2023 BlueDental℠ PROVIDER MANUAL

azblue.com/bluedentalprovider

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

1236611-23

BlueDental Provider Manual

Table of Contents

Introduction

About the BCBSAZ BlueDental Provider Manual

This BlueDental℠ Provider Manual ("Manual") sets forth policies and procedures to be followed by BlueDental providers in rendering services to Blue Cross® Blue Shield® of Arizona (BCBSAZ) members with a BlueDental stand-alone benefit plan (separate plan just for dental benefits) or a BlueDental Prime Medicare benefit ID card (included as part of a Medicare Advantage plan). It is an extension of the Provider Participation Agreement and incorporated by reference into your Agreement with BCBSAZ. In the event of a conflict between this Manual and your Agreement, the Agreement will govern.

Some sections of the Manual describe and summarize member benefit plans. If the information in the Manual differs from the applicable benefit plan summary, the terms of the member's benefit plan will apply. Details of a specific BlueDental member's benefit plan are available online at azblue.com/bluedentalprovider > Eligibility and Benefits, or by calling Provider Services at 1-888-271-7806.

Please reference the BCBSAZ Provider Operating Guide ("PO Guide") for information on general policies and procedures, as well as specific information regarding servicing members with other types of benefit plans (e.g., BCBSAZ medical plans that include embedded dental benefits for members up to age 19, BlueCard® (out-of-area) plans, Federal Employee Program® (FEP®) plans, and Medicare Advantage plans. Provisions of the PO Guide that are generally applicable to all network providers (e.g., dispute resolution) and provisions applicable to dental benefits and providers are also incorporated by reference into your Agreement. In the event of a conflict between the PO Guide and your Agreement, the Agreement will govern.

For BlueDental assistance or information that is not included in this manual or the PO Guide, contact BlueDental Provider Services at 1-888-271-7806, Monday through Friday, 6:00 a.m. to 6:00 p.m., Arizona time.

BCBSAZ Dental Products and Networks – Quick Reference Guide (QRG)

TYPE OF PLAN	BENEFIT PLAN INFO	MEMBER ID PREFIX	NETWORK AND CONTRACTING	PLAN ADMINISTRATOR
BCBSAZ Stand-Alone Commercial Dental Plans (separate dental ID card)	• **BlueDental PPO**	**99D, MUM**	**BlueDental PPO** 1-888-271-7806	**BlueDental Plan Administrator** azblue.com/bluedentalprovider 1-888-271-7806 Submit claims to BCBSAZ; **EDI: 53589** Claim and predetermination submissions that require **attachments** are *only* accepted electronically via DentalXchange, Vyne Dental, or Change Healthcare. If you can't use these services, mail a paper claim *with documentation to:* **BCBSAZ BlueDental Claims** P.O. Box 211424 Eagan, MN 55121 Fax (claims only): 1-833-517-1939
	• **BlueDental Prime**	**99D**	**BlueDental Prime** exclusive network 1-888-271-7806	
	• **BlueDental DHMO**	**99D**	**BlueDental DHMO** 1-888-271-7806	
BCBSAZ Medical Plans with dental benefits	• **Medical benefit plans** that cover oral surgery • **ACA medical plans** with embedded dental benefits for members up to age 19; Medical ID card displays **Pediatric Dental Benefits: YES**	**Various BCBSAZ prefixes for medical plans**	**BCBSAZ medical networks** (providers must be contracted for the network associated with the member's benefit plan) 1-888-271-7806	**BCBSAZ** azblue.com/providers 602-864-4231 **EDI: 53589** *Paper claims:* **BCBSAZ Claims** P.O. Box 2924 Phoenix, AZ 85062-2924
Federal Employee Program® (FEP®) Medical Plans (limited dental benefits)	Two FEP medical plans include limited dental benefits: • **Standard Option** • **Basic Option**	**R**	**FEP Dental Network** 1-888-271-7806	**BCBSAZ** azblue.com/providers 1-800-345-7562 **EDI: 53589** *Paper claims* :**BCBSAZ Claims** P.O. Box 2924 Phoenix, AZ 85062-2924
FEP Stand-Alone Dental Plans	BCBS FEDVIP coverage with separate dental ID card: • **High Option** • **Standard Option**	**F**	**BCBS FEP Dental Network** (also known as GRID+ Dental Network; all BCBSAZ BlueDental PPO providers are included) 1-888-271-7806	**BCBS FEP Dental** bcbsFEPdental.com 1-855-504-2583 **EDI Payer ID: BCAFD** *Paper claims:* **Dental Claims** P.O. Box 75 Minneapolis, MN 55440-0075
BlueCard® (Out-of-Area) Plans (for members from other BCBS Plans)	**Dental benefits** covered by medical plans and **stand-alone dental products**	**Varies**	**Varies** (BCBS GRID or other national network) 1-888-271-7806	**See back of member ID card** for specific information
BCBSAZ Medicare Advantage (MA) Plans with dental benefits (separate ID card for dental)	• **Blue MA Plus** • **Blue MA Classic** • **BluePathway Plan 2** (Maricopa County only) • **Blue Journey**	**99D**	**BlueDental Prime** exclusive network 1-888-271-7806	**Send claims to BCBSAZ EDI: 53589** *Paper claims:* **BCBSAZ MA Dental Claims** P.O. Box 211424 Eagan, MN 55121 Fax (claims only): 1-833-517-1939

BlueDental Networks – Overview

The following is a brief overview of the BlueDental networks and the product lines they service.

BlueDental PPO Network
Participation in this network requires a BCBSAZ provider participation agreement with a dental services reimbursement exhibit. Reimbursement is based on the BCBSAZ dental PPO fee schedule. BlueDental PPO providers are considered in-network for several types of benefit plans:

- BCBSAZ stand-alone BlueDental PPO plans with member ID prefixes 99D and MUM (includes preventive and enhanced PPO plans)
- Benefit plans using the BCBS National Dental GRID networks: All BCBSAZ BlueDental PPO providers are part of the BCBS GRID/GRID+ networks (administered by DeCare). These networks are used for the following types of members (GRID or GRID+ will be indicated on the back of the ID card):
  - Members with BlueCard® (out-of-area) dental plans
  - Members with BCBS FEP Dental stand-alone plans (member ID prefix is F) offered through the Federal Employees Dental and Vision Insurance Program (FEDVIP)

BlueDental Prime Network
BCBSAZ BlueDental Prime PPO is an exclusive (narrow) network for stand-alone BlueDental Prime plans and dental benefits covered under BCBSAZ Medicare Advantage plans (see page 7). Participation in the Prime network is optional for BlueDental PPO providers.

Please note that there are two provider directories for the Prime PPO network—one for the BlueDental Prime stand-alone plans and one for the BlueDental Prime Medicare plans. Not all Prime network providers are included in the directory for the BlueDental Prime Medicare plans.

BlueDental DHMO Network
The BCBSAZ DMHO Network is for members with BlueDental DHMO stand-alone plans. Provider participation in this network requires a separate provider participation agreement.

For a more comprehensive overview of BCBSAZ dental networks, please see the BCBSAZ Provider Operating Guide, Section 26.

