Blue Shield Plan other than BCBSNC, when services are provided for accidental injuries or other services that qualify under the out-of-state member's medical benefit plan.

Send claims for "dental-medical" services provided to out-of-state Blue Cross and/or Blue Shield Plan members to: BCBSNC P.O. Box 35, Durham NC, 27702. Questions about claims filed for out-of-state members should be placed by calling **1-800-487-5522**. Dental providers can also verify an out-of-state Blue Cross and/or Blue Shield Plan member's medical eligibility or benefits by calling **1-800-676-BLUE (2583)**.

7.21 Payment guidelines

Providers are notified of payment determination via messages contained on the notification of benefit (NOB). For example, a message will appear when services that are considered incidental to the primary service are not eligible for separate reimbursement.

7.22 Payment for covered services only

Participating dental providers are eligible for payment, only when, the services provided are clinically necessary and covered as part of the member's benefit plan. The issuance of the member's benefit payment amount is considered payment in full, with the exception of any applicable deductible, coinsurance, and/or copayment amounts.

7.23 Appeals and review of benefit determinations

Please contact BCBSNC Dental Blue® customer service for assistance with making a request for appeal or benefit determination review. Please use the call center appropriate for the member's benefit coverage type as outlined in section two of this ***e***-manual.

7.24 Billing BCBSNC members

Providers agree not to bill members for services until after receipt of the BCBSNC issued notification of benefits, except for member's copayments. Member's copayment amounts, when applicable, are listed on the member's BCBSNC identification card. However, dental providers may bill BCBSNC members prior to the receipt of the NOB for services verified in advance as non-covered. Any amounts that both you and the member agree were collected erroneously for any reason must be refunded to the member within 45 days of the receipt of the NOB or your discovery of the error.

7.25 Amounts billable to members

Providers may collect any applicable copayments at the time service is rendered. Any applicable coinsurance and/or deductible amounts may be collected from BCBSNC members only after receipt of the notification of benefits. Amounts for non-covered services may only be collected if they meet the criteria outlined in the instructions for the hold harmless provision as contained this ***e***-manual. Any amounts collected erroneously by a dental care provider, from a member, for any reason, shall be refunded to the member within forty-five (45) days of the error being identified.

7.26 Amounts not billable to members

Participating providers may not collect any payments from members for covered services, except for any applicable copayment, coinsurance and deductible amounts. Participating providers may not balance bill BCBSNC members for the difference between billed charges and the amount allowed on the notification of benefits for a processed claim. Any differences between a dental provider's charges and the allowed amount are considered contractual adjustments and are not billable to members. Participating providers may not seek payment from either members or BCBSNC if a proper claim has not been submitted to BCBSNC within 180 days of the date a service is rendered. Participating providers charging fees for administrative services, such as paper work completion or furnishing clinical records may not bill BCBSNC members for these fees.

7.27 Billing members for non-covered services

Sometimes a dental provider may be asked by a member to provide services that are not covered by the member's benefit plan. Only under the following conditions may the provider bill the member for such services:

- The provider informs the member in advance of providing the service, in a written notification, that the specific service might not be covered.
- The member signs a written acknowledgment that he/she received such notification prior to receiving the specific service at issue. That notification must inform the member that the particular service at issue may not be covered.

- The member also acknowledges in advance and in writing that he/she has chosen to have the service at issue and if it is indeed not covered, the member is responsible for the expense and will pay the dental provider directly.
- The written notice regarding a particular service must be specific, defining the exact treatment of care being provided to the member. It is not acceptable to use a generic release form with a general statement regarding member's obligations to pay for non-covered services.

7.28 Coordination of benefits

When a member is covered by more than one coverage plan, one plan must be designated as primary and the other as secondary. Coordination of benefits (COB) logic is used to determine which plan pays first on the claim.

If BCBSNC is primary and another insurance plan is secondary, use the following guidelines:

- Any prior approval and/or certification requirements must be followed according to the member's BCBSNC plan.
- File a claim first with BCBSNC. The secondary plan may be billed any copayment, coinsurance and/or deductible amounts and for services not covered under the BCBSNC member's benefit plan.

If BCBSNC is secondary, use the following guidelines:

- Any prior approval and/or certification requirements must be followed according to the member's BCBSNC plan.
- File a claim with the primary plan first, after the primary plan pays its benefits, then file the secondary claim along with the primary payment information to BCBSNC.

BCBSNC and our member's combined liability are limited to the BCBSNC contractual allowed amount. The contract between the provider and BCBSNC allows that benefits will be coordinated up to the contractual allowance. Disallowed amounts and/or services cannot be billed to the member.

