Dental Plan

Your Benefit Plan Details

Group Name
Baldwinsville CSD

Plan Type
Dental Plan 2

Excellus BlueCross BlueShield

National strength.
Local focus.
Individual care.℠

Baldwinsville CSD

Dental Plan 2

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 Summary of Benefits

Employer Group name: Baldwinsville Central School District	Plan D02

Plan Features

Plan Year: 1/1/2020	Type of Tier:
Network: In and Out of Network	Dependent / student age limit: 19/25
Reimbursement In network: Dental Blue Options Reimbursement Out-of-network (In & Out of Area): Fee Rule (PRI31)	
Annual Plan Deductible: N/A Deductible applies to: N/A	Annual Plan Maximum per member: $1250 Annual Max applies to: I, II, III
Ortho Age Limit: N/A Lifetime Orthodontia Maximum: $1500	
Timely Filing: 180 Days from Date of Service	Coordination of Benefit: Make Whole

Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays: 100% of Plan Allowance for In & Out of Network
Class I Preventive & Diagnostic	• Comprehensive or Periodic Oral Examination – 2 per calendar year • Cleanings – 2 per calendar year • Fluoride treatments – 4 per calendar year, under age 19 • Palliative treatment • Emergency exam • Bitewing x-rays – 2 per calendar year • Full mouth/Panoramic x-rays – once every 36 months • X-rays misc. • Diagnostic Pulp Vitality Test • Diagnostic Caries Susceptibility Test • Diagnostic Oral Pathology and Lab • Diagnostic Test and Exams • Diagnostic Cast • Sealants – one per posterior tooth per 36 months, under age 19 • Periodontal cleaning – 2 per calendar year	

Type of Care	Benefits Included	Excellus BCBS Pays: 80% of Plan Allowance for In & Out of Network
Class II Basic	• Basic service • Extraction • Impacted teeth • Fillings – amalgam & composite • Space maintainers - under age 19 • Endodontics • Oral surgery • General Anesthesia • Minor Restoration	

Type of Care	Benefits Included	Excellus BCBS Pays: 60% of Plan Allowance for In & Out of Network
Class III Major	• Prosthodontics (removable/fixed) Full or Partial Dentures, Crowns- eligible for replacement every 5 years • Periodontics • Periodontal surgery – osseous surgery, gingivectomy, gingivoplasty, gingival flap procedure • Restorative – gold foil • Inlays / Onlays - eligible for replacement every 5 years • Stainless Steel Crowns • Relines / rebases - once every 36 months, must be at least 6 months after initial placement • Repair/Re-cement (Crowns) • Re-cement (Prosthetics) • Repair (Prosthetics)- must be at least 6 months after initial placement • Tissue conditioners • Implants - eligible for replacement every 5 years	

Type of Care	Benefits Included	Excellus BCBS Pays: 50% of Plan Allowance for In & Out of Network
Class IV Orthodontia	• Initial banding & monthly follow-up treatment • Diagnostic Photograph/Facial Image • Additional Panoramic X-ray – 1 every 36 months • Orthodontic Harmful Habits • Lifetime benefit maximum is applied monthly	

Type of Care	Non-Covered
	• Prosthetic Appliance • Dental Consultation • Anesthesia – local, regional and inhalation • Occlusal Adjustments • Dental veneers • Occlusal Guard • Dental Charges – Drugs • TMJ

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.

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
P.O. Box 21146
Eagan, MN 55121

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

Excellus
LIVE FEARLESS

*Centers for Disease Control and Prevention, "Periodontal Disease," March 2015.

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。

B-6636 / 12764-18M

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: **PO Box 21146**
Eagan, MN 55121

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																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	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 HlPAA 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 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	1223D000IX
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P022IX
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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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 *(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

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:
  - 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: 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.