BlueDental PPO Stand-Alone Benefit Plans

BCBSAZ stand-alone PPO dental benefit plans are designed to promote good oral health through easy access to diagnostic and preventive services. We offer two types of PPO dental benefit plans:

BlueDental PPO (these plans use the BlueDental PPO Network)

BlueDental Prime PPO (these plans use the exclusive BlueDental Prime Network)

Reimbursement for in-network and out-of-network claims is based on the BCBSAZ dental fee schedule. Network dentists receive the BCBSAZ allowed amount for covered services, which includes the member cost-share. The allowed amount is the total amount of reimbursement allocated to a covered service, It includes any applicable member cost-share payment and adjustments for less expensive alternative treatment (LEAT) considerations.

Diagnostic and preventive care

All stand-alone PPO dental plans cover in-network diagnostic and preventive care with no or minimal member cost share. These services are generally not subject to deductibles, and do not count against the calendar year maximum for many plans. (However, most of the plans require members to pay coinsurance for out-of-network preventive care and diagnostic services.)

Orthodontic rider

Optional orthodontic benefits are available to employer groups as child-only or child-and-adult options for stand-alone dental plans. Lifetime maximums of $1,000, $1,500, or $2,000 per member, are standard offerings.

Amounts applied to the benefit maximum are calculated based on the lesser of the BCBSAZ dental fee schedule or billed charges for covered services, plus or minus any contractual allowance. No benefits will be paid over the maximum amount specified in the benefit plan. Only the amounts paid by BCBSAZ count toward the benefit maximum, not the cost-share amounts paid by the member.

Orthodontic payments made by BCBSAZ are based on the plan benefit and are paid at the time of banding at 100% of the covered expense .

Orthodontic claim submission guidelines

The procedure for reporting and billing orthodontic services covered under stand-alone dental plans requires a single billing to BCBSAZ for the entire case at the beginning of treatment, using one of the CDT procedure codes in the range D8010 through D8090. This total case (global) billing and reimbursement includes:

- All diagnostic records
- All pretreatment consultations
- Initial appliance placement
- Periodic visits for appliance adjustments
- Any repair, replacement, or removal of appliances
- Any necessary retention appliances, including necessary adjustments

Note: When circumstances require a change of provider prior to treatment completion, the new provider must bill per visit.

Predeterminations

BCBSAZ does not require predeterminations for any dental services. However, for BCBSAZ BlueDental members, pre-treatment estimates or “predeterminations” are available as a courtesy to dentists and members. Please see more information on predeterminations on page 15.

BlueDental PPO Stand-Alone Benefit Plans

Eligibility and benefits

Providers can access BlueDental eligibility and benefit information, including benefit summaries, in the secure provider portal at azblue.com/bluedentalprovider or call 1-888-271-7806.

Waiting periods may apply

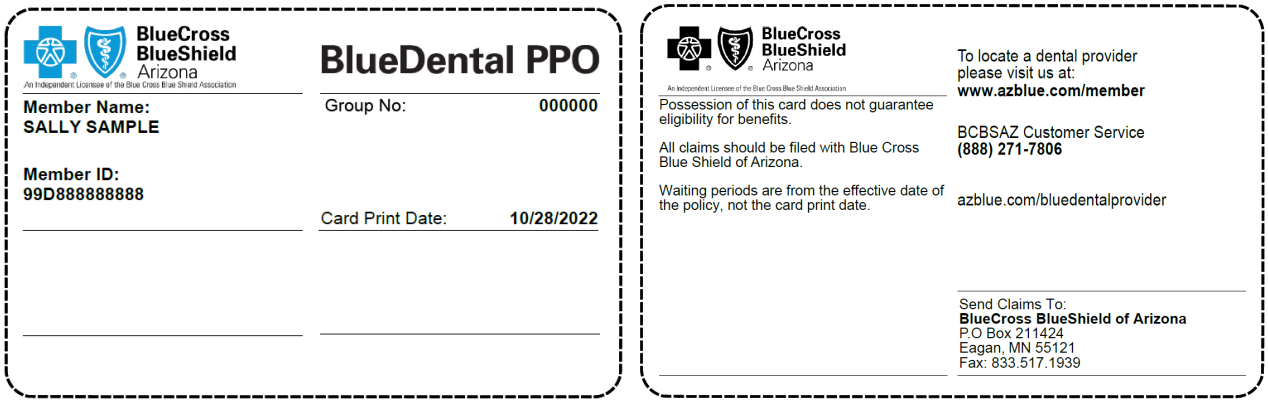
Certain groups may have waiting periods for some types of benefits. Please contact BCBSAZ Dental Customer Service at 1-888-271-7806 for this information.

Member ID cards

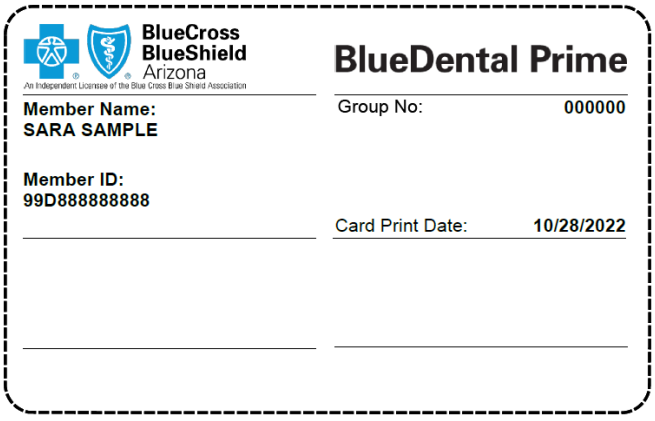
Members with BCBSAZ stand-alone dental plans will have a separate dental ID card. Use the information on the member's card for claim submission information.

The member ID prefix for most BlueDental (formerly known as BluePreferred) and BlueDental Prime stand-alone dental plans is 99D. One employer group uses the prefix MUM.

Sample BlueDental PPO individual member ID card:



Sample BlueDental Prime PPO member ID card:



BlueDental DHMO Stand-Alone Benefit Plans

BlueDental DHMO benefit plans

BCBSAZ stand-alone BlueDental DHMO benefit plans are available to individuals and families.