7.29 Hold harmless provision

Providers agree not to bill or otherwise hold members, BCBSNC or any third party responsible for payment for services and/or supplies provided to members, which are determined not to be clinically necessary and/or not eligible under the member's benefit plan, except when the following conditions shall have been met:

- The dental provider obtained prior authorization or certification in advance of providing the specific services and/or supplies to the member – and/or – the dental provider gave specific written notification to the member in advance of providing the non-medically necessary services or other non-covered services, explaining that such service might not be covered under the member's benefit plan; and the member signed a written authorization stating that:
  - ‡ The member received from the provider notification that the specific services and/or supplies may not be covered by his or her benefit plan.
  - ‡ The member received the notification prior to receiving the specific services and/or supplies.
  - ‡ The notification informed the member that the particular services and/or supplies, if not covered by member's benefit plan, are provided at the member's own expense, if the member elects to receive the specific services and/or supplies.
  - ‡ The provider obtained the member's written authorization prior to rendering the specific services and/or supplies.
  - ‡ The member's authorization includes that such services and/or supplies may not be covered by his or her benefit plan and the member agrees to pay for such services and/or supplies apart from his or her benefit plan.
  - ‡ The member's authorization specifies that the member elects to receive such services and/or supplies at the member's own expense and the provider has obtained the member's written authorization.
  - ‡ The notification by the provider and the authorization by the member, as set forth in the agreement, shall be given regarding a particular service at issue in the specific treatment of a member and not as a matter of general or standard procedure in all cases.

Dental providers agree to provide BCBSNC and/or ACS with a copy of any and all such written authorizations upon request.

Please refer to your dental care practice's contractual agreement with BCBSNC to review the hold harmless provision and how the provision applies. If you have questions regarding the hold harmless provision, please contact your regional BCBSNC network management representative.

Pre-treatment estimates and prior approval

BlueCross BlueShield of North Carolina

8.1 Pre-treatment estimate of benefits

A pre-estimate of benefits is a request made prior to a procedure being performed, to verify benefits and clinical appropriateness of a procedure. This allows both the dental care provider and the patient to make an informed decision of potential coverage for a given procedure in advance.

When the charges from a dentist for a proposed course of treatment are expected to be over $250, a pre-treatment estimate of benefits is strongly recommended before any services are performed. The member or the dentist can make a request for a pre-treatment estimate of benefits (however, certain procedural and dental necessity information will most often be needed from the dental provider rendering care). Once received, the information will be reviewed and a pre-treatment estimate of benefits will be provided.

When requesting a pre-estimate of benefits, please send a written request along with any supporting documentation to the claims mailing address that's listed on the member's identification card, or use the claims mailing information located in chapter two of this ***e***-manual.

Pre-treatment requests for a specific diagnosis or procedure must be submitted in writing. This chart provides information regarding required documentation needed before a pre-treatment estimate of benefits can be determined:

Description	Information required for claims processing
Single unit fixed restorations	
Crowns Build-ups Post and cores	Pre-operative X-ray(s)
Periodontics	
Root planing and osseous surgery	Pre-operative X-ray(s) Periodontal charting
Multiple unit fixed restorations	
Abutments Pontics	Pre-operative X-rays (full arch)
Endodontics	
Conventional endodontics on permanent teeth and re-treatments	Pre- and post-operative X-rays
Oral surgery	
Surgical extractions Impactions	Pre-operative X-rays
Anesthesia	
General IV sedation	Type, duration of agent

If you are unsure about whether a service or procedure should be pre-authorized please contact BCBSNC customer service for assistance.

8.2 Prior approval (under a member's medical benefit)

Prior approval (also referred to as prior review and prior authorization) is the process by which BCBSNC reviews the provision of certain "dental-medical" services (dental services paid under a member's medical benefit, such as, TMJ or accidental injury) against health care management guidelines prior to the services being provided.

Reviews are done to confirm the following:

- Member eligibility
- Benefit coverage
- Compliance with BCBSNC corporate medical policy regarding medical necessity
- Appropriateness of setting
- Requirements for utilization of in-network and out-of-network facilities and/or providers

For general information or if requesting prior approval for a "dental-medical" procedure please call BCBSNC member health partnership operations at **1-800- 672-7897**.

Orthodontic care

9.1 Orthodontic care
(orthodontic benefits are not available on individual plans)

When applicable, benefits for a comprehensive orthodontic treatment are covered for all eligible members through age 18. Non-standard plans may cover orthodontics on adults. The following are covered services that are typically considered part of the comprehensive orthodontic care (but only if the group has purchased the orthodontic rider):

- Diagnosis, including the examination, study models, radiographs, and other aids needed to define a specific problem.
- Appliances or devices worn during the course of treatment. Coverage includes the design, making, placement and adjustment of the device. Benefits are not provided to repair or replace an appliance.

9.2 Notes on orthodontic claims

- The dental provider must submit a complete treatment plan.
- Initial fee/down payment (date braces are placed)
- Number of treatment months
- Monthly fee
- File orthodontic claims on a monthly basis
- Phase I treatment is minor orthodontic treatment and can be paid in one total fee when treatment begins. Phase II treatment is comprehensive orthodontics and is divided into multiple payments. The first benefit payment is 50% of your initial payment, but no more than half of the LIFETIME MAXIMUM for orthodontics. This is followed by monthly coinsurance payments based on the existing treatment plan, up to the LIFETIME MAXIMUM for orthodontics. In order for benefits to continue throughout the treatment plan, this dental benefit plan must remain in effect, the MEMBER must remain enrolled on the plan, and the MEMBER'S orthodontic LIFETIME MAXIMUM must not be met.
- Liability for orthodontic treatments should be assumed with the effective date of coverage, even if the braces were in place prior to coverage. Coverage is available from the effective date forward but only for the remaining time and fees (even if only a part of a member's lifetime orthodontic benefits are used).

