Pediatric dental and vision FAQs

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Pediatric services – including oral and vision care for children up to age 19 – are among the benefits that the Affordable Care Act (ACA) says must be included in all health plans offered to small businesses as essential health benefits.

At Blue Shield, for businesses of one to 50 employees, pediatric vision coverage is an embedded benefit in our small business medical plans, while pediatric dental coverage is a mandatory bundled purchase of a separate plan at a separate premium.

This Q&A answers the most frequent questions about Blue Shield pediatric dental and vision coverage and processes.

**General eligibility – dental and vision coverage**

**Q:** Who is eligible for pediatric benefits?
**A:** Anyone newborn to age 19, whether employee or dependent, is eligible for pediatric dental and pediatric vision benefits. Eligibility ends the first day of the month following the 19th birthday for dental coverage and at group renewal following the 19th birthday for vision coverage.

**Pediatric dental Q&A**

Because pediatric dental care is an essential health benefit, an ACA-compliant Blue Shield pediatric dental plan must be bundled with every Blue Shield small business medical plan.

**Plans**

**Q:** How many pediatric dental plans can an employer select?
**A:** An employer must select at least one, but may offer both Blue Shield pediatric dental plans:
- Blue Shield of California Children’s Dental HMO
- Blue Shield of California Children’s Dental PPO

**Q:** Does an employer need to select a pediatric dental plan at open enrollment even if there are no eligible participants?
**A:** Yes.

**Q:** Can an employer or employee waive coverage for any reason?
**A:** No.

**Q:** Do the pediatric dental plans need to match the “metal” level or plan type of the medical plan?
**A:** No.
Q: **Is the dental out-of-pocket (OOP) maximum combined with the medical OOP maximum?**
A: No. Once an employee or dependent satisfies the in-network $350 per member ($700 per family) pediatric dental OOP maximum, covered dental benefits from a participating provider will be paid at 100% for the remainder of the calendar year.

Q: **What is the out-of-network reimbursement schedule for the pediatric dental PPO plan?**
A: The out-of-network reimbursement schedule is a MAC (Maximum Allowable Charge) schedule. This schedule is the same MAC schedule as our small business dental PPO MAC plans.

**Pediatric dental coverage eligibility**

Q: **What is the “age-out” process for pediatric dental coverage?**
A: Eligibility ends the first day of the month following the 19th birthday, when the member is no longer eligible for the benefit.

Q: **Is aging out of pediatric dental coverage considered a qualifying event?**
A: Blue Shield will not issue a HIPAA certificate when an employee or dependent ages out of a Blue Shield pediatric dental plan. Aging out is considered a qualifying event for enrollment into a small business group dental plan; enrollment would be required within 31 days of the date of the loss of pediatric benefits.

Q: **Are aging-out dependents eligible for COBRA or Cal-COBRA coverage?**
A: No.

Q: **Is a disabled dependent age 19 or older eligible for pediatric dental benefits?**
A: No.

**Enrollment and premiums**

Q: **Will a member ID card be issued for pediatric dental benefits?**
A: Yes, all eligible enrolled subscribers and dependents will receive a dental ID card.

Q: **Will an employee be charged premiums for pediatric benefits if they are not eligible or have no eligible dependents?**
A: No. The employee will be enrolled in the plan but will not be charged unless, and until, there is eligible pediatric enrollment.

Q: **How will enrollment and premium charges work for newborns?**
A: As soon as the newborn is added to the medical plan (based on medical enrollment guidelines), the newborn will automatically be enrolled and charged for pediatric dental benefits.

Q: **Will Blue Shield allow “split” enrollment within a family for pediatric dental, allowing one member to enroll in an HMO and another in a PPO?**
A: No. All members must be enrolled in the same pediatric dental plan.

Q: **For pediatric dental “coordination of benefits” who is the primary payer?**
A: The pediatric dental plan will be the primary payer.

Q: **Does a primary care dentist need to be listed on the employee application for an eligible member at the time of enrollment into a pediatric DHMO plan?**
A: Yes.
Q: If a pediatric DHMO plan application is submitted for a pediatric-eligible member and a primary care dentist has not been listed, will the application be delayed?
A: No, the application will not be delayed for not listing a primary care dentist (PCD). A PCD will be assigned based on the employee’s ZIP code. However, the designated PCD can be changed up to once a month.

Availability

Q: Are all pediatric dental plans available in all areas?
A: The dental PPO is available in all areas. For a listing of eligible DHMO providers near you, visit www.blueshieldca.com to Find a Provider; choose Dental HMO (Individual or Group Plans) when you Set Your Plan and then enter your city, state or ZIP code.

Q: What plans are available to pediatric-eligible members outside the state of California?
A: The pediatric dental PPO (Children’s Dental PPO) is available for members not residing in California.

Q: Where would a subscriber/member go to look for a selection of DHMO primary care dentists?
A: Go to www.blueshieldca.com, click on Explore, Find a Provider, Dentists, Select your plan-dental plan, Dental HMO (Individual/Family or Group plans), and enter ZIP code. There is an Edit Location feature to set a different distance from the default of five miles.

Q: What information and services are available to dental plan members online?
A: Members have access to our dental website at www.yourdentalplan.com/bsca. Members can look up benefits, providers, claims information, view selected primary care dentist information, and even change their PCD online, among many other features and capabilities.

Pediatric vision Q&A

Q. May an employer select a stand-alone pediatric vision plan?
A. No. Pediatric vision benefits, defined as essential health benefits by the ACA, are embedded in the medical plan.

Q. How does a member know what pediatric vision benefits are covered?
A. The medical plan Evidence of Coverage/Certificate of Insurance specifies which pediatric vision benefits are covered. Members can also access benefit information online at the member portal of www.blueshieldca.com.

Q. What is the “age-out” process for pediatric vision?
A: Eligibility ends at the group’s renewal after the 19th birthday. Aging out is considered a qualifying event for enrollment into a small business group vision plan; enrollment would be required within 31 days of the date of the loss of pediatric benefits.

Q. Is a member ID card issued for pediatric vision benefits?
A. No. A “generic” Vision Plan Information Card can be accessed online to assist in accessing care, or members can call (877) 601-9083 for assistance.

Q. Where would a subscriber/member go to look for a vision provider?
A: Go to www.blueshieldca.com, click on Explore, Find a Provider, Vision Care, Select your plan-Vision Plans (Individual and Family or Group plans), and enter ZIP code. There is an Edit Location feature to set a different distance from the default of five miles.
Q: For pediatric vision “coordination of benefits” who is the primary payer?
A: There is no coordination of benefits for pediatric vision plans.

Q: Are pediatric vision members subject to the medical calendar-year deductible?
A: As an essential health benefit, pediatric vision is a first-dollar benefit not subject to any deductibles.

Q: Do members enrolled in an HMO medical plan have access to out-of-network vision providers for pediatric vision benefits?
A: No, out-of-network vision benefits are not available.