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

Excellus
LIVE FEARLESS

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**

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.

Excellus 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 Deductible applies to: Classes II, IIA and III services	Annual Plan Maximum per member: $1,000 per member 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	Excellus BCBS Pays: 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

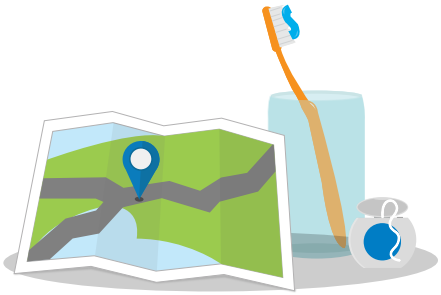
Mailing address for claims
Excellus BCBS
PO Box 21146
Eagan, MN 55121

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 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

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

B-6636 / 115926-22M

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Customer Submitted Dental Claim Form

Mail Completed Forms to:
P.O. Box 21146, Eagan, MN 55121

For Internal Use

Subscriber Information (from ID card)

Subscriber ID	Subscriber Last Name	Subscriber First Name

Subscriber Address	Subscriber City, State, Zip

Patient Information (who received services?)

Patient Name	Patient Date of Birth	Relationship to Subscriber (select one)
		☐ Self ☐ Spouse ☐ Dependent ☐ Other

Patient Address	Patient City, State, Zip

Is another insurance primary?	☐ No ☐ Yes	If yes, please provide carrier name:

About Your Visit

Type of Claim Being Submitted	☐ Pretreatment Estimate for Services to be rendered in the future ☐ Services already performed	
Is treatment due to an accident?	☐ No ☐ Yes (enter accident date)	Accident Date:

Name of Treating Dentist	Treating Dentist NPI	Treating Dentist Tax ID

Treatment Location Address	Treatment Location City, State, Zip

Is the dentist part of a group?	☐ No ☐ Yes	Group Name:

Date of Service	CDT Procedure code or description of service	Tooth # (if applicable)	Tooth Surface (if applicable)	Oral Cavity (if applicable)	Cost

Please attach itemized bill from the provider

Total

Payment and Signature

Have you already paid for this service?	☐ No ☐ Yes
If no, would you like us to pay the provider directly?	☐ No, pay me directly ☐ Yes, I authorize my insurer to make payments directly to the provider on my behalf

I CERTIFY THAT THE INFORMATION SUBMITTED IS ACCURATE TO THE BEST OF MY KNOWLEDGE, I AUTHORIZE THE RELEASE OF ANY RELEVANT INFORMATION TO MY INSURANCE CARRIER.

SUBSCRIBER SIGNATURE:	DATE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 each violation.

Mail completed form and any supporting documentation to: P.O. Box 21146, Eagan, MN 55121-1146

INSTRUCTIONS

ITEMIZED BILL(S) FOR SERVICES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED.

Original itemized receipts including all pertinent information **must be submitted** with this claim form.
The itemized bill must clearly indicate all of the following:

- Patients full name and address on the letterhead of the provider of service or supply
- Treating provider Tax identification number and National Provider Identifier (NPI)
- Type of service performed
- Place of service
- Date and charge for each service provided

Complete this form with the following information:

- Identification Number
- Subscriber Last Name
- Subscriber First Name
- Patient's full name
- Patient's date of birth
- Patient's relationship to the Subscriber Holder
- Treating providers name and address
- Treating providers tax identification number and National Provider Identifier (NPI)
- For coordination of benefits (secondary insurance payment)
  a copy of the primary insurance explanation of payment **must be included** with this form.
- Tooth Number(s) are required for Fillings, sealants, extractions, crowns and root canals.
- Tooth Surface Letter(s) are required for Fillings
- Sign and date the form

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:
  - 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.

B-5495

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 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.

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