Provider certification

10.1 Provider certification

BCBSNC electronically submits annual payment information to the IRS. An IRS Form W-9 is required to be submitted as requested for the registration process, or when you file your first claim with BCBSNC, or as the result of an IRS action due to a CP2100 report. Failure to provide a W-9 or certified W-9 when requested, may result in an IRS required withhold of payment. Dental providers may also find it necessary to re-file an IRS Form W-9 to reflect changes in a practice as recommended by a tax accountant.

BCBSNC participates in the IRS TIN matching service to verify provider certification. A description of the matching services is available on the Web at ***http://www.irs.gov/govt/tribes/article/0,,id=131207,00.html***. BCBSNC utilizes the matching service to validate IRS Forms W-9 submitted by dental providers. The tax name and TIN, either an employer identification number (EIN) or social security number (SSN), submitted on the IRS Form W-9 must match the IRS records. When this information does not match, payment will be delayed until a valid IRS Form W-9 can be received by BCBSNC. Dental providers may download an approved IRS Form W-9 from the ***bcbsnc-dental.com*** Web site. Completed forms may be sent by e-mail to ***providerWebServices@bcbsnc-dental.com***, or by fax to **1-336-759-0968**, or by mail to:

BCBSNC Provider Web Services Registration
8025 North Point Blvd.
Suite 100
Winston-Salem, NC 27106

10.2 Credentialing and re-credentialing

BCBSNC credentials all practitioners of care applying for membership in the network(s) and re-credentials any applicable contracted practitioner every three years. Practitioners of care that are required to be credentialed and re-credentialed include both doctors of dental surgery (DDS) and doctors of dental medicine (DMD).

Guidelines are followed for all providers applying for participation in the BCBSNC networks. These guidelines have been adopted by BCBSNC and adhere to the guidelines established by the National Committee for Quality Assurance (NCQA) and the North Carolina Department of Insurance (NCDOI). NCQA is responsible for accrediting managed care organizations (MCO's) using specific standards for credentialing, quality management, utilization management, member rights and responsibilities, preventive care, and medical records. The NCDOI is the regulatory body for the state of North Carolina for managed care organizations.

BCBSNC makes best efforts to process and complete all credentialing and re-credentialing applications within 60 days of receipt of a completed application. For further information about the credentialing and/or re-credentialing process and to download forms and applications, please visit the "providers applying for credentialing page" located on the BCBSNC Web site at ***bcbsnc.com/content/providers/application/***.

NEA accepted codes for *Fast*Attach™

BlueCross BlueShield of North Carolina

11.1 NEA accepted codes for FastAttach™

The following listing of CDT codes has been compiled for dental providers for use when sending electronic attachments using FastAttach™ (when supplying the needed supporting documentation with electronic claims). This chart has been designed to help dental providers distinguish the appropriate documentation accepted by NEA for transmission, based on CDT code submission and BCBSNC coverage plan.

Please note that the below chart has been designed as a guide but is not intended to be all inclusive. The absence of a code or attachment type does not preclude our requesting that other or additional information be provided, if needed to properly administer a member's dental benefits. Additionally, inclusion of a code does not guarantee payment or a member's eligibility for benefits. This listing is subject to change.

Dental care providers can view the attachment requirements for BCBSNC, as well as, other dental care payors when using NEA *Fast*Look.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D0160	DETAILED & EXTEN ORAL EVAL-PROBLEM FOCUSED BR	NARRATIVE	NARRATIVE	NARRATIVE
D0170	RE-EVAL-LTD PROB FOCUSED (ESTAB PT-NOT POSTOP)	NARRATIVE	NARRATIVE	NARRATIVE
D0999	UNSPECIFIED DIAGNOSTIC PROC BR	NARRATIVE	NARRATIVE	NARRATIVE
D2510	INLAY-METALLIC-1 SURFACE	PRE OP X-RAYS		PRE OP X-RAYS
D1510	SPACE MAINTAINER-FIXED-UNILATERAL	NARRATIVE	NARRATIVE	NARRATIVE
D1515	SPACE MAINTAINER-FIXED-BILATERAL	NARRATIVE	NARRATIVE	NARRATIVE
D1520	SPACE MAINTAINER-REMOVABLE UNILATERAL	NARRATIVE	NARRATIVE	NARRATIVE
D1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	REPORT	REPORT	REPORT
D2410	GOLD FOIL - ONE SURFACE	PRE OP X-RAYS		PRE OP X-RAYS
D2520	INLAY-METALLIC-TWO SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2530	INLAY-METALLIC-3/MORE SURFACES	PRE OP X-RAYS		PRE OP X-RAYS

