



A **dental plan** for more complete health and wellbeing.

Your Benefit Plan Details

Group Name

The U.A. Local 13

Plan Type

Dental Blue Options

Welcome to Excellus BlueCross BlueShield!

Good dental hygiene and care promote overall health. With an emphasis on no-cost preventive care and access to a broad network of dentists, dental plans from Excellus BCBS help you maintain complete oral health, reducing the need for more costly dental care in the future.

You can count on your Excellus BCBS dental plan for care when and where you need it:



Preventive dental care



Easy access to a broad network of providers



Lower out-of-pocket costs when you use the network



Free digital support tools for answers anytime, anywhere

- Online member account
- Find a dentist, specialist or facility that accepts your plan



Find more answers and support at
[ExcellusBCBS.com](https://www.ExcellusBCBS.com)

The U.A. Local 13

Dental Blue 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.

Questions? For assistance call (800) 724-1675,
Call our TTYphone at 1 (800) 421-1220,
or visit us at ExcellusBCBS.com





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

Network: BlueShield local network	Dependent / student age limit: 26/26
Reimbursement In network: Fee Schedule	
Reimbursement Out-of-network: Fee Schedule, subject to balance billing	
Reimbursement Out-of-area: UCR90	
Annual Plan Deductible: \$25 Ind / \$75 Fam	Annual Plan Maximum per member: \$2,000 per member
Deductible applies to: Classes II, IIA and III services	Annual Max applies to: Classes II, IIA and III services
Ortho Age Limit: Children to age 19	
Lifetime Orthodontia Maximum: \$1,500 per member (does not apply toward annual plan maximum)	

Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays:	
		In-Network	Out-of-Network
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	100%	100%
Class II Basic Restorative	- Fillings – amalgam & composite; each surface covered once every 12 months - Oral surgery – simple extractions	80%	80%
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	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	Plan Benefits	In-Network	Out-of-Network
Class III Major Restorative	- Fixed prosthetics – bridgework, abutments, pontics - Removable prosthetics – partial / complete dentures - Inlays / onlays / crowns – includes coverage for re-cementation - Relines / rebases – once every 36 months and at least 6 months following initial placement - Above services eligible for replacement every 5 years - Implants – eligible for replacement every 10 years, and subject to alternate benefits provision	65%	65%
Class IV Orthodontia	- Initial banding & monthly follow-up treatment - No more than 1/2 the lifetime maximum can be paid in any calendar year	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.

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

1-800-724-1675

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.



Dental checkups? You're covered

Nearly 42% of adults over age 30 have 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



*Centers for Disease Control and Prevention, "Gum Disease Facts," May 2024

B-6636 / 19792-24M

Excellus  

Everybody
Benefits

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 Identifier):** 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/mpi**

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 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

Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.
- 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.
- 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 for sexually transmitted diseases, abortion, and drug or alcohol abuse unless the child specifically authorizes the release of such information.
- This form is used 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.
- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form 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>.
- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at <https://www.excellusbcbs.com> and search for "Manage Your Privacy".
- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

**AUTHORIZATION TO EXCELLUS HEALTH PLAN, INC. ("HEALTH PLAN")
TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

☐ **Check here only if you are authorizing access to psychotherapy notes.** If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED				
LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)
CURRENT ADDRESS			CITY	STATE/ZIP CODE
PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)				
NAME OF PERSON/ORGANIZATION			ADDRESS	
NAME OF PERSON/ORGANIZATION			ADDRESS	
PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE				
☐ At my request ☐ Other: _____				
PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION <i>(select D-1 <u>or</u> D-2 and if applicable, D-3)</i> NOTE: Skip this section if psychotherapy was checked at the top of this form				
D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed. - OR - D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information. ☐ Enrollment (e.g. eligibility, address, dependents, birth date) ☐ Benefit (e.g. benefit coverage, usage, limits) ☐ Claim (e.g. status, provider, dates, payment, diagnosis) ☐ Clinical records (e.g. doctor/facility, case management) ☐ Other limitation: _____ ☐ Date Range _____ to _____ - AND, IF APPLICABLE - D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions. ☐ Genetic testing ☐ Substance use disorder ☐ Mental health (excluding psychotherapy notes) ☐ Sexually transmitted diseases ☐ Abortion Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm				
CONTINUED ON THE NEXT PAGE				

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- Unless you receive revocation in writing, this authorization will be valid until the date specified here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ **Date:** _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

** You must provide documentation supporting your legal authority to act on behalf of the member*

RETURN TO:

**Excellus Health Plan
P.O. Box 21146
Eagan, MN 55121**

or Fax: 315-671-7079

Please keep a copy for your records

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 gender.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o 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:
 - o Qualified interpreters
 - o 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: 1-315-671-6656

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, 1-800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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 anvlòp 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 ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

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

تنبيه: إذا كنت تتحدث 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.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

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 εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

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

Dental plan terms

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

Deductible

The amount of money you have to pay before the health insurance company will make any payments towards dental services. The deductible amount will vary based upon your plan, so make sure you know what that amount is.

Coinsurance

Your share of the costs of a covered dental service, calculated as a percent. Coinsurance is similar to a copay, but instead of a fixed dollar amount, it is a percentage of the total bill. For example, if your filling costs \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance company would pay the rest, or \$80.

Out-of-pocket maximum

An annual limit on the amount of money that you would have to pay for dental services, not including your monthly premium. This is also called the Out-of-Pocket Maximum (OOPM).

Schedule of allowances/Fee schedule

The maximum amount the insurance company will pay for specific dental procedures or services. To obtain information on the current fee schedule, please call the Customer Care number on the back of your member card.

Participating dentist (in-network)

These dentists agree to accept the fee schedule as payment in full for services performed and will not bill you for an additional amount.

Non-participating dentists (out-of-network)

These dentists are not part of the dental network. When you receive care from a non-participating dentist it will cost you more out-of-pocket.

You can reduce your out-of-pocket costs by seeing a participating dentist. Find a participating dentist by visiting our website at [ExcellusBCBS.com/FindADentist](https://www.ExcellusBCBS.com/FindADentist) or call Customer Care at the number on the back of your member card.



*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.



All rights reserved.

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For information about your benefits, please refer to your health plan booklet or contact your Plan Administrator.

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