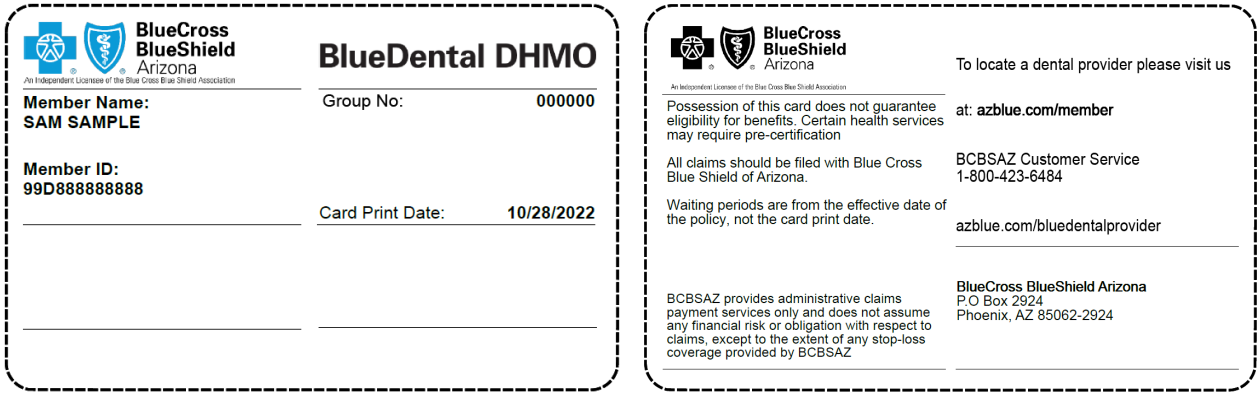
Primary care dentists

A general dentist is contracted as a primary care dentist and paid a monthly capitation amount for each member who designates that dentist for primary care. The monthly capitation plus any required plan fees paid directly to the dentist constitute the full reimbursement for services rendered to covered members. Members pay a fixed rate for services directly to the provider.

Specialty care providers, including Orthodontists

Contracted specialists agree to provide services at a discount from their billed charges. Members pay the discounted amount directly to the specialist.

BlueDental DHMO member ID card sample



BlueDental Prime Medicare Benefit Plans

Many Medicare Advantage plans include dental benefits

Several of our Medicare Advantage plans include preventive and restorative dental benefits that are administered by BCBSAZ. To qualify as an in-network provider for these benefits, you must be contracted with us for the BlueDental Prime dental network . You must also have a separate reimbursement exhibit for Medicare Advantage. For more information about this participation arrangement, contact the BlueDental team at 1-888-271-7806.

All dental office visits require a $10 co-pay. Other than the office visit copay, preventive services are covered with no additional cost share. Type II and III services vary in coverage and cost share. Here is an overview (for details, visit the BlueDental provider portal at azblue.com/BlueDentalProvider):

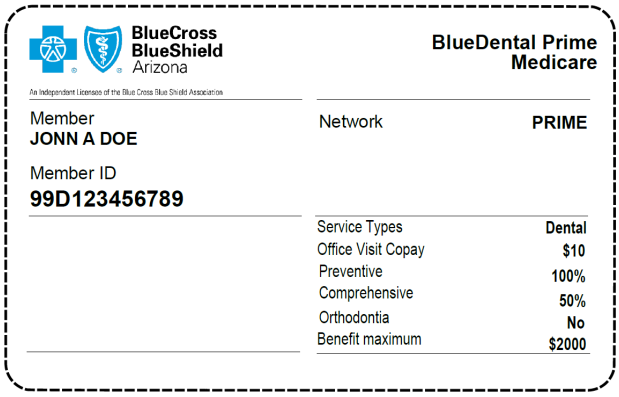
BENEFIT PLAN NAME and ID #	PREFIX (DENTAL)	SERVICE AREA	BENEFIT MAXIMUMS
Blue Medicare Advantage Plus (HMO) H0302-001 (prefix M2K for medical plan)	**99D**	Maricopa and Pinal counties	$3,000 per calendar year
Blue Medicare Advantage Classic (HMO) H0302-006 (prefix M2K for medical plan)	**99D**	Maricopa and Pinal counties	$2,000 per calendar year
BluePathway Plan 2 (HMO) H6936-003 (prefix M2V for medical plan)	**99D**	Maricopa County only	$2,000 per calendar year
BlueJourney (PPO) H5140-001 and H5140-002 (prefix M3P for medical plan)	**99D**	Maricopa and Pima counties	$3,000 per calendar year

Claim submission

Effective January 1, 2023, we will accept 837D transactions for dental services rendered to Medicare Advantage members.

MA dental ID cards

Starting in 2023, Medicare Advantage members have a separate ID card for dental benefits. Like the BlueDental stand-alone plans, these cards display the 99D prefix in the member ID.



BlueDental Online Resources

BCBSAZ's secure BlueDental provider portal at azblue.com/bluedentalprovider supports providers with information, tools, and resources, including:

- Eligibility and benefits
- Claim status
- Online remits
- Benefit confirmation
- Fee schedules
- DHMO panel roster
- Provider resources
- BCBSAZ Provider Operating Guide

Creating an account

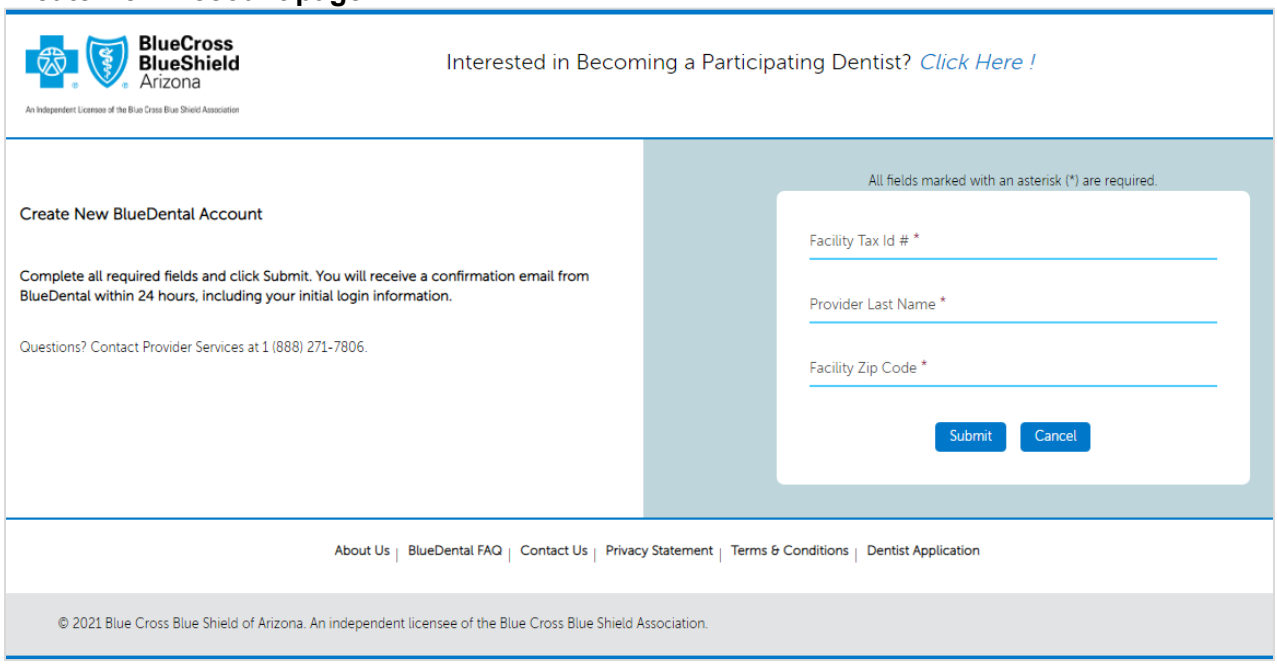
To create an account on the azblue.com/bluedentalprovider portal you will need of the following information:

- Your organization's tax ID
- The last name of an active provider within your facility
- Your facility's ZIP code

Once you enter this information, you will be guided through the steps necessary to create an account.

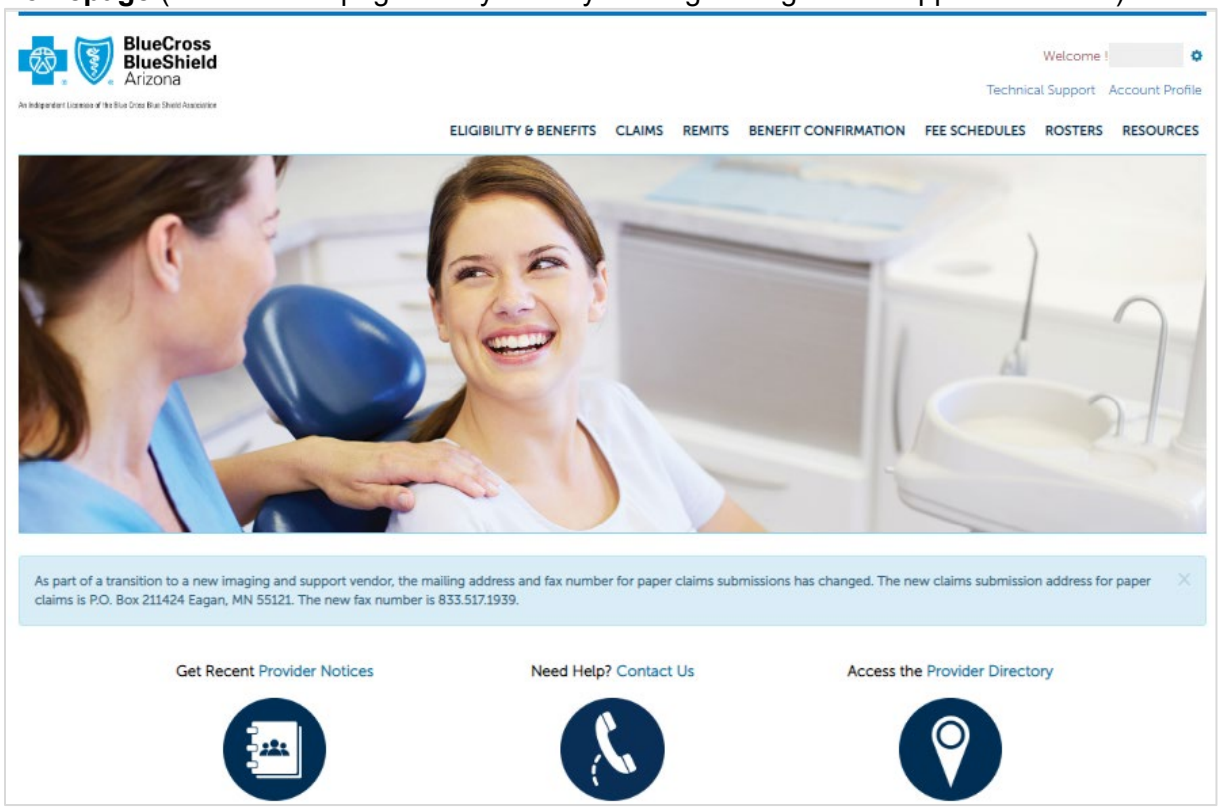
You only need to set up one BlueDental account and login/password for your facility, regardless of the number of dentists practicing in that location.

Create New Account page

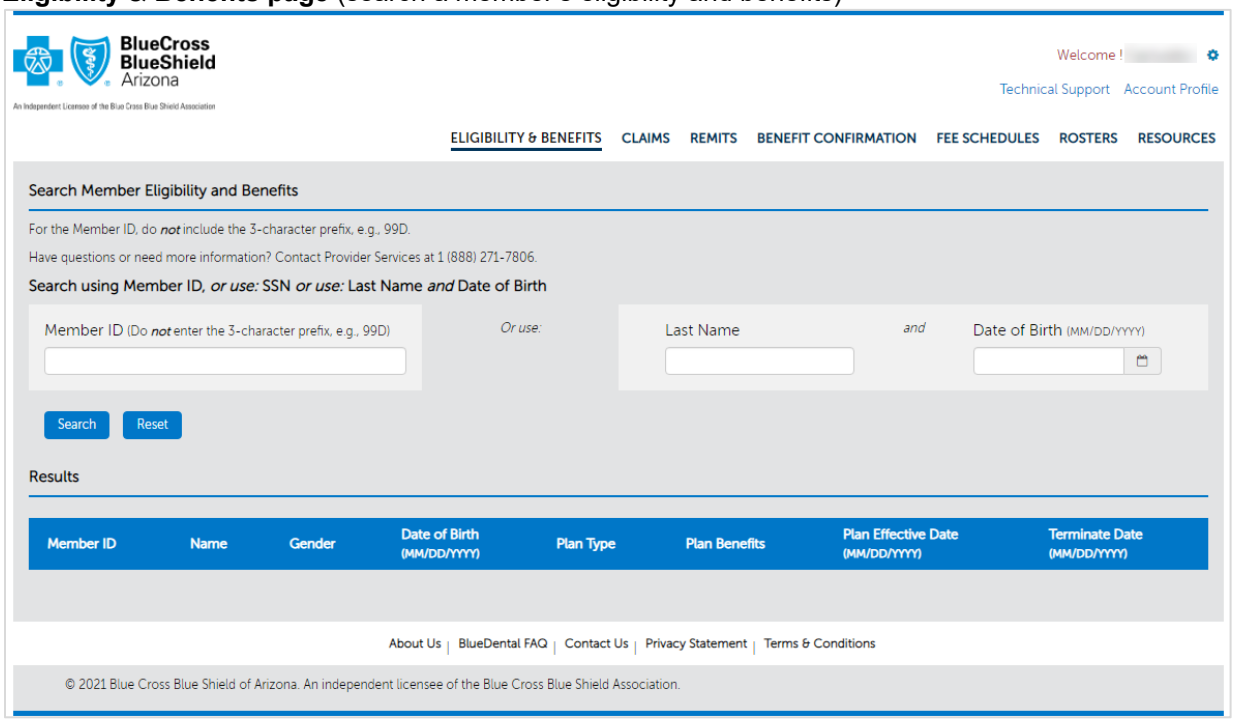


BlueDental Online Resources

Homepage (return to this page at any time by clicking the logo in the upper left corner)