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D2542	ONLAY-METALLIC-2 SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2543	ONLAY-METALLIC-3 SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2544	ONLAY-METALLIC-4/MORE SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2610	INLAY-PORCELAIN/CERAMIC-1 SURFACE	PRE OP X-RAYS		PRE OP X-RAYS
D2620	INLAY-PORCELAIN/CERAMIC-2 SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2630	INLAY-PORCELAIN/CERAMIC-3/MORE SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2642	ONLAY-PORCELAIN/CERAMIC-2 SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2643	ONLAY-PORCELAIN/CERAMIC-4/MORE SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2644	ONLAY-PORCELAIN/CERAMIC-4/MORE SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2650	INLAY-RESIN-BASED COMPOSITE/RESIN-1 SURFACE	PRE OP X-RAYS		PRE OP X-RAYS
D2651	INLAY-RESIN-BASED COMPOSITE/RESIN-2 SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2652	INLAY-RESIN-BASED COMPOSITE/RES-3/MORE SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2662	ONLAY-RESIN-BASED COMPOSITE/RESIN-2 SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2663	ONLAY-RESIN-BASED COMPOSITE/RESIN-3 SURFACES	PRE OP X-RAYS		PRE OP X-RAYS
D2664	ONLAY-RESIN-BASED COMPOSITE/RES-4/MORE SURFACES	PRE OP X-RAYS		PRE OP X-RAYS

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D2710	CROWN-RESIN BASED COMPOSITE (INDIRECT)	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2712	CROWN-3/4 RESIN BASED COMPOSITE (INDIRECT)	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2720	CROWN-RESIN W/HI NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2721	CROWN-RESIN W/PREDOMINANTLY BASE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2722	CROWN-RESIN W/NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2750	CROWN-PORCELAIN FUSED TO HI NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2780	CROWN-3/4 CAST HI NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2781	CROWN-3/4 CAST PREDOMINANTLY BASE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2782	CROWN-3/4 CAST NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2783	CROWN-3/4 PORCELAIN/ CERAMIC	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2790	CROWN-FULL CAST HI NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D2792	CROWN-FULL CAST NOBLE METAL	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2794	CROWN-TITANIUM	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2810	FREE SOFT TISSUE GRAFT PROC (INCL DONOR SITE SURG)	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D2931	PREFAB STAINLESS STEEL CROWN-PERM TOOTH	PRE OP X-RAYS		PRE OP X-RAYS
D2950	CORE BUILDUP INCL ANY PINS	PRE OP X-RAYS		PRE OP X-RAYS
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION	PRE OP X-RAYS		
D2952	POST & CORE IN ADDITION TO CROWN- INDIRECTLY FAB	PRE OP X-RAYS		PRE OP X-RAYS
D2953	EACH ADDL INDIRECTLY FABRICATED POST-SAME TOOTH	PRE OP X-RAYS		PRE OP X-RAYS
D2954	PREFAB POST & CORE IN ADD TO CROWN	PRE OP X-RAYS		PRE OP X-RAYS
D2955	POST REMOVAL (NOT IN CONJ WITH ENDODONTIC THERAPY)	PRE OP X-RAYS		
D2957	EACH ADDL PREFAB POST-SAME TOOTH	PRE OP X-RAYS		PRE OP X-RAYS
D2960	LABIAL VENEER (RESIN LAMINATE)-CHAIR SIDE	PRE OP X-RAYS		PRE OP X-RAYS
D2961	LABIAL VENEER (RESIN LAMINATE)-LAB	PRE OP X-RAYS		PRE OP X-RAYS
D2962	LABIAL VENEER (PORCELAIN LAMINATE)-LAB	PRE OP X-RAYS		PRE OP X-RAYS
D2980	CROWN REPAIR BR	NARRATIVE	NARRATIVE	NARRATIVE

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D3310	ANT (EXCLD FINAL RESTORATION) (ROOT CANAL)	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED
D3320	BICUSPID (EXCLD FINAL RESTORATION) (ROOT CANAL)	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED
D3330	MOLAR (EXCLD FINAL RESTORATION) (ROOT CANAL)	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED	PRE OP X-RAYS, POST OP X-RAYS AND NARRATIVE ARE REQUIRED
D3331	TX ROOT CANAL OBSTRUC-NON-SURG ACCESS	NARRATIVE	NARRATIVE	NARRATIVE
D3332	INCOMPLETE ENDODONTIC THERAP-INOPER/FX TOOTH	NARRATIVE	NARRATIVE	NARRATIVE
D3333	INTERNAL ROOT REPAIR-PERFORATION DEFECTS	NARRATIVE	NARRATIVE	NARRATIVE
D3346	RETX PREV ROOT CANAL THERAPY-ANT	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED
D3347	RETX PREV ROOT CANAL THERAPY-BICUSPID	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED
D3348	RETX PREV ROOT CANAL THERAPY-MOLAR	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED	PRE/POST OP X-RAYS, NARRATIVE & DATE OF ORIGINAL ROOT CANAL REQUIRED
D3410	APICOECTOMY/PERIRADICULAR SURG-ANT	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL

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	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D3410	APICOECTOMY/PERIRADICULAR SURG-ANT	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL
D3421	APICOECTOMY/PERIRADICULAR SURG-BICUSP (1ST ROOT)	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL
D3425	APICOECTOMY/PERIRADICULAR SURG-MOLAR (1ST ROOT)	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL
D3426	APICOECTOMY/PERIRADICULAR SURG (EA ADD ROOT)	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL
D3430	RETROGRADE FILLING-PER ROOT	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL	PRE OP AND POST OP X-RAYS REQUIRED-ALSO DATE OF ORIGINAL ROOT CANAL
D3999	UNSPECIFIED ENDODONTIC PROC BR	NARRATIVE	NARRATIVE	NARRATIVE
D4249	CLIN CROWN LENGTHENING-HARD TISS	PRE OP X-RAYS REQUIRED.		PRE OP X-RAYS REQUIRED.
D4260	OSSEOUS SURG (INCL FLAP ENTRY & CLOS)-PER QUAD	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.		PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.

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	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D4261	OSSEOUS SURGERY (INCL FLAP ENTRY & CLOSURE)1-3 TEETH	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.		PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4263	BONE REPLACE GRAFT-FIRST SITE IN QUADRANT	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.		PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4264	BONE REPLACE GRAFT-EA ADD SITE IN QUADRANT	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.		PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4265	BIOLOGIC MATERIALS / SOFT AND OSSEOUS TISSUE REGEN	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.		PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4266	GUID TISS REGEN-RESORB BARRIER PER SITE	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.		PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4267	GUID TISS REGEN-NONRESORB BARRIER PER SITE	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.		PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4341	PERIODONTAL SCALING & ROOT PLANING PER QUADRANT	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4342	PERIODONTAL SCALING/ROOT PLANING/1-3 TEETH PER QUAD	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.	PRE OP X-RAYS AND RECENT PERIO CHARTING REQUIRED.
D4381	LOCALIZ DELIV ANTIMICROBIAL AGENTS PER TOOTH BR	NARRATIVE	NARRATIVE	NARRATIVE
D4910	PERIODONTAL MAINTENANCE	HISTORY OF PERIODONTAL THERAPY	HISTORY OF PERIODONTAL THERAPY	HISTORY OF PERIODONTAL THERAPY

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D4920	UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST)	NARRATIVE	NARRATIVE	NARRATIVE
D5110	COMPLT DENTURE-MAXIL	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5120	COMPLT DENTURE-MANDIB	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5130	IMMED DENTURE-MAXIL	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5140	IMMED DENTURE-MANDIB	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5211	MAXIL PART DENTURE-RESIN BASE(INCLD CLASP-RESTS)	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5212	MANDIB PART DENTURE-RESIN BASE(INCLD CLASP-REST)	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5213	MAXIL PART DENTURE-CAST METAL FRAME W/RESIN BASE	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5214	MANDIB PART DENTURE-CAST METAL FRAME W/RES BASE	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5226	MANDIBULAR PARTIAL DENTURE-FLEXIBLE BASE	PRE OP AND FULL ARCH X-RAYS		PRE OP AND FULL ARCH X-RAYS
D5860	OVERDENTURE-COMPLT BR	NARRATIVE	NARRATIVE	NARRATIVE
D5861	OVERDENTURE-PART BR	NARRATIVE	NARRATIVE	NARRATIVE
D5862	PRECISION ATTACHMENT BR	NARRATIVE	NARRATIVE	NARRATIVE
D5999	UNSPECIFIED MAXILLOFACIAL PROSTH BR	NARRATIVE	NARRATIVE	NARRATIVE

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D6010	SURGICAL PLCMT-IMPLANT BODY-ENDOSTEAL IMPLANT	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6012	SURGICAL PLACEMENT INTERIM IMPLANT BODY-ENDOSTEAL	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6020	ABUT PLACEMENT/SUBSTITUTION ENDOSTEAL IMPLANT	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6040	SURGICAL PLACEMENT-EPOSTEAL IMPLANT	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6050	SURGICAL PLACEMENT-TRANSOSTEAL IMPLANT	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6053	IMPLANT/ABUTMENT REMOVABLE DENTURE COMPLETE ARCH	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6054	IMPLANT/ABUTMENT REMOVABLE DENTURE PARTIAL ARCH	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6056	PREFABRICATED ABUTMENT-INCLUDES PLACEMENT	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6057	CUSTOM ABUTMENT- INCLUDES PLACEMENT	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6059	ABUTMENT SUPPORT PORCL FUSD METL CRWN (HI NBL MET)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6060	ABUTMNT SUPPRT PORCL FUSD METL CROWN (BASE METL)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6061	ABUTMNT SUPPRT PORCL FUSD METL CRWN (NOBLE METL)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HI NBL MET)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS

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	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (BASE METAL)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METL)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6067	IMPLANT SUPPORTED METAL CROWN	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6068	ABUTMENT SUPPORTED RETAINER-PORCELN/CERAMIC FPD	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6069	ABUT SUPPRTD RETAINER-PORC FUSD MET FPD (HI NOBLE)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6070	ABUT SUPPRTD RETAINER-PORC FUSED METAL FPD	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6071	ABUT SUPRTD RETAINR-PORC FUSD MET FPD (NOBLE MET)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6072	ABUTMNT SUPPORTD RETAINR-CAST METL FPD (HI NOBLE)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6073	ABUTMNT SUPPORTD RETAINR-CAST METAL FPD(BASE MET)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6074	ABUTMNT SUPPORTD RETAINER-CAST MET FPD-NOBLE MET)	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6075	IMPLANT SUPPORTED RETAINER-CERAMIC FPD	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6076	IMPLANT SUPPRTD RETAINR-PORCELAIN FUSED METAL FPD	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6077	IMPLANT SUPPORTED RETAINER-CAST METAL FPD	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS

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	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D6078	IMPLANT/ABUT SUPPRTD FIXD DENT-COMPLT ENDENT ARCH	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6079	IMPLANT/ABUT SUPPRTD FIXD DENTUR-PART ENDENT ARCH	PRE-OP X-RAYS	PRE-OP X-RAYS	PRE-OP X-RAYS
D6080	IMPLANT MAINTENANCE PROC INCL REMOV-CLEAN-REINSRT	PRE-OP X-RAY	PRE-OP X-RAY	PRE-OP X-RAY
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS B/R	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE
D6095	REPAIR IMPLANT ABUTMENT B/R	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE
D6100	IMPLANT REMOVAL	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, B/R	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE
D6199	UNSPECIFIED IMPLANT PROC B/R	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE	PRE-OP X-RAY & NARRATIVE
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6210	PONTIC-CAST HI NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6212	PONTIC-CAST NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6214	PONTIC- TITANIUM	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6240	PONTIC-PORCELAIN FUSED TO HI NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE MTL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS

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	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6245	PONTIC-PORCELAIN/ CERAMIC	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6250	PONTIC-RESIN W/HI NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6251	PONTIC-RESIN W/PREDOMINANTLY BASE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6252	PONTIC-RESIN W/NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIX PROSTH	FULL ARCH X-RAYS	FULL ARCH X-RAYS	FULL ARCH X-RAYS
D6548	RETAINR-PORCELAIN/CERAMIC-RESIN BOND FIX PROSTH	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6601	INLAY-PORCELAIN/CERAMIC, 3/MORE SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6602	INLAY- CAST HIGH NOBLE METAL, 2 SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6603	INLAY-CAST HIGH NOBLE METAL, 3/MORE SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6604	INLAY-CAST PRED BASE METAL, 2 SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6605	INLAY-CAST PRED BASE METAL, 3/MORE SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6606	INLAY-CAST NOBLE METAL , 2 SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6607	INLAY-CAST NOBLE METAL, 3/MORE SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6608	ONLAY- PORCELAIN/CERAMIC, 2 SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS

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	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D6609	ONLAY- PORCELAIN/CERAMIC, 3/MORE SURFACES	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6610	ONLAY- CAST HIGH NOBLE METAL, 2 SURFACES	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6611	ONLAY-CAST HIGH NOBLE METAL, 3/MORE SURFACES	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6612	ONLAY-CAST PRED BASE METAL, 2 SURFACES	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6613	ONLAY-CAST PRED BASE METAL, 3/MORE SURFACES	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6614	ONLAY- CAST NOBLE METAL, 2 SURFACES	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6615	ONLAY- CAST NOBLE METAL, 3/MORE SURFACES	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6624	INLAY-TITANIUM	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6634	ONLAY-TITANIUM	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6710	CROWN- INDIRECT RESIN BASED COMPOSITE	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6720	CROWN-RESIN W/HI NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6721	CROWN-RESIN W/PREDOMINANTLY BASE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6722	CROWN-RESIN W/NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6740	CROWN-PORCELAIN/ CERAMIC	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6750	CROWN-PORCELAIN FUSED TO HI NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS

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	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6780	CROWN-3/4 CAST HI NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6781	CROWN-3/4 CAST PREDOMINATELY BASED METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6782	CROWN-3/4 CAST NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6783	CROWN-3/4 PORCELAIN/ CERAMIC	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6790	CROWN-FULL CAST HI NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6792	CROWN-FULL CAST NOBLE METAL	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6793	PROVISIONAL RETAINER CROWN	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6794	CROWN- TITANIUM	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS	PRE OP AND FULL ARCH X-RAYS
D6940	STRESS BREAKER	NARRATIVE	NARRATIVE	NARRATIVE
D6970	POST & CORE IN ADD TO FIX PART DENT RETAINER	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6971	CAST POST AS PART OF FIX PART DENTURE RETAINER	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6972	PREFAB POST & CORE-ADD TO FIX PART DENT RETAINER	FULL ARCH X-RAYS		FULL ARCH X-RAYS

