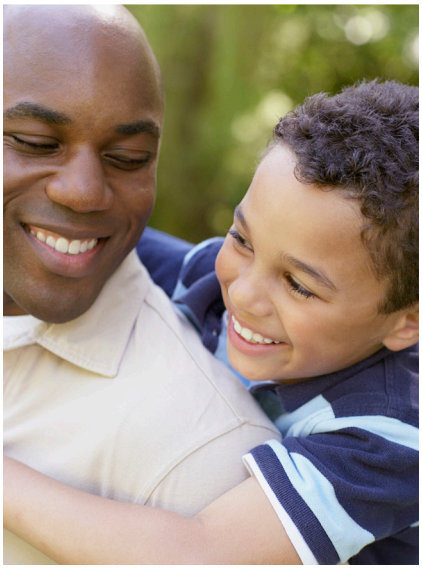
# Dental Plan

## Your Benefit Plan Details





**Group Name**
Le Moyne College

**Plan Type**
Active Employee Dental

Excellus BlueCross BlueShield
National strength.
Local focus.
Individual care.℠

## Le Moyne College

## Active Employee Dental

Good oral hygiene starts with basic dental care.
Here are helpful tips to keep in mind:

- Brush your teeth twice a day.
- Replace your toothbrush every three or four months.
- Clean between teeth daily with floss.
- Use mouthwash to keep your mouth clean and fresh.
- Eat a balanced diet and limit between-meal snacks.
- Avoid tobacco products, which can cause gum disease and cancer.
- Visit your dentist regularly for oral exams and professional cleanings.

Excellus

# Dental Blue Options Summary of Benefits

Employer Group name: Le Moyne College

Plan Type: Contributory (employer-sponsored) Product Type: Passive PPO (same coinsurance in & out-of-network)

## Plan Features

| | |
|---|---|
| Network: BlueShield local network | Dependent / student age limit: 26/26 |
| Reimbursement In network: Fee Schedule<br>Reimbursement Out-of-network: Average Market Rate (UCR90) | |
| Annual Plan Deductible: $50 Ind / $150 Fam<br>Deductible applies to: Classes II, IIA and III services | Annual Plan Maximum per member: $1,000 per member<br>Annual Max applies to: Classes I, II, IIA III services |
| Ortho Age Limit: Children to age 19<br>Lifetime Orthodontia Maximum: $1,000 per member (does not apply toward annual plan maximum) | |

## Plan Benefits

| Type of Care | Benefits Included | Excellus BCBS Pays: In-Network | Excellus BCBS Pays: Out-of-Network |
|---|---|---|---|
| **Class I Preventive & Diagnostic** | • Cleanings & exams - twice per cal year<br>• Fluoride treatments – twice per cal year to age 16<br>• Sealants – unrestored 1st and 2nd permanent molars, once every 36 months<br>• Bitewing x-rays – up to 4 every cal year<br>• Full mouth / panorex x-rays – once every 36 months<br>• Space maintainers – up to age 16<br>• Emergency palliative treatment | 100% | 100% |
| **Class II Basic Restorative** | • Fillings – amalgam & composite; each surface covered once every 12 months<br>• Oral surgery – simple extractions | 80% | 80% |
| **Class IIA Basic Restorative** (12 month waiting period applies for voluntary plans) | • Oral surgery – surgical extractions<br>• Endodontics – root canal treatment<br>• Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months<br>• Periodontal scaling & root planing – once per quadrant every 24 months<br>• Periodontal maintenance following surgery – twice per cal year | 80% | 80% |

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

| Type of Care | Benefits Included | Excellus BCBS Pays: | |
|---|---|---|---|
| | | In-Network | Out-of-Network |
| **Class III Major Restorative** (12 month waiting period applies for voluntary plans) | • Fixed prosthetics – bridgework, abutments, pontics<br>• Removable prosthetics – partial / complete dentures<br>• Inlays / onlays / crowns – includes coverage for re-cementation<br>• Relines / rebases – once every 36 months and at least 6 months following initial placement<br>• Above services eligible for replacement every 5 years<br>• Implants – eligible for replacement every 10 years, and subject to alternate benefits provision | 50% | 50% |
| **Class IV Orthodontia** (12 month waiting period applies for voluntary plans) | • Initial banding & monthly follow-up treatment | 50% | 50% |

