Notice of Nondiscrimination

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

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - 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.

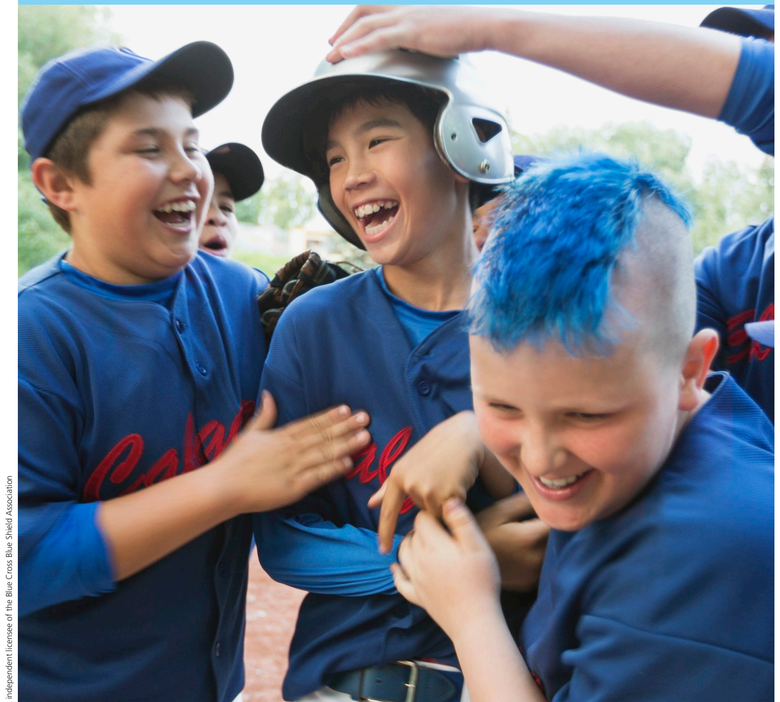
Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

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

Excellus

B-5172Y20/13452-19M

A HEALTHY MOUTH IS A HAPPY MOUTH



Learn more about your Pediatric Dental Benefits

Excellus
LIVE FEARLESS

How do pediatric dental benefits work?

Your new plan provides great oral health benefits for kids up to age 19. These benefits are included in your medical health plan.

If your medical plan includes a deductible, you have to pay it first before you begin paying at the copay or coinsurance amount. The deductible amount will vary based upon your plan, so make sure you know what that amount is.

When you take your child to the dentist, simply show them your Excellus BCBS medical ID card. You can reduce your out-of-pocket costs by seeing a participating dentist.

Find a participating dentist by visiting our website at ExcellusBCBS.com or call Customer Care at 1-800-724-1675.

Your child will have coverage for:

- **Preventive Dental Care** which provides coverage for cleanings, fluoride treatments and sealants to keep teeth healthy
- **Routine Dental Care** covering services such as exams, x-rays and fillings
- **Major Restorative Care** covering services such as dentures and treatment of a cleft palate, and root canals
- **Orthodontia Care** is only covered under this plan to treat serious medical conditions such as cleft palate and cleft lip
- **Off Exchange** non-standard Hybrid and Deductible HSA plans now offer preventive dental cleanings and exams for children not subject to the in-network deductible.

You can reduce your out-of-pocket costs by seeing a participating in-network dentist. Find a participating dentist by visiting our website at ExcellusBCBS.com or calling 1-800-724-1675.

The example shown is based on a plan with a $500 single deductible.

This is not a contract. This is intended to highlight the coverage of this plan. Benefits are determined by the terms of the member contract.

How your pediatric dental benefits work with your medical plan (available OFF Exchange only):

Find your plan and see how your pediatric dental benefits work

Plan Name	Base	Bronze Standard/ Bronze Standard HSA	Bronze Select	NEW Bronze Secure Plus 3 (OFF Exchange Only)	Silver Standard	NEW Silver Standard Plus 3	Silver Select	Gold Standard	NEW Gold Standard Plus 3	Gold Select	Standard Platinum	Platinum Select
Preventive Dental Care	Deductible, then covered in full	Covered at 50%, subject to medical deductible	Covered at 80%, subject to medical deductible	Deductible, then covered in full	$30 copay, subject to medical deductible	$35 copay, subject to medical deductible	Covered at 80%, subject to medical deductible	$25 copay, subject to medical deductible	$25 copay, subject to medical deductible	Covered at 80%, subject to medical deductible	$15 copay	Covered at 80%
Routine Dental Care	Deductible, then covered in full	Covered at 50%, subject to medical deductible	Covered at 80%, subject to medical deductible	Deductible, then covered in full	$30 copay, subject to medical deductible	$35 copay, subject to medical deductible	Covered at 80%, subject to medical deductible	$25 copay, subject to medical deductible	$25 copay, subject to medical deductible	Covered at 80%, subject to medical deductible	$15 copay	Covered at 80%
Major Dental Care	Deductible, then covered in full	Covered at 50%, subject to medical deductible	Covered at 50%, subject to medical deductible	Deductible, then covered in full	$30 copay, subject to medical deductible	$55 copay, subject to medical deductible	Covered at 50%, subject to medical deductible	$25 copay, subject to medical deductible	$40 copay, subject to medical deductible	Covered at 50%, subject to medical deductible	$15 copay	Covered at 50%
Orthodontic Dental Care	Deductible, then covered in full	Covered at 50%, subject to medical deductible	Covered at 50%, subject to medical deductible	Deductible, then covered in full	$30 copay, subject to medical deductible	$55 copay, subject to medical deductible	Covered at 50%, subject to medical deductible	$25 copay, subject to medical deductible	$40 copay, subject to medical deductible	Covered at 50%, subject to medical deductible	$15 copay	Covered at 50%

Pediatric dental coverage is available only when purchasing directly through Excellus BCBS or OFF Exchange/not through the NY State of Health Marketplace.

Your child has a cleaning at a participating dentist office	Your child needs a minor medical surgical procedure done in an outpatient setting	Your child has a cavity and has a filling with a participating dentist.	Your child has an oral exam, x-rays and a cleaning with a participating dentist
Actual Cost: $200	Actual Cost: $2,500	Actual cost: $150	Actual cost $250
Because you must reach your child's deductible first, the Plan pays: $0	You must pay the child's deductible balance, which is: $300	Fillings are "routine care" so you will pay 20% of the $150 or $30.	These services are "preventive and routine," so you will pay 20% of the $250 or $50.
Child's deductible: $500	For outpatient surgical care, you have a copay of $250		
You pay out-of-pocket: $200	You pay out-of-pocket: $550	You pay out-of-pocket: $30	You pay out-of-pocket: $50
	Plan pays: $1,950	Plan pays: $120	Plan pays: $200
Leaving a balance of: $300	Your child's deductible is now met for both medical and dental care.		

If you have questions or are looking for a dentist, call the number on your ID card or 1-800-724-1675.

Important terms to know:

Deductible
The amount of money you have to pay before the health insurance company will make any payments towards health care 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 health care 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 child's cleaning 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 health care services (including pediatric dental), not including your monthly premium. This is also called the Maximum Out-of-Pocket (MOOP).

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 card, or 1 (800) 724-1675.

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 or call Customer Care at 1-800-724-1675.

Find a dentist using our online search tool.
Go to **ExcellusBCBS.com**

A11y 10/9/19