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D6973	CORE BUILD UP FOR RETAINER INCL ANY PINS	FULL ARCH X-RAYS		FULL ARCH X-RAYS
D6976	EACH ADDL INDIRECTLY FABRICATED POST-SAME TOOTH	NARRATIVE	NARRATIVE	NARRATIVE
D6977	EACH ADDL PREFAB POST-SAME TOOTH	NARRATIVE	NARRATIVE	NARRATIVE
D6980	FIXED PARTIAL DENTURE REPAIR BR	NARRATIVE	NARRATIVE	NARRATIVE
D6999	UNSPECIFIED FIX PROSTHODONTIC PROC BR	NARRATIVE	NARRATIVE	NARRATIVE
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D7220	REMOV IMPACTED TOOTH-SOFT TISS	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D7230	REMOV IMPACTED TOOTH-PART BONY	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D7240	REMOV IMPACTED TOOTH-COMPLT BONY	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D7241	REMOV IMPACTED TTH-COMPLT BONY W/UNUSUAL COMPLIC	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D7250	SURG REMOV RESIDUAL TOOTH ROOTS (CUTTING PROC)	PRE OP X-RAYS	PRE OP X-RAYS	PRE OP X-RAYS
D7290	SURGICAL REPOSITIONING TEETH	NARRATIVE	NARRATIVE	NARRATIVE
D7291	TRANSSEPTAL FIBEROTOMY BR	NARRATIVE	NARRATIVE	NARRATIVE
D7451	REMOV ODONTOGENIC CYST/TUMOR-LES DIAM >1.25 CM	PRE OP X-RAYS AND PATHOLOGY REPORT	PRE OP X-RAYS AND PATHOLOGY REPORT	PRE OP X-RAYS AND PATHOLOGY REPORT
D7465	DESTRUC LES(S) BY PHYS/CHEM METHD BR	NARRATIVE		NARRATIVE

Continued on the following page.

	NEA accepted CDT codes	Dental Blue® for groups	Dental Blue® Select℠	Dental Blue® for individuals
CDT Code	Description	Attachments		
D7960	FRENULECTOMY (FRENECTOMY/ FRENOTOMY)-SEPART PROC	NARRATIVE		NARRATIVE
D7963	FRENULOPLASTY	NARRATIVE		NARRATIVE
D7995	SYNTHETIC GRAFT-MANDIB/ FACIAL BONES BR	NARRATIVE		NARRATIVE
D7999	UNSPECIFIED ORAL SURG PROC BR	NARRATIVE		NARRATIVE
D8999	UNSPECIFIED ORTHODONTIC PROC BR	NARRATIVE	NARRATIVE	NARRATIVE
D9310	CONS (DIAG SERV BY NON TREATING PRACTITIONER)	NARRATIVE	NARRATIVE	NARRATIVE
D9410	HOUSE/EXTEN CARE FACILITY CALL	NARRATIVE	NARRATIVE	NARRATIVE
D9610	THERAPY PARENTERAL DRUG-SINGLE ADMINISTRATION	NARRATIVE	NARRATIVE	NARRATIVE
D9612	THERAPY PARENTERAL DRUGS, 2/MORE, DIFF MEDICATIONS	NARRATIVE	NARRATIVE	NARRATIVE
D9630	OTH DRUGS &/OR MEDS BR	NARRATIVE	NARRATIVE	NARRATIVE
D9920	BEHAVIOR MGMT BR	NARRATIVE	NARRATIVE	NARRATIVE
D9930	TX COMPLIC (POST-SURG)-UNUSUAL CIRCUMSTANCES BR	NARRATIVE	NARRATIVE	NARRATIVE
D9940	OCCLUSAL GUARD BR	NARRATIVE	NARRATIVE	NARRATIVE
D9950	OCCLU ANALY-MOUNTED CASE	NARRATIVE	NARRATIVE	NARRATIVE
D9952	OCCLUSAL ADJUSTMENT-COMPLETE	NARRATIVE	NARRATIVE	NARRATIVE
D9999	UNSPECIFIED DIAG PROC	NARRATIVE	NARRATIVE	NARRATIVE

Glossary

The following abbreviated glossary of terms contains common terminology used in the descriptions of BCBSNC products and procedures. Terminology specific to dental procedures can be referenced by accessing the ADA Glossary of Dental Terms available on the American Dental Association's Web site located at: ***ada.org/public/resources/glossary.asp***.

Administrative costs - the costs assumed by a health and dental care plan for administrative services, such as claims processing, billing and overhead costs.

Administrative services only "ASO" - an account that assumes full claims liability (self-insured) for funding the dental and/or health benefits contract with a third party (such as BCBSNC) providing all or a portion of the administrative services that would be available under a regular health and/or dental plan. Because the service company assumes no liability for coverage, claim reserves normally are not required.

Allowable charge/amount - the maximum amount to be reimbursed to a provider as negotiated.

Allowed amount - the charge that BCBSNC (or contracted vendor) determines is reasonable for covered services provided to a member. This may be established in accordance with an agreement between the dental provider and BCBSNC.

Alpha prefix - a letter code that precedes a member's identification number.

BCBS - Blue Cross and Blue Shield (BCBS) is used to refer to national Association programs.

Beneficiary - a person who is eligible to receive insurance benefits (includes member, dependent and subscriber).

Benefit booklet - The document that contains a general explanation of the member's benefits.

Benefits package - services an insurer, government agency or dental plan offers to a group or individual under the terms of a contract. The components that make up a product's dental benefit plan (e.g., deductible, out-of-pocket limit, lifetime maximum, etc.).

Benefit period - the period of time, usually 12 months as stated in the group or individual contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC (or our vendor). A charge shall be considered incurred on the date the service or supply was provided to a member.

Billed charge - the amount a dental provider bills a patient for a particular dental service or procedure. This is referred to as actual charge or public charge.

Billing - (a) an itemized account of subscriber dues owed to the Plan by a group or subscriber; (b) an itemized account of services rendered by a dental provider or supplier.

