Genesee Area Healthcare Plan

Dental Benefits

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

PLAN DESCRIPTION

PLAN ADMINISTRATOR:	GENESEE AREA HEALTHCARE PLAN (GAHP) c/o Genesee Valley BOCES 80 Munson Street LeRoy, NY 14482
TYPE OF PLAN:	Dental
AGENT FOR SERVICE OF LEGAL PROCESS:	GENESEE AREA HEALTHCARE PLAN (GAHP)
PLAN NUMBER:	501
PLAN YEAR:	July 1 through June 30
PLAN REVISION DATE:	July 1, 2023
FUNDING AND ADMINISTRATION:	The Plan is funded by direct benefit payments by the Participating Schools for claims having been paid on behalf of the Participating Schools by Excellus BlueCross BlueShield.
HOW TO CONTACT US:	Excellus BlueCross BlueShield 165 Court Street Rochester, NY 14647 585-325-3630 Toll-Free 877-253-4797
BENEFIT AND CLAIMS:	Customer Service 585-325-3630 or 1-877-253-4797 Monday - Thursday 8AM - 7PM Friday 9AM - 7PM Saturday 9AM - 1PM E-Mail: CustomerService@excellus.com *E-mail our Customer Service Department with any inquiries*
HOW TO FIND A PPO PROVIDER:	Visit www.excellusbcbs.com or call 1-800-810-BLUE (2583) or Download the Excellus BCBS app on your smartphone via the Apple App Store or the Google Play Store

DENTAL PLAN RIDERS

Participants are required to remain in the dental plan for a minimum of two years.

Your annual benefit maximums are based on the calendar year and services will follow you throughout the calendar year even when you switch plans mid-year during open enrollment.

DENTAL BLUE BASIC BENEFITS

Dental Blue Basic is designed to provide basic dental coverage for the most commonly performed procedures.

Preventive and Restorative Services	**BCBS Payment Amount**
Initial Examination	$6
Full-Mouth X-rays	$20
Biopsy (hard/soft)	$24/$20
Prophylaxis (cleaning)	$12
Fluoride Treatment (to age 19)	$6
Restorations	
Amalgam (adult) 1/2/3 surfaces	$10/$14/$17
Resin 1/2/3 surfaces	$8/$10/$13
Root Canal (Endodontia) 1/2/3 canals	$50/$80/$100
Emergency Treatment	$10
(sedative filling, recement cr., etc.)	
Repairs to Dentures	$13
Adding One Tooth	$17
Each Additional Tooth	$6
Simple Extractions (initial)	$10

Orthodontia Services

Initial Exam (including cephalometric study, treatment plan and study models)	$40
Placing of Appliances	$100
Monthly Payments	$20
Maximum Dollar Amount (per individual)	$600

One-half total Orthodontia maximum paid in year one and the other half paid in year two.

Exclusion

Procedures not listed above are not covered under Dental Blue Basic Plan.

DENTAL BLUE SELECT BENEFITS

Participants are required to remain in the dental plan for a minimum of two years.

Dental Blue Select represents an enhanced plan design to encourage preventive care and early treatment, and also includes coverage for specialized treatment. Dental Blue plans give you the freedom to see any dentist. However, it is beneficial to see dentists that participate with us as these dentists have agreed to discounted fees, which result in lower out-of-pocket costs for you.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 100% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants through age 16

Restorative Services

All restorative services are paid at 50% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit

Orthodontia Services

1. Initial banding and monthly follow up treatment

Dental Blue Select Deductible and Maximums

There is a $25 annual individual deductible or a $75 family deductible that applies to restorative and orthodontia services per calendar year.

For Orthodontia services, no more than $1,000 per individual up to age 19 will be covered per lifetime. One-half total Orthodontia maximum paid in year one and the other half paid in year two. For all other covered services, the maximum payable in a calendar year shall be $1,000 per individual.

DENTAL BLUE PREMIER BENEFITS

Participants are required to remain in the dental plan for a minimum of two years.

Dental Blue Premier represents an enhanced plan design to encourage preventive care and early treatment, and also includes coverage for specialized treatment. Dental Blue plans give you the freedom to see any dentist. However, it is beneficial to see dentists that participate with us as these dentists have agreed to discounted fees, which result in lower out-of-pocket costs for you.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 100% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants through age 16

Restorative Services

All restorative services are paid at 100% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit

Orthodontia Services

1. Initial banding and monthly follow up treatment

Dental Blue Premier Deductible and Maximums

There is a $25 annual individual deductible or a $75 family deductible that applies to restorative and orthodontia services per calendar year.

For Orthodontia services, no more than $1,500 in the individual's lifetime will be covered. One-half total Orthodontia maximum paid in year one and the other half paid in year two. For all other covered services, the maximum payable in a calendar year shall be $1,500 per individual.

DENTAL BENEFIT EXCLUSIONS

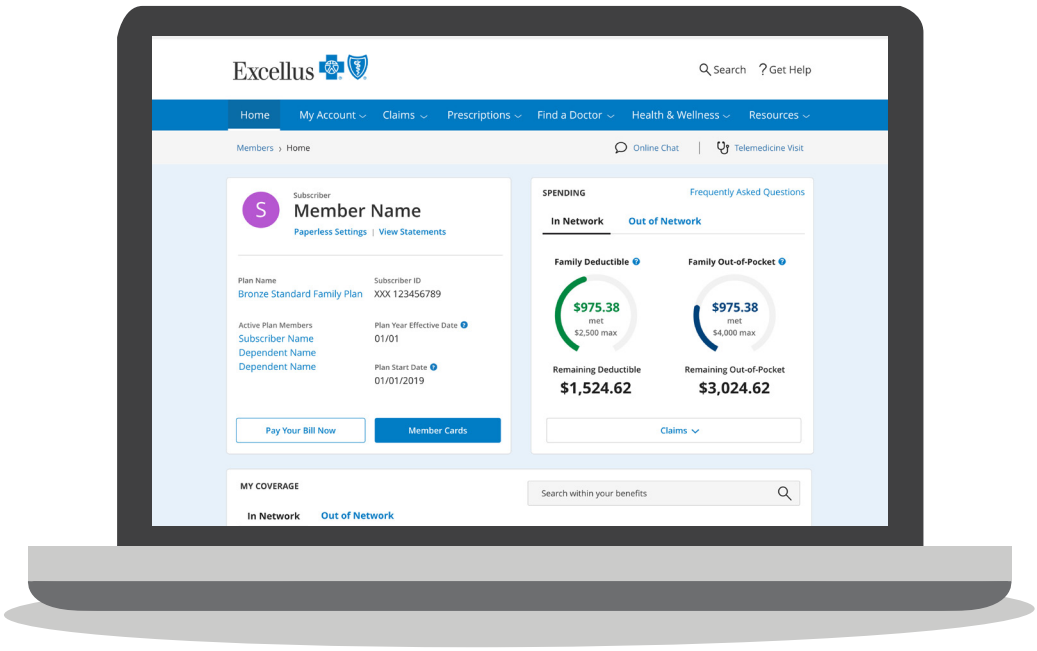
Coverage under Dental Blue Basic, Dental Blue Select, and Dental Blue Premier will not apply to:

1. Charges for dentures or bridgework (including crowns and inlays forming the abutments) when such charges are incurred for replacement teeth, all of which were extracted prior to the date the individual became a covered employee;
2. Charges for services not considered necessary and appropriate;
3. Charges for replacement of a lost or stolen prosthetic device;
4. Charges for dentistry for cosmetic purposes, including the alteration or extraction and replacement of sound teeth to change appearance;
5. Charges for the replacement of dentures less than 5 years after a preceding placement, except a replacement made necessary by the initial placement of an opposing full denture which necessitates the replacement of an existing denture;
6. Charges incurred for myofunctional therapy, oral hygiene, dietary or plaque control programs or other educational programs;
7. Charges in connection with an injury or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.

IT'S YOUR PLAN. GET MORE OUT OF IT ONLINE.

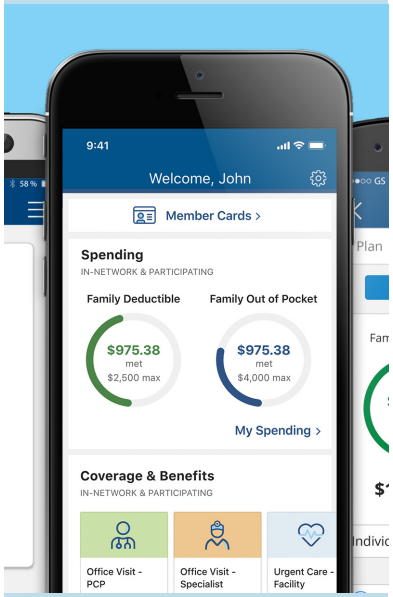
Excellus LIVE FEARLESS

Making the most of your plan shouldn't be complicated. When you sign up for an Excellus BlueCross BlueShield online member account, you get instant access to a variety of tools and other resources to make living healthy a little easier.



DOWNLOAD THE EXCELLUS BCBS APP.

Take your health plan with you for on-the-go access 24/7.



View your member card.

•

Track deductibles and out-of-pocket spending.

•

Find a provider or medical facility.

•

Access your benefits and claims information.

Download on the App Store

GET IT ON Google Play

1 My Account

Create an online account to access your member card, view a summary of benefits and coverage, claims, go paperless, and more.

2 Find a Doctor/Dentist

Easily find access to care locally, nationally, and globally.

3 Spending

Gives a breakdown of your health spending.

4 Coverage & Benefits

Shows a summary of your plan details.

5 Claims

Allows you to submit and view claims.

6 Get Rewards

Provides quick access to spending and rewards programs.

7 Estimate Medical Costs

Research and get a personalized estimate of out-of-pocket medical costs for over 1,600 treatments and over 400 procedures.

Visit Member.ExcellusBCBS.com to register today.

MORE BENEFITS, ACCESS, AND CONTROL IN 5 EASY STEPS

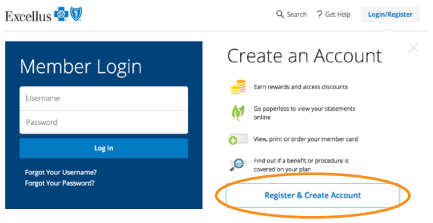
If you have a few minutes, you have plenty of time to create your online member account. Make sure you're getting the most value out of your health plan with a breakdown of how you're using your benefits, the ability to see and submit claims, go paperless, and more.

1 In Your Browser, Type Member.ExcellusBCBS.com

This will take you directly to the registration screen.

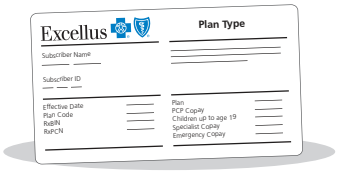
2 Create a New Account

Select the Register & Create Account button on the right side of the screen.



3 Complete the Form

You'll need your Subscriber ID, so be sure you have your Member Card handy.



4 Choose a Username and Password

You'll also choose a pair of security questions in case you forget either of these.

Username*

Password*

5 Verify Your Email Address

We'll send you an email to verify your new account. Sign in and you're ready to go!

DON'T FORGET TO DOWNLOAD THE APP

Log in to more features, tools, and resources online.

- View a Summary of Benefits and Coverage
- Find a Doctor or Dentist
- Track Deductible and Out-of-Pocket Spending
- Submit and View Claims
- Estimate Medical Costs
- View Online Member Cards
- Download Statements and Forms

Create your account at Member.ExcellusBCBS.com today for anytime, anywhere access to your health plan.

B-7184

Excellus LIVE FEARLESS

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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

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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 *(select D-1 **or** D-2 and if applicable, D-3)*
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
____ Sexually transmitted diseases
____ Substance use disorder
____ Abortion
____ Mental health *(excluding psychotherapy notes)*

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

Customer Submitted Dental Claim Form

Excellus
A nonprofit independent licensee of the Blue Cross Blue Shield Association

Mail Completed Forms To: PO Box 21146
Eagan, MN 55121-0146

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	19. 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. Date of Service (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 Tooth Information Place an "X" on each missing tooth)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 16 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ ☐ (ICD-9 = B; ICD10 = A8)

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 _____
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. Enclosures (Y or N) ☐
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.