Excellus | National strength. Local focus. Individual care.™

A nonprofit independent licensee of the Blue Cross Blue Shield Association

FOR INTERNAL USE ONLY

HIOS ID# _____

EC _____

CONFIDENTIAL

Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information

To be completed with your Group Administrator

_____
Employer Name

_____
Association/Chamber Name (if applicable)

_____
Group Administrator's Signature (required)

_____
Date

_____
Employee Number

_____
Department Number

Medical Information

_____
Medical Group Number (8 digits)

_____
Medical Subgroup Number (4 digits)

_____
Medical Class Number (4 digits)

If enrolling in a Medical plan, who do you need coverage for?
- ☐Self Only
- ☐Self & Child(ren)
- ☐Self & Spouse, or Self & Domestic Partner
- ☐Family

_____ /_____ /_____
Medical Effective Date

Subscriber Status:
- ☐Actively Working
- ☐Retired
- ☐Disability
- ☐Canceled
- ☐COBRA

Dental Information

_____
Dental Group Number

_____
Dental Subgroup Number

_____
Dental Class or Package #

If enrolling in a Dental plan, who do you need coverage for?
- ☐Self Only
- ☐Self & Child(ren)
- ☐Self & Spouse, or Self & Domestic Partner
- ☐Family

_____ /_____ /_____
Dental Effective Date

Medical Plan Selection

Dental Plan Selection

Section 2: Subscriber's Information

_____
Last Name

_____
First Name

_____ _____
Middle Initial **Title (e.g., Jr, Sr, III, etc.)**

_____
Street Address

_____ _____
City **State**

_____ _____
Zip Code **Phone**

Birthdate: _____ /_____ /_____

Gender:
- ☐Male
- ☐Female

Social Security Number** _____

Date of Hire/Rehire: _____ /_____ /_____

Retire Date: _____ /_____ /_____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced Marital Status Event Date: ___ /___ /_____

_____
Subscriber's Medicare Number (if applicable)

☐Age 65+ ☐Disability ☐End Stage Renal *

_____ /_____ /_____
Part A Effective Date

_____ /_____ /_____
Part B Effective Date

Section 3: Reason for enrollment or change - To be completed by the Group Administrator - Not required for cancelations

Enrollment Opportunity: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

Special Enrollment Opportunity: ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____
☐Change in employment status ☐A move in or out of the service area
☐Involuntary loss of coverage ☐Former dependent regains eligibility

Date of Event ___ /___ /_____

COBRA Election - Please indicate the reason for COBRA if applicable:
☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse
☐Disability ☐Dependent Reached Max Age ☐ Other: _____

Demographic Change: ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber

Cancel Code:	Medical Cancel Date:	Dental Cancel Date:
	/ /	/ /

Cancel Codes:
SB02-Left Employment SB05-Per Group Request SB06-Subscriber Request (voluntary) SB07-Deceased SB09-Enrolled in Error

Dependent(s)

Dependent Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:
		/ /	/ /
		/ /	/ /
		/ /	/ /

Cancel Codes:
M001-Per Group Request M004-Enrolled in Error M008-Moved Out of Area M013-Ineligible
M002-Deceased M005-Divorced M010-Overage Dependent M014-YAO Ineligible
M003-Per Subscriber Request M007-Per Member Request (voluntary) M011-No Longer a Student M040-Mx Same Group

Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child (Separate application form required)
☐Other_____

_____ _____ _____ _____
Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender:
☐Male ☐Female **Birthdate** _____ /_____ /_____

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university _____ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

↓ Additional Dependent(s) ↓

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

_____ _____ _____ _____
Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender:
☐Male ☐Female **Birthdate** _____ /_____ /_____

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university _____ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

_____ _____ _____ _____
Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender:
☐Male ☐Female **Birthdate** _____ /_____ /_____

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university _____ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

Note: Use an additional application if more than three dependents need coverage.

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No
If yes, what type of coverage? ☐Medical ☐Dental
What is the effective date of the other coverage? ☐Medical: ____ /____ /_____ ☐Dental: ____ /____ /_____
What is the name of the other carrier? _____
Are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage end? _____ /_____ /_____
Policyholder's name _____ ID# _____
Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).
I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, 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 such violation.

Subscriber Signature _____ **Date** _____

Please return to P.O. Box 21146 Eagan, MN 55121
If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information

This section should be completed by the Subscriber.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 3: Reason for enrollment or change

Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)

Please include information about all the people who you would like coverage for.

Use an additional application if more than three dependents need coverage.

If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.

Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 6: Other coverage information (Required)

Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release

Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

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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