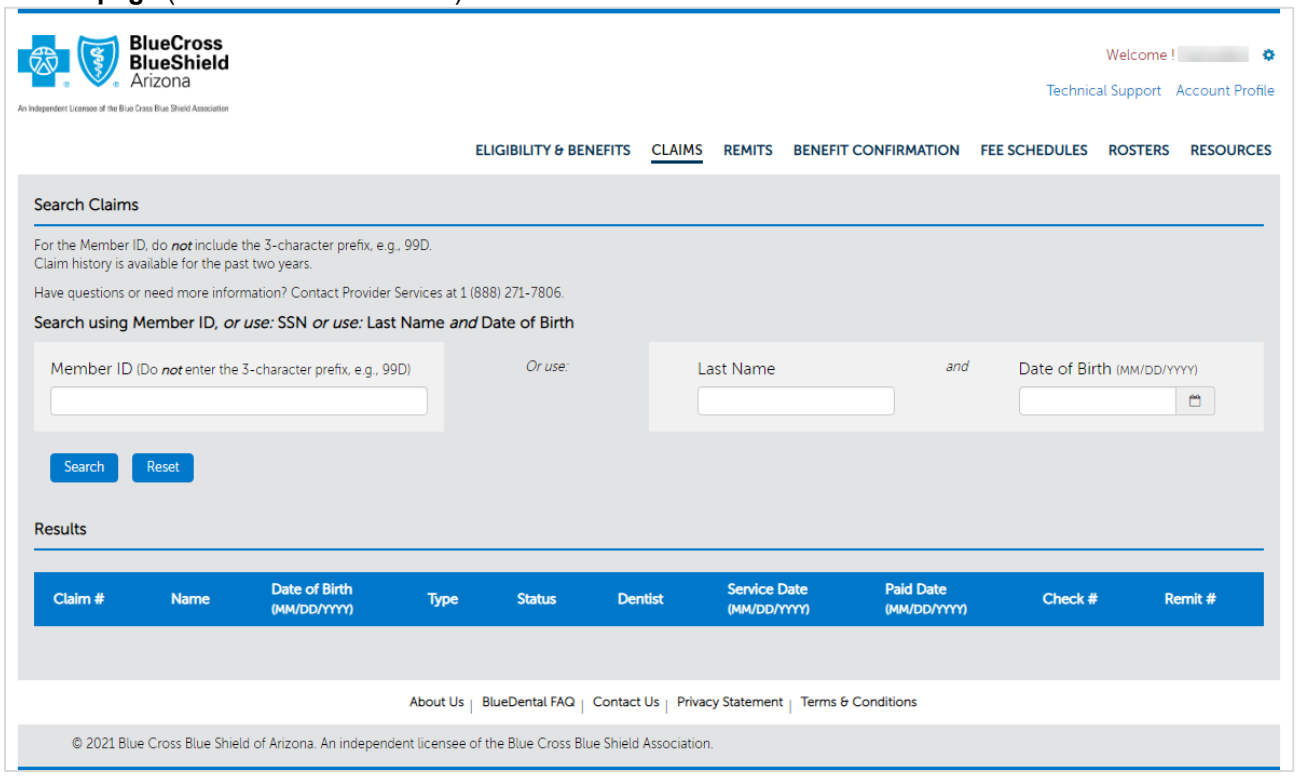


Eligibility & Benefits page (search a member's eligibility and benefits)

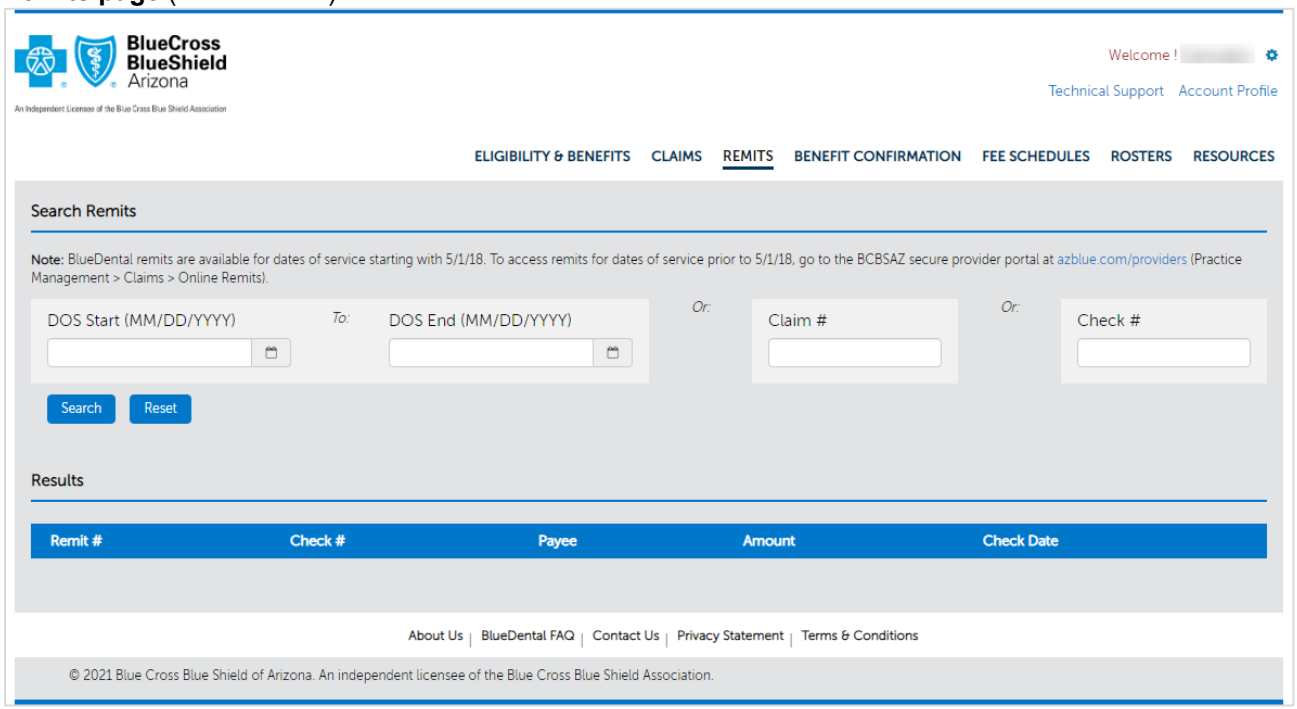


BlueDental Online Resources

Claims page (claim status search tool)

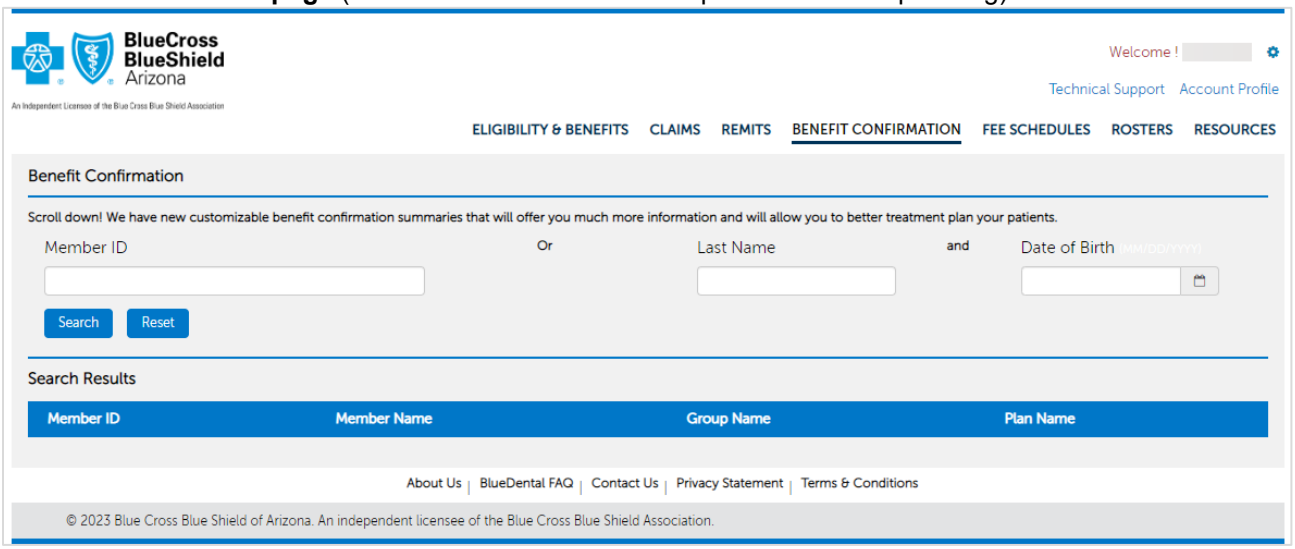


Remits page (online remits)

