Your Benefit
Plan Details

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Group Name
The U.A. Local 13

Plan Type
DentalBlue Options
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:** Plumbers Local 13

**Plan Type:** Contributory (employer-sponsored)

**Product Type:** Passive PPO (same coinsurance in & out-of-network)

### Plan Features

<table>
<thead>
<tr>
<th>Network: BlueShield local network</th>
<th>Dependent / student age limit: 26/26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement In network: Fee Schedule, 2017 SOA</td>
<td></td>
</tr>
<tr>
<td>Reimbursement Out-of-network: Fee Schedule, 2017 SOA, subject to balance billing</td>
<td></td>
</tr>
<tr>
<td>Reimbursement Out-of-area: UCR90</td>
<td></td>
</tr>
</tbody>
</table>

- **Annual Plan Deductible:** $25 Ind / $75 Fam
- **Annual Plan Maximum per member:** $1,000 per member
- **Ortho Age Limit:** Children to age 19

**Lifetime Orthodontia Maximum:** $1,500 per member eff 5/1/19

(Increased from $500 does not apply toward annual plan maximum)

### Plan Benefits

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Benefits Included</th>
</tr>
</thead>
</table>
| **Class I Preventive & Diagnostic** | - Cleanings & exams - twice per calendar year  
  - Fluoride treatments - twice per calendar year to age 16  
  - Sealants - unrestored 1st and 2nd permanent molars, once every 36 months to age 16  
  - Bitewing x-rays - up to 4 every calendar year  
  - Full mouth/Panoramic x-rays - once every 36 months  
  - Diagnostic Photograph/Facial Images - once per calendar year  
  - Space maintainers - up to age 16  
  - Emergency palliative treatment                                                                                                                                                                                                                                                                                                    |
| **Class II Basic Restorative** | - Fillings - amalgam & composite; each surface covered once every 12 months  
  - Oral surgery - simple extractions                                                                                                                                                                                                                                                                                          |
| **Class IIA Basic Restorative** | - Oral surgery - surgical extractions  
  - Endodontics - root canal treatment  
  - Periodontal surgery - osseous surgery, gingivectomy, gingival flap procedure - covered once per quadrant every 36 months  
  - Periodontal scaling & root planing - once per quadrant every 24 months  
  - Periodontal maintenance following surgery - twice per calendar year |

**Excellus BCBS Pays:**

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

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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.
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<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Plan Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class III</td>
<td>• Fixed prosthetics – bridgework, abutments, pontics</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>Major Restorative</td>
<td>• Removable prosthetics – partial / complete dentures</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Inlays / onlays / crowns – includes coverage for re-cementation</td>
<td></td>
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<tr>
<td></td>
<td>• Relines / rebases – once every 36 months and at least 6 months following initial placement</td>
<td></td>
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<tr>
<td></td>
<td>• Above services eligible for replacement every 5 years</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Implants – eligible for replacement every 10 years, and subject to alternate benefits provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class IV</td>
<td>• Initial banding &amp; monthly follow-up treatment</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>• No more than 1/2 the lifetime maximum can be paid in any calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

Waiting Periods - Timely Entrants
Timely Entrants are those employees that join the plan within 31 days of the following events: During initial open enrollment with Excellus (for new dental groups), As a new hire, After a qualifying event

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
1-800-724-1267
Hours: Monday - Thursday 8:00 am – 5:30 pm
       Friday 9:00 am – 5:30 pm

Mailing address for claims
Excellus BCBS
PO Box 21146
Eagan, MN 55121

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.
NEARLY 50% OF ADULTS OVER AGE 30 HAVE ADVANCED GUM DISEASE*

Checkups twice a year are included in your dental coverage. So see your dentist regularly and catch problems early, before they become serious – and more costly.

FIND A DENTIST

Don’t have a dentist? We can help. To access a list of dentists near you, visit: ExcellusBCBS.com/FindADentist

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Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex.
Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.
注意：如果您说中文，我们可为您提供免费的语言协助。请参见随附的文件以获取我们的联系方式。
**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)
   - Statement of Actual Services
   - Request for Predetermination/Preauthorization
   - EPSDT/Flexible Spending
2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

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

**RECORD OF SERVICES PROVIDED**

<table>
<thead>
<tr>
<th>24. Procedure Date (MM/DD/CCYY)</th>
<th>25. Area of Orifice or Tooth Surface</th>
<th>26. Tooth or Tooth Number(s) or Letter(s)</th>
<th>27. Tooth Number(s) or Letter(s)</th>
<th>28. Tooth Surface</th>
<th>29. Procedure Code</th>
<th>30. Description</th>
<th>31. Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**MISSING TEETH INFORMATION**

<table>
<thead>
<tr>
<th>Tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>3</td>
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<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

**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

**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**

49. NPI
50. License Number
51. SSN or TIN
52. Phone Number
52A. Additional Provider ID
53. 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 to file 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 charged and intended to collect.

Dentist signature
Date

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

MSA-56 • 10/08
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)
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
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
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.

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>12230000X</td>
</tr>
<tr>
<td>Dental Practice</td>
<td>1223G001X</td>
</tr>
<tr>
<td>Dental Specialty</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>1223D001X</td>
</tr>
<tr>
<td>Endodontics</td>
<td>1223E020X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1223X040X</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>1223P021X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>1223P030X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>1223P070X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>1223P0106X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>1223D0008X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1223S0112X</td>
</tr>
</tbody>
</table>

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

RECEIVED
By A11y Updated at 10:33 am, Mar 23, 2018
Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department  
Attn: Civil Rights Coordinator  
PO Box 4717  
Syracuse, NY 13221  
Telephone number: 1-800-614-6575  
TTY number: 1-800-421-1220  
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan’s Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)  
Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvìlò la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l’italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenere, consultate il documento allegato.

আপনার ভাষা এই ইতালীয় ভাষায় হলে তাই তিনি এই গ্রাম ভাষার সাহায্য প্রদান করবেন। সংযোগ পথ দেখুন এই কাগজের জন্য।

नजर दिखा: यदि आप अपनी भाषा क्षेत्र में बोलते हैं तो आपके लिए भाषा सहायता उपलब्ध होगी। आपके सेल में नोट करें कि यह संयुक्त नई गढ़वाल है।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تذبیه: اگر تحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωτερικά για πληροφορίες σχετικά με τους διαδέσμευσις τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejt jojuni dokumenttit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495
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.*

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

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