Birthday rule - a process under coordination of benefits clauses in a contract that determines which patient's coverage pays first when a dependent child has dental insurance coverage through both parents. This rule states that the parent whose birthday falls first during the calendar year is primary (his or her coverage pays first).

BlueCard® - a collection of programs and policies that enable members to receive services while traveling or living in another Plan's service area.

Calendar year - the period of time beginning January 1 and ending December 31 of a given year.

Claim - a request for retrospective payment by a member or, on his/her behalf, by the provider for services or supplies rendered. Each document or request for payment should be counted as one claim.

Coinsurance - the sharing of charges by BCBSNC and the member for covered services received by a member, usually stated as a percentage of the allowed amount.

Coinsurance maximum - the maximum amount of coinsurance that a member is obligated to pay for covered services per calendar year/benefit period.

Copayment - the fixed-dollar amount which is due and payable by the member at the time a covered service is provided.

Coordination of benefits "COB" - a method of determining the primary payment source when a person is covered under more than one program.

Coverage - benefits available to eligible members.

Covered service(s) - a service, drug, supply or equipment specified in a member's benefit booklet for which members are entitled to benefits in accordance with the terms and conditions of their dental benefit plan.

Dependent - a member other than the subscriber, who is eligible for dental insurance through a spouse's, parent's or other family member's policy.

Dependent child(ren) - the covered child(ren) of a subscriber, spouse or domestic partner up the maximum dependent age, as specified in the subscribers policy.

Empty suitcase - an ID card logo that indicates away from home care coverage that is administered through the BlueCard® system.

Exclusions - specific conditions or services listed in the dental benefit plan for which benefits are not available.

Explanation of benefits "EOB" - a statement to the subscriber that explains the action taken on each claim.

Family deductible - a deductible that is satisfied by either the combined expenses of all family members or a certain number of family members.

Group - an employer or other entity that has entered into a contract for dental care and/or administration of benefits for its eligible members.

Group administrator - a representative of the group designated to assist with member enrollment and provide information to subscribers and members concerning the dental benefit plan.

Group contract - the agreement between BCBSNC and the group. It includes the master group contract, the benefit booklet(s) and any exhibits or endorsements, the group enrollment application and dental questionnaire when applicable.

Dental benefit plan - the evidence of coverage issued to a group or individual by us or other Blue Cross and/or Blue Shield Plans that describes the scope of covered services and establishes the level of benefits payable, on an insured or administered basis, for such services rendered to members.

HIPAA - Health Insurance Portability and Accountability Act - calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans and employer groups.

Hold harmless - a contract provision whereby providers agree not to charge members more than the allowable charges for covered services and not to charge members for non-covered services. The subscriber's only liability would be the deductible, coinsurance, and/or copayment.

Home Plan - the Blue Cross and/or Blue Shield Plan that carries the member's contract when the member receives services out-of-area.

Host Plan - a Blue Cross and/or Blue Shield Plan participating in the (Inter-Plan Service) Benefit Bank that provides payment for dental care to a subscriber of another Blue Cross and/or Blue Shield Plan (home). BCBSNC serves as the host Plan in the BlueCard® program.

In-network - refers to participating dental providers.

Inquiry - a request for information, action or a document from a subscriber, provider, account, another plan or the general public. Inquiries may be received in any area within a plan office.

Investigational (experimental) - the use of a service or supply, including but not limited to treatment, procedure, equipment, drug or device that BCBSNC does not recognize as standard dental or medical care of the condition, disease, illness or injury being treated. The following criteria are the basis for BCBSNC's determination that a service of supply is investigational:

- Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration "FDA" for final approval from any other governmental regulatory body for use in treatment of

a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

- There is insufficient or inconclusive scientific evidence in peer-reviewed medical or dental literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply.
- There is inconclusive evidence that the service or supply has a beneficial effect on dental health outcomes.
- The service or supply under consideration is not as beneficial as other established alternatives.
- There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on dental health outcomes and is as beneficial as any established alternatives.

Lifetime maximum - the maximum amount of covered services that will be provided to a member while they have coverage under a dental benefit plan or any prior dental benefit plan sponsored by the group in any member's lifetime.

Member - a subscriber or dependent, whose enrollment application and change form has been accepted and approved by BCBSNC as eligible for coverage benefits.

Notification of benefits "NOB" - a statement to the provider that explains the action taken on each claim.

Primary payor - when a member is covered by more than one insurance carrier, the primary payer is the carrier responsible for providing benefits before any other insurer makes payment.

Retrospective review - a manner of judging dental necessity and appropriate billing practices for services that have already been rendered.

Secondary payor - when a member is covered by more than one insurance carrier, the secondary payor is the carrier responsible for providing benefits after the primary payor has provided benefits.

Subrogation - the substitution of one person for another who has a legal claim or right.

Underwriting - the process by which an insurer determines if, and on what basis, an application for insurance will be accepted.

IVR - the IVR system is a voice response front end application that allows callers to access member's benefits information and check eligibility, claims and payment status for individual accounts.

Workers' compensation - insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured on the job, and to pay benefits to dependents of employees killed in the course of or in circumstances arising from their employment.

The Blue Book℠ Dental e-Manual

A guide for dental care providers

BlueCross BlueShield of North Carolina

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