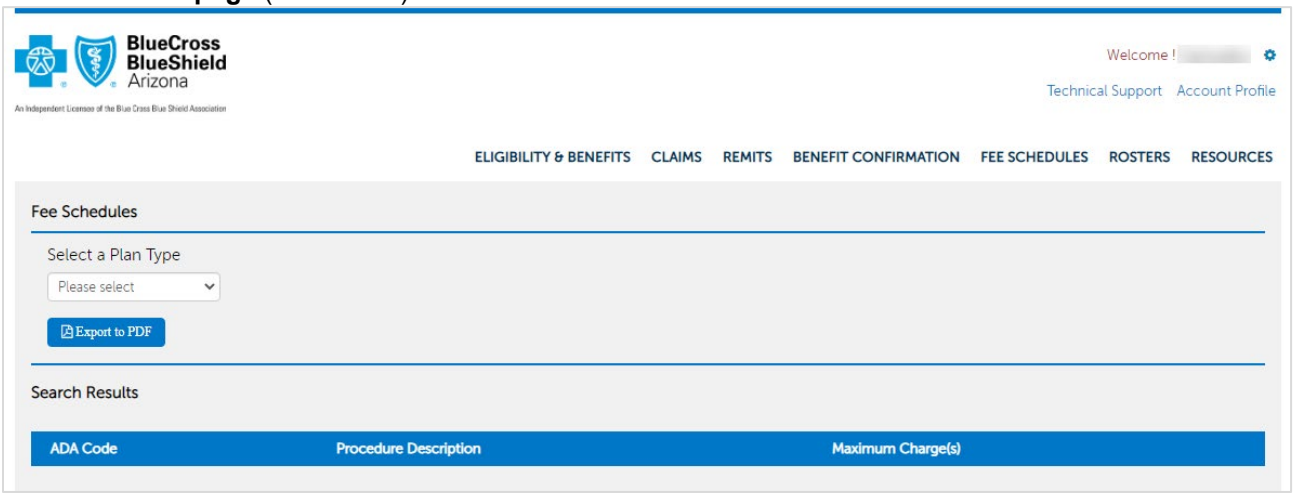


BlueDental Online Resources

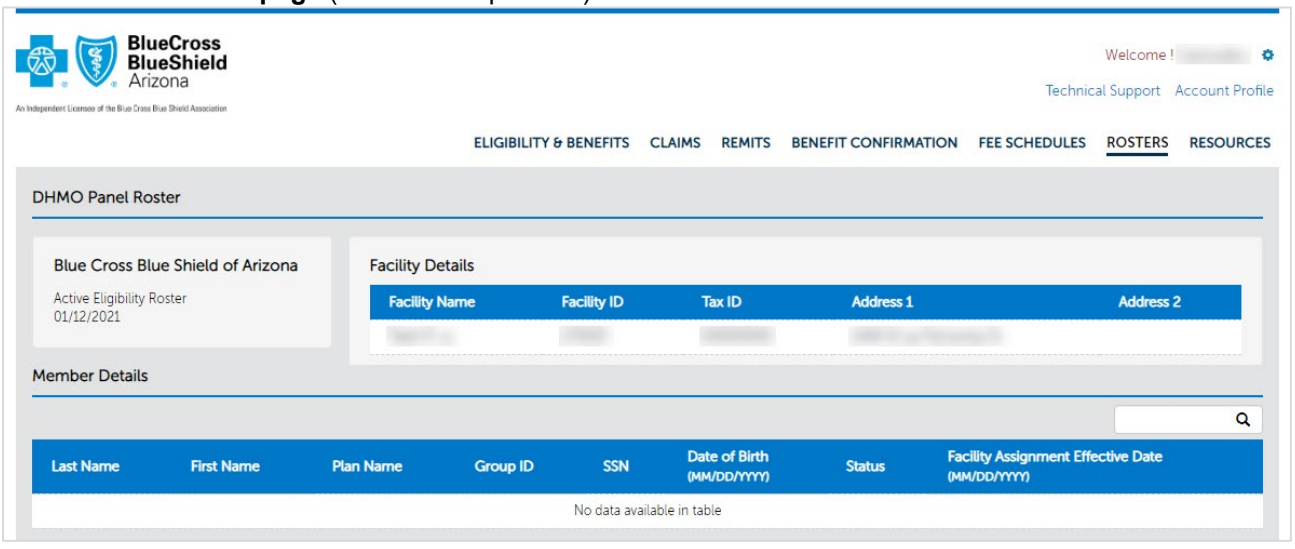
Benefit Confirmation page (view benefit summaries to help with treatment planning)



Fee Schedules page (check fees)

