Know Your Dental & Vision Coverage: Open Access Plans Explained

Your Freedom to Choose — No Network Restrictions

Blue Water Benefits Administrators manages Open Access dental and vision plans. This means you can visit any licensed provider you choose — even if that provider says they are “out of network.”

Important: If a provider tells you they don’t accept your plan and asks you to pay out of pocket, your coverage is still valid.

They can still treat you and receive payment from Blue Water.

What Is an Open Access Plan?

An Open Access plan allows you to use any dental or vision provider without being limited to a specific network. Here’s how it works:

- No network limitations. You can visit any provider without needing a referral.
- Reimbursement at fair market value. Blue Water reimburses providers based on the fair market value of services rendered.
- No penalties for using non-network providers.

What to Say to Your Provider

If your provider says, ***“We don’t take this insurance,”*** you can respond:
“My plan is an open access plan. That means you don’t need to be in a network. Please bill Blue Water Benefits Administrators directly. They will reimburse you at fair market value.”
Provide them with the billing information from your member ID card.

Frequently Asked Questions

Q: What if the provider asks me to pay up front?

A: You may do so and submit the receipt for reimbursement, but providers are encouraged to bill Blue Water directly.

Q: Do I receive the same benefits regardless of provider?

A: Yes. Reimbursement is based on the fair market value of the procedure, not the provider’s network status.

Q: What if the provider is unfamiliar with Open Access plans?

A: Explain that the plan operates like a standard indemnity plan. Providers simply need to submit a claim to the address on your card.

Need Help?

If you or your provider have questions, contact Blue Water Benefits Administrators:

bluewaterbenefitsadmin.com **1-800-229-2210** **info@bluewaterbenefitsadmin.com**

MEMBER REIMBURSEMENT CLAIM FORM

Employer Name		**Date of Service**	
Employee Name		**Member ID Number**	
Claimant Name *(if not the employee)*		**Claimant DOB**	
Address where check should be mailed			
Address			
City		**State**	**Zip**

VISION EXPENSES

Please complete services and materials received.

Vision Provider Name		**Vision Provider Phone**	
Eye Exam		Paid	$
Frames		Paid	$
Lens	Single		
	Bi-focal		
	Tri-focal		
	Lenticular	Paid	$
Contact Lens		Paid	$
		Total Vision Expenses Paid	**$**

DENTAL EXPENSES

Please complete services received or attach the Dental Claim Form provided by your Dental Office. Dental providers may also use the ADA Dental Claim Form on reverse for submission.

Dental Provider Name		**Dental Provider Phone**	
Dental Exam		Paid	$
Service Type			
	Preventive Services	Paid	$
	Basic Services	Paid	$
	Major Services	Paid	$
		Total Dental Expenses Paid	**$**

Form Completed by _____

Signature _____ **Date** _____

Please return this form with a copy of your paid, itemized receipt to:

Blue Water Benefits Administrators
5910 Harper Road Solon OH 44139
Secure Fax: (440) 349-4268

Questions? You can contact our office at (800) 229-2210.

BLUE WATER
BENEFITS ADMINISTRATORS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION (alll dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID