Monroe Boces #1

Dental Benefit Summary

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This booklet contains information of the benefits available to you through your employer and Excellus BlueCross BlueShield, Rochester Region. It is intended to provide you with descriptions of services allowed by the Dental Assistance Plan.

QUESTIONS

If you have questions regarding the Plan, call the Excellus BlueCross BlueShield, Rochester Region Customer Service Department at 1-800-724-1675.

For your convenience, requests for duplicate identification cards and claim forms can be made by calling the ExpressLine at (585) 454-5010 or 1-800-548-6428.

Visit our website @ **www.excellusbcbs.com**

INTRODUCTION

Your Dental Assistance Plan is designed to encourage you to maintain good oral health. The Plan emphasizes prevention by paying 100% of the Plans allowed amount for routine preventive care including cleanings, exams and dental x-rays.

The Plan also includes benefits for services rendered by specialists, such as oral surgeons, periodontists and endodontists.

YOUR MEMBER IDENTIFICATION CARD

You will receive an identification card once your enrollment application has been processed by Excellus BlueCross BlueShield, Rochester Region. If you have family coverage, you will receive two identification cards. Your identification card has important information for you or your dentist to submit claims for dental services.

Keep your membership card with you at all times. It will help you get efficient services from both your dentist office and Excellus BlueCross BlueShield, Rochester Region.

HOW THE DENTAL PLAN WORKS

Reimbursement:
All covered services are paid in accordance with the Excellus BlueCross BlueShield, Rochester Region Dental Schedule of Allowances or charges, whichever is less.

In the Rochester Service Region:

Participating Dentists:
Over 80% of the Rochester region dentists participate with Excellus BlueCross BlueShield Dental Plans. The participating dentist agrees to accept the Schedule of Allowances for covered services. Payment is made directly to the dentists. The member is responsible for the copayment amounts, deductible and charges after the Plan limitations and maximums are met.

Non-Participating Dentists:
Payment for covered services provided by a dentist who does not participate with the Plan are made directly to the member. The member is responsible for any charges up to the amount billed by the dentist.

Out of the Rochester Service Region:

Dentists:
The dentist may file the claim on your behalf directly to the Plan. The member is responsible for all charges. If you sign benefits over to the provider, payment will be made directly to the dentist, otherwise payment will be made to the member. The member is responsible for any charges up to the amount billed by the dentist.

DENTAL ASSISTANCE PLAN BENEFITS

Preventive and Diagnostic Services: Payable at 100% of the Plan allowed amount or charges, whichever is less.

Following services are allowed twice per calendar year:

- Initial and/or Periodic Exams
- Cleaning, scaling and polishing of teeth
- Topical fluoride application for members under age 19
- Bitewing dental x-rays
- Full mouth x-ray series or panoramic x-ray once in three years
- Sealants: for members under age 16. Allowed once per tooth in 36 consecutive months on first and second unrestored permanent molars.
- Palliative emergency exam to relieve pain

Basic Restorative Services: Payable at 50% of the Plan allowed amount or charges, whichever is less.

- Fillings: amalgam (silver) or anterior resin (white) for treatment of cavities allowed once per surface in 12 months. Benefits for resin fillings placed on molar teeth are limited to the allowance of amalgam material. Bonding is not covered.
- Periodontal surgery: gingivectomy or osseous surgery allowed once per quadrant in 36 months
- Periodontal root planing and scaling allowed once per quadrant in 24 months
- Extractions: routine and surgical
- Root canal treatment

Major Restorative Services: ***Alternate Benefits Enforced***
(see page 6)
Payable at 50% of the Plan allowed amount or charges, whichever is less.

Prosthetics: crowns, inlay/onlay, complete or partial dentures, bridge abutments/pontics.

- Benefits for replacement of an existing prosthetic is allowed only if more than five years have lapsed since last placement that was covered under a dental plan.
- Replacement of a partial denture with fixed bridgework or replacement due to loss or theft is not covered.
- Benefits for replacement of multiple missing teeth and/or bilaterally missing teeth are allowed as a partial denture. Double abutments are not covered.
- Benefits for crown/inlay/onlay are allowed only when teeth cannot be restored by a filling, and if more than 5 years lapsed since initial placement. Benefits for upgrading fillings to crown/inlay/onlay are limited to the allowance of a filling.
- Benefits for porcelain/resin (white) material placed on molar teeth are limited to the allowance of metallic material.
- Space Maintainers for members under age 19 once in 5 years

Orthodontic Services: for members under age 19 Payable at 50% of the allowed amount or charges, whichever is less, up to a lifetime maximum. Subject to deductible.

ANNUAL AND LIFETIME MAXIMUMS

Basic and Major Restorative Services: none.

Orthodontic Services: lifetime maximum of $750 per person under age 19.

LIMITATIONS

In the event of a treatment by more than one provider, the Plan will not pay more than it would have if a single provider had performed the entire service.

The allowances specified by your Plan are not intended to represent what the dentist's charge will or should be, but merely show the maximum amount that will be considered as covered expenses by your Plan.

PREDETERMINATION OF BENEFITS

The Dental Plan recommends a Predetermination of Benefits for any extensive treatment such as periodontics, orthodontics, prosthetics: crown/inlay/onlay, fixed bridges. 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

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

EXCLUSIONS

Your Dental Assistance Plan does not cover:

- Oral hygiene instructions, plaque / tobacco control programs or dietary instructions.
- Temporary procedures.
- Replacement of lost or stolen appliances.
- Implants and/or related procedures.
- Services of dentists if fees or charges are claimed by hospitals, clinics, laboratories or other institutions.

- Grafting and/or splinting procedures, including related services.
- Dental services for which the member incurs no charge. Dental care or treatment when such services are rendered by/to an individual by/to an immediate family member such as spouse, child, brother, sister, parent of such persons spouse.
- Dental services for cosmetic or esthetic purposes.
- Appliances, prosthetics, restorations or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion, attrition or wear.
- Services or treatment of disturbances of the temporomandibular joint.
- Services or supplies which do not meet the accepted standards of dental practice.
- Charges for any dental treatment started prior to the effective date of coverage and/or charges for treatment after the cancellation date of coverage.
- Services recoverable by automobile no-fault benefits, Worker's Compensation Act or similar legislation.
- Services not listed under "Dental Assistance Plan Benefits".

COORDINATION OF BENEFITS

Coordination of benefits is a method of limiting the cost of dental plans by preventing duplicate payments for the same dental bill. The dental plan that covers an individual as an employee is considered primary; the plan that covers an individual as a spouse will be secondary. When children are covered by the dental plan of both parents, the parent with the earliest birth date in the calendar year will provide primary benefits. If both parents have the same date, the plan that has been in effect the longest will provide primary benefits. For example, one parents birth date is March 8 and the other is October 20. The parent with the March 8 birth date is primary for the children. Under coordination of benefits, the dental plan that does not have a coordination of benefits clause automatically becomes the primary carrier and therefore is responsible for paying benefits first. (This does not apply to no-fault insurance).

This dental plan provides dental benefits only. It does not provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

FILING YOUR CLAIM

Participating Dentists

If dental care is rendered by a Excellus BlueCross BlueShield, Rochester Region participating dentist, the office will file the claim and will receive payment directly from the Plan. In addition, many participating dentists have the ability to submit claims electronically on your behalf. When you have finished your visit, the dentist will submit your claim by way of an electronic transaction while you are still in the dentist's office. The electronic claim submission system produces an Explanation of Benefits (EOB) for you at the time of your dental visit for most services.

What You Should Know About Your Electronically Produced EOB:

- You will receive an EOB at the time of your visit for most procedures including: preventive and diagnostic services, fillings and basic restorative treatment.
- You can use your EOB to submit to a secondary dental plan if you have one.
- Predetermination of benefits is available for non-routine services, but still has to be filed before your treatment begins. Your dentist can electronically submit an estimate to your Plan. Your Plan will mail a predetermination of benefits form directly to you and your dentist. The form will show benefit information and patient liability.
- If you have a Flexible Spending Account (FSA) with Excellus BlueCross BlueShield, Rochester Region, any balances for copayment or non-covered expenses will automatically transfer to your FSA for consideration.
- If you need a duplicate EOB or have any questions, please call our Customer Service Department at the telephone number listed on your identification card.
- The service for on-line electronic claim submission and explanation of benefits is available only through Excellus BlueCross BlueShield, Rochester Region for eligible, participating dentists.

Non-Participating and Out of Rochester Region Dentists

Most non-participating and out of the Rochester region dentists will submit a claim on your behalf. However, if your dentist does not file a claim for you, it will be the member's responsibility to complete and file a claim form. A dentist's itemized bill does not always contain sufficient information; a claim form should be completed to insure proper claims processing. Benefit payment for services rendered by non-participating dentists will be made directly to the member. Benefit payment for services rendered by a dentist outside of the Rochester area can be assigned to the provider by the member. The member is responsible for paying non-participating and out of area dentist's charges in full. A claim form for future services and complete instructions will be mailed to you (the member) with each check and/or Explanation of Benefits.