## How to Get The Most From Your Plan

### Pre-determination of Benefits

Pre-determination of benefits is recommended for any extensive treatment such as periodontics, orthodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be included as Covered Expenses will be determined by your Plan and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, your Plan will determine the expenses that will be included as Covered Expenses at the time the claim is received. Predetermination of Benefits does not guarantee payment and expires one year from date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

### Alternate Benefits Provision

All covered procedures are subject to an alternate benefit allowance. When there is more than one technology or material type for a dental procedure, the dental plan will reimburse for the procedure which has the lesser allowance. When alternate benefit is enforced, your benefits are not intended to interfere with the treatment plan recommended by the dentist. You and your dentist should discuss which treatment is best suited for you, and may proceed with the original treatment plan regardless of benefit determination. If the more expensive treatment is chosen, you are liable for the balance up to the billed amount.

### Participating Dentists

Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas.

You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

### Non-participating Dentists

You have the freedom to see any dentist. Non-participating dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of non-participating dentists' charges.

**Dental Customer Service – for members and dentists**
1-800-724-1675
**Hours:** Monday – Thursday 8:00 am – 5:00 pm

**Mailing address for claims**
Excellus BCBS
P.O. Box 22999

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

Friday 9:00 am – 5:00 pm

Rochester, NY 14692

# *Preventive Dental Care is Good Health Care.*

Maintaining optimal oral health not only gives you a brighter, healthier smile, but it may also help prevent many potentially chronic diseases in the future. Good oral hygiene, along with preventive dental care, is a vital component to your overall health.

Preventive dental care, including check–ups, cleanings, x-rays and dental sealants, is essential to identify and treat minor problems, which if left undetected, could become more serious and costly to fix.

For a complete prevention plan, be sure to include dental care with your other annual exams such as physicals, Pap smears, mammograms, colonoscopys, and/or well child visits.

## Why is dental coverage so important?

Like other insurance plans, dental insurance is important to protect you from expensive services associated with unplanned events. These can range from a cracked tooth or impacted wisdom teeth, to needing an extraction, or even periodontal disease.

Our dental coverage is designed to ensure that you and your family receive regular preventive dental care with minimal or no out–of–pocket costs. We also provide comprehensive coverage should you need more extensive dental care.

**Young professionals** - The last thing you may be thinking about is the chance to access fully-covered routine cleanings, but now is the time since prevention today leads to a healthy future tomorrow.

**Young families** - You're just starting a new family or working towards keeping your children healthy and on the right path towards a life of good dental health.

**Established employees** - You've arrived at family independence or simply a new age that includes planning for retirement and your future medical coverage. But, don't forget dental care – it's still about prevention to ensure a bright and healthy retirement.

## The surprising connection between oral and overall health.

Poor oral health has a proven link to:

**Heart disease:** Oral bacteria can affect the heart when entering the blood stream, as they attach to fatty plaques in blood vessels, helping to form clots.[1]

**Diabetes:** Periodontal disease can make it harder for diabetics to control their blood sugar levels, among other issues.[2]

**Pregnancy problems:** Studies have shown that pregnant women with periodontal disease may be at risk of having a premature, low-birth weight baby.[3]

## Home care tips:

1. Brush twice a day for at least 5 minutes
2. Use a soft brush and replace it promptly when it's worn
3. Floss every day
4. See your dental hygienist for a cleaning at least twice a year

## Why Excellus BlueCross BlueShield dental coverage makes sense for you.

With access to quality dental benefits through Excellus BCBS, you have the ability to improve and maintain good oral health, which is key to your overall health.

### Quality benefits include:

- No copays or deductibles for preventive and diagnostic services
- Preventive services do not count against annual maximums, preserving your benefit dollars
- Easy access to providers through network or non-network products
- Low out-of-pocket costs
- No hassle customer service and claims processing
- Affordable premiums

One of our plans can complete your approach in maintaining good health care.