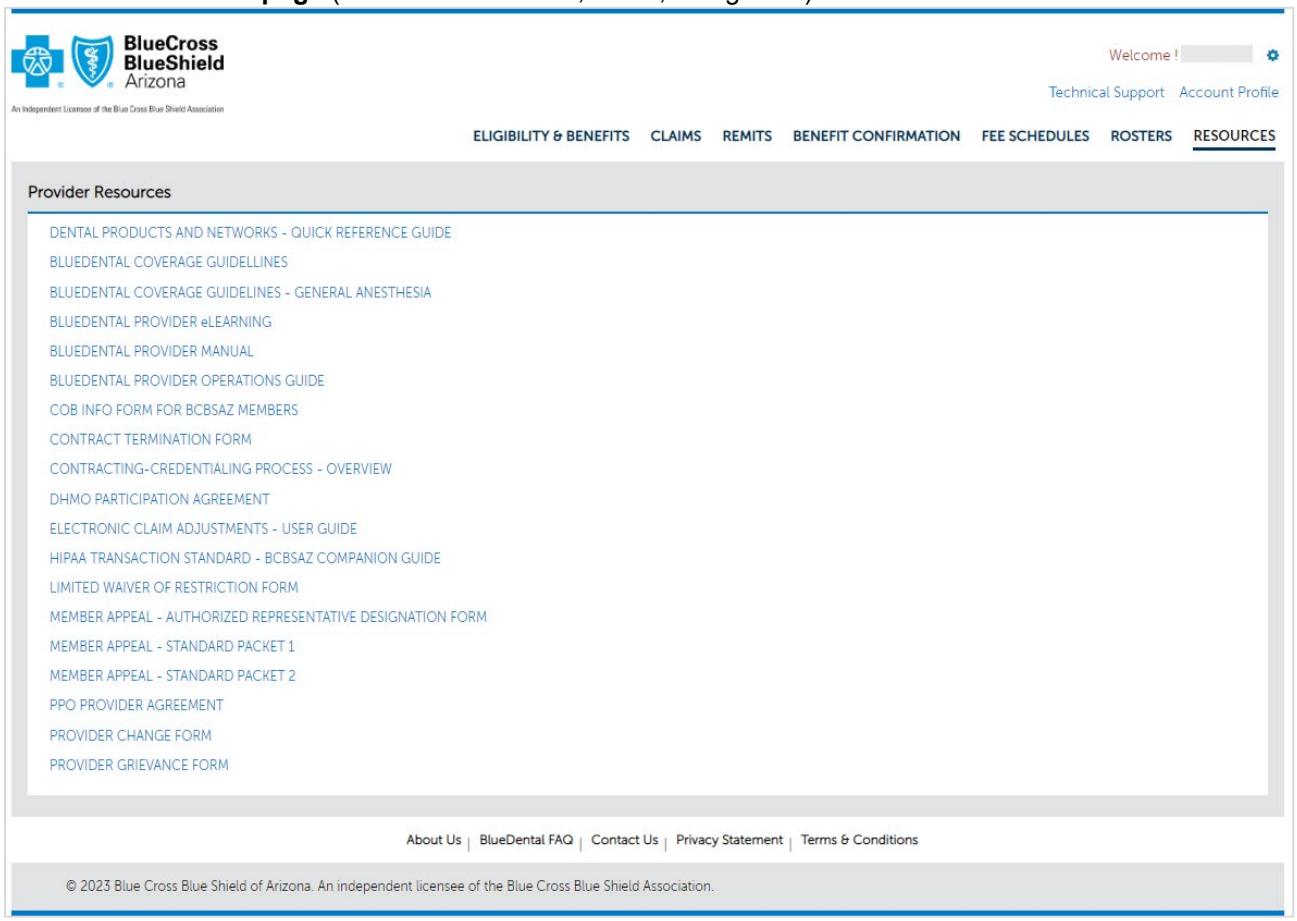


DHMO Panel Roster page (view current patients)



BlueDental Online Resources

Provider Resources page (includes information, forms, and guides)



BlueDental Coverage Guidelines

Our BlueDental coverage guidelines assist BCBSAZ in making dental coverage determinations and support providers in treating members with BlueDental stand-alone plans. BCBSAZ continually evaluates and updates its coverage guidelines to align with industry standards.

The guidelines are not a guarantee of coverage. Rather, they provide a review of the available scientific evidence, if applicable, to determine dental necessity.

Dentally necessary service

A dentally necessary service is one that meets all of the following criteria:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease, or injury.
- Is not primarily for the convenience of a member or provider.
- Is not primarily for improving the cosmetic appearance of a member.
- Meets BCBSAZ's dental necessity guidelines and criteria in effect when the service is rendered. If no such guidelines or criteria are available, BCBSAZ will base its decision on the judgment and expertise of a BCBSAZ healthcare professional or dental consultant retained by BCBSAZ.

BCBSAZ's decision about dentally necessary services may differ from the provider's opinion. A provider may prescribe, order, recommend, or approve a service that BCBSAZ decides is not dentally necessary and, thus, not a covered benefit. The member and provider should decide whether to proceed with a service that is not covered.

Eligibility for coverage

To be eligible for coverage, all services must be dentally necessary. The final benefit determination is also based on benefits included the member's benefit plan. Always check eligibility and benefits for specific information.

Where to find the BlueDental Coverage Guidelines

The most current version of the BlueDental Coverage Guidelines is available at azblue.com/bluedentalprovider > Provider Resources. The guidelines also detail documentation requirements for a variety of procedures, including:

Procedures	Documentation Requirements
Inlays Onlays Crowns Prosthodontics Surgical extractions Implants	**Radiographs and charting**
Periodontal Procedures	**Documentation Requirements**
Gingival flap procedures Crown lengthening Guided tissue regeneration Periodontal scaling and root planing Osseous surgery	**Radiographs and periodontal charting**
Gingivectomy Grafts	**Periodontal charting**

BlueDental Claim Submission

Claim submission for BlueDental plans

Claims for BlueDental plans should be submitted directly to BCBSAZ (EDI 53589). We can receive dental records electronically only if your practice uses one of the following options for electronic claim attachments (such as x-rays and chart notes):

DentalXchange

Vyne Dental

Change Healthcare

Be sure to enter the attachment reference number in the “Remarks” section (field 35) of your claim. This allows us to access the electronic attachments upon receipt of the claim.

If you don’t use DentalXchange, Vyne Dental, or Change Healthcare for electronic attachments and are billing for services that require documentation (e.g., radiographs, images, provider notes), submit the claim using the ADA paper form, along with all required documentation, to:

BCBSAZ BlueDental Claims
P.O. Box 211424
Eagan, MN 55121

Electronic claim submission

BCBSAZ offers electronic services through:

- **DirectConnect with BCBSAZ**
  Arizona Blue DirectConnect (ABDC) allows providers to conduct electronic transactions directly with BCBSAZ in a quick and efficient way with no added fees . Talk to your software vendor to determine if this is an option for you.
  Transactions offered include: 837 electronic claims transmission, 835 electronic remittance advice, as well as others. Additional features include payer specific edits, HIPAA 5010 999 acknowledgement reports, HIPAA 5010 Custom Claim Acknowledgement Reports (CCAR).
- **Third party clearinghouse**
  If connecting directly to BCBSAZ does not fit your needs, you can conduct electronic business through a third party clearinghouse. BCBSAZ works with multiple national clearinghouses that conduct business in Arizona. For a current list of these clearinghouses, visit the Electronic Options page at azblue.com/providers.

Claim submission for other types of benefit plans

Please refer to the Quick Reference Guide on page 2 for claim submission information for BCBSAZ medical plans, FEP, FEDVIP, and BlueCard plans.

BlueDental Billing Guidelines

You can avoid most claim processing delays by including these key data elements:

- ☐ Accurate and complete information identifying the patient and policyholder (if different from patient), including full names, identification numbers, and dates of birth
- ☐ Date and place of service
- ☐ Identification of the service(s) provided by appropriate diagnosis code(s), procedure code(s), and applicable modifiers
- ☐ Evidence that any required prior authorization was obtained
- ☐ Identification of the treating and billing provider, including NPI numbers as indicated in the following table:

LOOP	ELEMENT	ADA Field	DESCRIPTION	BCBSAZ REQUIREMENTS
2310B	**NM109**	**54**	Treating provider NPI	Required. Enter the individual (not organizational) NPI number corresponding with the treating dentist's name. All dental claims must have the treating dentist's NPI.
2310C	**N301-N403**	**56**	Treating provider address, city, state, ZIP code	Required when different from billing address. Enter the physical location where the treatment was rendered. Must be a street address, not a P.O. box.
2010AA	**NM103 NM301-403**	**48**	Billing provider info	Required. Enter the name and complete address of the billing dentist or dental entity that furnished the services to the patient. Use the full nine-digit ZIP code.
2010AA	**NM109**	**49**	Billing provider NPI	Required. Enter the appropriate NPI number for the billing dentist or dental entity. All dental claims must have the billing provider/entity NPI.
2010AA	**REF*EI**	**51**	Billing provider SSN or Federal tax ID	Required. Enter the federal tax ID number of the billing dentist or dental entity.

Tax ID edits

Note: Our claim processing system includes edits to filter out and reject claims that have one or more of the following tax ID number (TIN) errors:

- Billing TIN not valid for date of service
- NPI/TIN combination not in our database for treating provider (treating provider NPI must be an individual NPI, not an organizational NPI)
- NPI/TIN combination not in our database for billing provider

How to update your information

If you need to update your provider directory listing or ensure our claim systems have your current NPI/TIN information, use the Dental Provider Information Change Form. You can access the form at azblue.com/BlueDentalProvider or in the secure provider portal at "azblue.com/providers > Provider Resources > Forms > Provider Information Change > Provider Information Change - Dental."

BlueDental Predeterminations

When to request a BlueDental predetermination

If treatment costs are expected to exceed $300, BCBSAZ recommends that you obtain a pretreatment estimate of benefits.

How to request a BlueDental predetermination

To request a predetermination for a member with a BlueDental stand-alone plan (prefix 99D or MUM), submit an 837D transaction according to the provider's treatment plan, along with estimated charges, periodontal charting, and diagnostic radiographs. In the CLM19 field, enter PB for predetermination.
Please note: When submitting a predetermination, Loop 2300 and 2400 DTP SVC Date are not used.

BCBSAZ will provide an estimate of the amount to be paid to the provider and the member's cost share. The predetermination estimate is nonbinding as the availability of benefits may change subsequent to the date of estimate due to changes in eligibility status, available maximum benefits, or application of frequency limitations.

BCBSAZ may determine that an alternate course of treatment will provide a professionally satisfactory result. Submitting your treatment plan in advance will allow you and your patient to determine what the available benefit is and any applicable plan limitations.

If you are unable to submit predeterminations electronically, you may mail the paper claim request (with documentation) to:

BCBSAZ Predeterminations
P.O. Box 211424
Eagan, MN 55121

Fax: 1-833-517-1939

Coordination of Benefits (COB)

Coordination of benefits

The coordination of benefits (COB) provision applies when a person has dental healthcare coverage under more than one plan. The order in which each plan pays a claim for benefits is governed by specific "order of benefit determination" rules.

- The plan that pays first is considered the "Primary Plan." The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses.
- The plan that pays after the Primary Plan is considered the "Secondary Plan." The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

Order of benefit determination rules

When a member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
2. A plan that does not have a coordination of benefits provision as described in this section is always the Primary Plan unless both plans state that the plan with a coordination of benefits provision is primary.
3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
4. Each plan determines its order of benefits using the first of the following rules that apply:
    a. **Non-dependent or dependent:** The plan that covers the member as an employee, policyholder, subscriber, or retiree is the Primary Plan. The plan that covers the member as a dependent is the Secondary Plan.
    b. **Dependent child covered under more than one plan:** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:
    c. For a dependent child whose parents are *married or are living together,* whether or not they have ever been married:
        i. **Birthday rule:** The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan.
        ii. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
        iii. **Gender rule:** If one of the plans does not follow the birthday rule, then the plan of the dependent child's father is the Primary Plan.
    d. For a dependent child whose parents are *divorced, separated, or not living together,* whether or not they have ever been married:
        i. If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of this decree, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
        ii. If a court decree states that both parents are responsible for the child's health care expenses or coverage, the provisions of subparagraph (i) determines the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the provisions of subparagraph (i) determines the order of benefits; or

iv. If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows:

1. The plan covering the custodial parent;
2. The plan covering the spouse of the custodial parent;
3. The plan covering the noncustodial parent; and then
4. The plan covering the spouse of the noncustodial parent.

v. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

e. **Active employee, retired, or laid-off employee:** The plan that covers the member as an active employee is the Primary Plan. The plan covering that same member as a retired or laid-off employee is the Secondary Plan. The same would hold true if the member is a dependent of an employee covered by the active, retired, or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "non-dependent or dependent" rule can determine the order of benefits.

f. **COBRA or state continuation coverage:** If a member whose coverage is provided pursuant to COBRA, or under a right of continuation provided by state or other federal law, is covered under another plan, the plan covering the member as an employee, subscriber, or retiree or covering the member as a dependent of an employee, subscriber, or retiree is the Primary Plan. The COBRA, state, or other federal continuation coverage is the Secondary Plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "non-dependent or dependent" rule can determine the order of benefits.

g. **Longer or shorter length of coverage:** The plan that covered the member as an employee, policyholder, subscriber, or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the plan that covered the member the shorter period of time is the Secondary Plan. The status of the member must be the same for all plans for this provision to apply. The same primacy would be true if the member is a dependent of an employee covered by the longer or shorter length of coverage.

If the preceding rules do not determine the order of benefits, the allowable expense is shared equally between the plans. In addition, this coverage will not pay more than it would have paid had it been the Primary Plan.

Secondary coverage

When coverage is secondary, it may reduce benefits so that the total paid or provided by all plans for a service are not more than the total allowable expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other coverage. That amount is compared to any allowable expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid allowable expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all plans may not exceed the total allowable expense for that claim. In addition, the Secondary Plan credits to its deductible any amounts it would have otherwise credited to the deductible.

Coordination of Benefits (COB)

If a member is enrolled in two or more closed-panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed-panel plan, COB shall not apply between that plan and other closed-panel plans.

Right to receive and release needed information

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this coverage and other plans. BCBSAZ may obtain and use information necessary to apply these rules and determine benefits payable under this coverage and other plans covering the member claiming benefits. BCBSAZ need not tell, or get the consent of, the member or any other person to coordinate benefits. Each member claiming benefits under this coverage must give BCBSAZ any documentation or other information needed to apply those rules and determine benefits payable. Failure to complete any forms required by BCBSAZ may result in claims being denied.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this coverage. If it does, BCBSAZ may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under this coverage. BCBSAZ will not pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

Notwithstanding any other provision contained in this Provider Manual, if the amount of the payments made by BCBSAZ is more than the amount that should have been paid under this COB provision, BCBSAZ may recover the excess amount. The excess amount may be recovered from one or more of the persons or organizations paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Benefit plan limitations

When benefits are coordinated, any benefit plan limitations that apply to the member’s care may result in denial of a secondary payment.

Other payment sources

Although BCBSAZ participation agreements prohibit providers from collecting more than the BCBSAZ allowed amount for a covered service, BCBSAZ providers may have a right, under A.R.S. § 33-931 (Arizona’s provider lien law) to collect up to billed charges from other sources of payment, such as liability insurance when the provider properly perfects a lien.