The completed claim form must be submitted to:

Excellus BlueCross BlueShield, Rochester Region
Attn: Dental Claims Department
165 Court Street
Rochester, NY 14647

A separate claim form is required for each member of the family. If you have any questions about completing the form, please call Customer Service at the telephone number listed on your identification card. If you need additional claim forms, please call the ExpressLine at (585) 454-5010 or 1-800-847-1200.

Dental services must be filed within one year of the date of service. Claims submitted beyond the one year filing limit will be ineligible for payment.

HOW TO APPEAL A DENIED CLAIM

If you are not satisfied with the processing of your claim, you can appeal the claim decision by writing to Excellus BlueCross BlueShield, Rochester Region. Your appeal should be accompanied by any records or documents that support your appeal. You should do this within 60 days of receiving the claim response in question.

Excellus BlueCross BlueShield, Rochester Region may request that you appear in person to clarify certain information. If so, you may bring a legal representative or other representative(s) with you if you wish.

Excellus BlueCross BlueShield, Rochester Region will notify you, in writing, of their decision within 120 days.

Claims Appeals should be sent to:

Excellus BlueCross BlueShield, Rochester Region
Attn: Customer Advocacy Department
165 Court Street
Rochester, NY 14647

WHEN YOUR COVERAGE STOPS

Coverage under your dental assistance Plan stops if you leave employment, when you are no longer eligible to participate in the Plan, or if the Plan is discontinued. Your dependent's coverage stops when your coverage is terminated or when they are no longer eligible dependents. If you or one of your eligible dependents is under treatment when your coverage stops, some benefits may be payable, subject to review, for 30 days after the termination date as follows:

- **Root Canals:**If the tooth canal was opened while your coverage was in effect.
- **Prosthetics:** If the teeth were prepared and impressions were made while your coverage was in effect.

If your coverage stops due to termination or change to ineligible status, you will be sent a separate document called, Notification of Rights to Continue Health Care Coverage, explaining your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

CONTINUATION OF COVERAGE (COBRA)

If you or an eligible dependent cease to be covered by your dental assistance Plan, you or your dependents are eligible to continue coverage under the Plan for a limited time by paying the COBRA premium. This continued coverage is limited to your dental Plan coverage that was in effect at the time of your termination.

As part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), employees and/or dependents who lose dental coverage as a result of the circumstances noted below, may elect to continue coverage at you or your dependents own expense. Continued coverage will be for 18 to 36 months depending on the following events.

CONTINUATION OF COVERAGE

If you terminate (for reasons other than gross misconduct) or have a reduction in hours of employment that causes you to become ineligible for coverage, you and your dependents may continue coverage for up to 18 months.

However, if your termination (or reduction in working hours) is due to disability or you and your dependents become disabled within 60 days of your termination, you and your dependents may continue coverage for up to 29 months. If you or your dependents recover from the disability prior to 29 months, then eligibility for COBRA coverage will cease.

Eligible covered dependents may continue dental coverage for up to 36 months for the following reasons:

- death of employee;
- divorce or legal separation;
- dependent child ceases to meet dependency requirements; or
- employee elects Medicare as the primary coverage.

The election in place at the time of termination or another qualifying event (i.e., death, divorce/legal separation) determines the coverage your and your dependents can continue for the remainder of the Plan year.

You have 60 days to elect to continue coverage from the date coverage would end or when notice is given, whichever is later.

The cost of coverage then due is retroactive to the effective date of COBRA coverage. The payment is due 45 days from the date that you sign the COBRA Election Form.

If you waived dental coverage and are not covered under the Plan, then you are not permitted to elect continuation of coverage upon termination of employment. Similarly, if you had enrolled for employee only coverage and waived dependent coverage, you will not be permitted to elect dependent Continuation of Coverage. However, if you marry or acquire a dependent while on continued COBRA coverage, you may elect to cover your eligible dependents within 31 days of the date your dependent is first eligible. You are also eligible to make coverage changes during the employers open enrollment

timeframe. The premium for continued COBRA coverage might be increased due to this change. You must notify your former employer immediately of this change in your family status.

END OF COBRA COVERAGE

This continued coverage would cease sooner than the 18 or 36 months period for you or your dependents if:

- the former employer ceases to provide dental coverage to all employees;
- the full monthly or quarterly cost is not paid by the due date;
- you or your dependents become eligible under a new group Plan after the election of COBRA.

Your coverage under the dental Plan will stop for you and your covered dependents on the last day of your Continued Coverage. There is no Conversion Privilege for direct pay coverage.