**Get more information at ExcellusBCBS.com**

1 - WebMD - http://www.webmd.com/heart-disease/features/periodontal-disease-heart-health
2 - WebMD - http://www.webmd.com/diabetes/dental-health-dental-care-diabetes
3 - Gum Disease in Pregnancy Linked to Premature Low-Weight Babies - http://www.teamperio.com/PatientCenter/DentalArticles/GumDiseaseinPregnancy.aspx

Dental Care. 10.14 EX 8116-14M

# Customer Submitted Dental Claim Form

Excellus
165 Court Street
Rochester NY 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

**Mail Completed Forms To:** Excellus BlueCross BlueShield
PO Box 22999
Rochester, NY 14692

## HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

## OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

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

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID

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

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company 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

15. Policyholder/Subscriber ID

16. Plan/Group Number

17. Employer Name

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

18. Student Status ☐ FTS ☐ PTS

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

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

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 | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

## MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent

| 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 |

Primary

| A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|
| T | S | R | Q | P | O | N | M | L | K |

32. Other Fee(s)

33. 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 _____
Patient/Guardian 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

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

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

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

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date 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 have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56A. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

**Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.**

I certify that the procedures as indicated by date, have been completed, personally supervised or rendered by me the attending dentist, that the fees submitted are actual fees I have charged and intended to collect.
Dentist signature: Date:

*For assistance in filing your claim, please read the instructions on the back.*

## General Instructions

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

## Coordination Of Benefits (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.

## National Provider Identifier (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: **www.ada.org/goto/npi**

## Additional Provider Identifier

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

## Provider Specialty Codes

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

| Category / Description Code | Code |
|---|---|
| **Dentist**<br>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. | 122300000X |
| **General Practice** | 1223G0001X |
| **Dental Specialty** (see following list) | Various |
| Dental Public Health | 1223D0001X |
| Endodontics | 1223E0200X |
| Orthodontics | 1223X0400X |
| Pediatric Dentistry | 1223P0221X |
| Periodontics | 1223P0300X |
| Prosthodontics | 1223P0700X |
| Oral & Maxillofacial Pathology | 1223P0106X |
| Oral & Maxillofacial Radiology | 1223D0008X |
| Oral & Maxillofacial Surgery | 1223S0112X |

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
**www.wpc-edi.com/codes/taxonomy**

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## AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION

To comply with Federal HIPAA regulations, health plans must obtain a member's permission to share that member's protected health information with any other person. There are limited exceptions to this rule. Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information, including payment information, for venereal diseases, abortion, and drug and alcohol abuse, unless the child specifically authorizes the release of such information.

As a member, you can use this form to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

This authorization will include the disclosure of information relating to genetic testing, alcohol and drug abuse, mental health (excluding psychotherapy notes), abortion, and venereal disease information only if you place your initials on the corresponding line in Step 2. Additionally, if you would like to authorize us to release information regarding HIV/AIDS, a different form must be completed. To obtain a copy of this form please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

Your authorization is completely voluntary. We will not condition your enrollment in a health plan, eligibility for benefits, or payment of claims on giving this authorization. If you need additional forms, you may copy this form, visit our Web site at: www.excellusbcbs.com/download/forms/authform.pdf, or contact our office at the telephone number listed on your identification card.

As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

☐ **Please check here if you would like to authorize access to psychotherapy notes. If this box is checked, then this authorization cannot be used for another reason. If checked, steps two and three below can be skipped.**

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**Please be sure to complete all of the following steps.**

**Step 1: Member to whom this authorization applies.** *Please use one form per member.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Member ID Number(s): _____ Birth Date: _____/_____/_____

**Step 2: Reasons to share your information.** *So Excellus Health Plan, Inc. can:*

- ❑ Respond to all requests for confidential information about me made by the individual(s) or organization(s) I list below.
- ❑ I choose to include information regarding the following conditions in this authorization (please initial next to all that apply):

  _____ Genetic testing
  _____ Abortion
  _____ Alcohol or substance abuse
  _____ Venereal diseases
  _____ Mental health

  *(Please note: You must complete a separate form to authorize release of information related to HIV/AIDS. The New York State-approved consent form can be found at: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm*
- ❑ Respond to requests for only the following specific information (such as claims submitted by a specific provider or information related to one of the protected diagnosis listed above):

  *Please specify* _____
- ❑ Respond to inquiries related to a specific date of service:

  *Please specify* _____

**Step 3: Specific information you'd like us to share:** *Please list the specific protected health information you wish us to disclose. Check all that apply:*

- ❑ My claim information (e.g. status, type of service, diagnosis, provider, dates of service, etc.)
- ❑ My membership information (e.g. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- ❑ My benefit information (e.g. benefits available, benefits used, contract limits, etc.)
- ❑ My medical records (e.g. physician or hospital records, case management, etc.)
- ❑ Other information (please specify): _____
- ❑ Please exclude the following information: _____

**Step 4: Indicate with whom you'd like us to share your information:** *Please list the person(s) and/or organization with which you want us to share the information you described above. Please remember if you'd like us to share information with more than one person, the information to be disclosed and the expiration date must be the same for each person.*

| Name/Organization | Address |
|---|---|
| _____ | _____ |
| _____ | _____ |

**Step 5:** **Indicate when you would like us to share your information:** *Please share my protected health information during the time period(s) below:*

- ❑ Until Excellus Health Plan, Inc., completes the activities outlined in Step 2.
- ❑ Until I send Excellus Health Plan, Inc. a form canceling my authorization.
- ❑ From _____/_____/_____ through _____/_____/_____

**Step 6:** **Member signature:** *To give Excellus Health Plan, Inc. authorization to share the protected health information noted above, please print your name on the line below and then provide your signature and today's date.*

I, _____ have had full opportunity to read and consider the contents of this
*(Print Name Above)*
form, I confirm my authorization for the use, request and release of my confidential member protected health information as described in this form. I understand that I may cancel this authorization at any time by completing an authorization cancellation form and sending it to the address below. I also understand that the revocation of this authorization will not take effect until Excellus Health Plan, Inc. receives my authorization cancellation form and will not affect any actions Excellus Health Plan Inc. took in reliance on this authorization before they received the authorization cancellation form.

I understand that the information disclosed as a result of this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the federal privacy laws.

**Signature:**_____ **Date:**_____
*(Member or Personal Representative)*

If this request is by a personal representative on behalf of our member, please give us the following information:

Personal Representative's Name: *(please print)*_____

Description of Personal Representative's Authority (a power of attorney, legal guardian or state executor):

_____

***Please note: personal representatives must provide legal proof of representation, such as power of attorney documentation.***

**This form can be completed real time by visiting our Web site at www.excellusbcbs.com/members/account_manager/index.shtml. Select the option to 'Share Your Protected Health Information'.**

**OR**

Please complete and return this form to**:**

Excellus Health Plan, Inc.
P.O. Box 22999
Rochester, NY 14692

**OR**

FAX: 1-315-671-7079

***PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS***

# Health plan terms

To help you better understand our plans and your coverage, here are a few definitions* for frequently used health care terms.

**Primary Care Physician (PCP)**—A doctor who serves as your health care manager and coordinates virtually all of the health care services you routinely receive. Some plans do not require you to choose a PCP.

**Referral**—Instructions provided by a PCP for specialty care. Most plans do not require referrals.

**In-network coverage**—The coverage available when you receive services from a provider who participates in your health plan.

**Out-of-network coverage**—The coverage available when you receive services from a provider who does not participate in your health plan. Some plans may not include out-of-network coverage.

**Out-of-area**—Describes when you receive services while outside the geographic service area of your health plan. Your plan benefits may differ if you live or work beyond the geographic service area.

**Copay**—A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

**Allowed Amount**—The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

**Coinsurance**—A cost-sharing method that requires you pay a portion of the allowed amount for certain medical services.

**Deductible**—A set dollar amount you pay for covered services you receive before your insurer will make a payment.

**Out-of-pocket maximum**—The maximum amount of deductible and coinsurance payments that you will pay for health services each calendar year.

* Some definitions may vary slightly by plan. In case of a conflict between your legal plan documents and this information, the plan documents will govern.

## Sign Up. Stay Informed.

Make the most of your membership. Sign up for email updates that include:

- Free recipes
- Fitness advice
- Nutrition tips
- Coupons and discounts
- Latest on changes in health care

It's information for your health and well-being—delivered right to your computer or smartphone.

## Sign up today at ExcellusBCBS.com/Email

Excellus