EmblemHealth®

Preferred Premier Dental Benefits Plan

Small Group: EmblemHealth Preferred Premier Dental with $2,500 yearly maximum

For the most up-to-date listings of participating dentists, visit **emblemhealth.com**, click on "Find a Doctor," and select the "Preferred/Preferred Premier" Dental Network option.

EmblemHealth Preferred Premier Dental Plan

This dental plan gives you quality coverage with access to over 12,700 dentists and specialists in New York and New Jersey, plus no balance billing by network providers. Members may not be billed by a participating provider for the difference between the amount billed and the amount allowed by the plan when certain enhanced services are provided and/or upgraded materials are used. You can choose a network dentist or specialist for services covered under your plan. You don't have to pick a specific primary care dentist.

Dependent Coverage: With this dental plan, you can cover your children until the end of the month they turn 26.

Predetermination of Benefits: EmblemHealth can give you an estimate of what dental services and materials will be paid for before you get the services. You can ask your dentist to send a Treatment Plan to EmblemHealth before you get oral surgery, prosthetics or appliances. EmblemHealth will review the Treatment Plan and give you and your dentist an estimate of what is covered. Please note: Predetermination of Benefits are not required.

Some examples of non-covered services are:

- Cosmetic surgery and treatment.
- Prescription drugs and medicines.
- Services and appliances for the treatment of temporomandibular joint (TMJ) dysfunction.
- Transplantations.
- Orthodontic services.

Annual Deductible: This is the amount you pay each year before your plan begins to pay. Your plan deductible is $50 per individual, $150 per family. The deductible only applies to Type B and Type C services you receive.

Annual Maximum: This is the maximum dollar amount your dental plan will pay toward the cost of dental care during your plan year. You are personally responsible for paying costs above the annual maximum. You plan annual maximum is $2,500 per individual.

Maximum Rollover Feature: EmblemHealth wants you to get the most out of your in-network dental benefits. The maximum amount your dental plan will pay for in-network services in a plan year is $2,500. If you use less than $1,250 in benefits in a plan year, we will add $1,250 to your annual maximum for the next plan year. This can accumulate every year until you reach a total of $2,500 maximum.

<table>
<tr><th>BENEFITS</th><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th></tr>
<tr><td colspan="3">Type A – Preventive and Diagnostic Services</td></tr>
<tr><td>Base Coverage Level</td><td>EmblemHealth will pay 100% of the set dollar amount for covered services when you see a Preferred Premier dentist or specialist.*</td><td>EmblemHealth will pay 100% of the set dollar amount for covered services under the Preferred Premier Network fee schedule. This is the dollar amount your plan has agreed to pay for covered services. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.*</td></tr>
<tr><td>Examinations – 2 periodic exams per each person on the plan per calendar year. 1 comprehensive examination per dentist, per lifetime.</td><td rowspan="6">Covered

You don't have to pay for these covered services.</td><td rowspan="6">See Type A base coverage level above.</td></tr>
<tr><td>Prophylaxes (Cleanings) – 2 per person on the plan per calendar year.</td></tr>
<tr><td>X-Rays –4 bitewing x-rays per person on the plan per calendar year.
• 1 full-mouth series of x-rays or 1 panoramic film per person on the plan once every 3 years.</td></tr>
<tr><td>Fluoride Treatments – 1 per child per calendar year. Coverage is available for this service until the end of the calendar year in which the child reaches age nineteen (19).</td></tr>
<tr><td>Space Maintainers – 1 per each child on the plan per lifetime. Coverage provided until the end of the calendar year the child turns 19.</td></tr>
<tr><td>Athletic Mouth Guards – 1 per each child on the plan per lifetime. Coverage provided until the end of the calendar year the child turns 19.</td></tr>
</table>

*This refers to the GHI Preferred Premier allowance for the covered service.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type B – Basic Services		
Base Coverage Level	**EmblemHealth will pay 80% of the set dollar amount for covered services when you see a Preferred Premier dentist or specialist.***	**EmblemHealth will pay 80% of the set dollar amount for covered services after you meet your deductible under the Preferred Premier Network fee schedule. This is the dollar amount your plan has agreed to pay for covered services. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.***
Simple Extractions	**Covered** **You are responsible for paying 20% coinsurance** after you meet the annual deductible.**	**See Type B base coverage level above.**
Basic Restorations (Fillings)		
Anesthesia & IV Sedation – Your plan will pay for general anesthesia and IV sedation for covered services. Charges for local anesthesia are included in the allowance for the dental procedure. No separate allowance for local anesthesia. Analgesia and monitoring devices will not be paid for by your plan.		
Palliative Services (Relief of pain) • 1 service per person on the plan per calendar year. This is for emergencies only.		
Repair of Appliances • Replacement of broken teeth or clasps. Recementation of inlays, crowns, bridges, and space maintainers. Replacement of broken facings.		
Tests and Laboratory Exams – Biopsy and examination of oral tissue.		
Type C – Major Services		
Base Coverage Level	**EmblemHealth will pay 50% of the set dollar amount for covered services when you see a Preferred Premier dentist or specialist.***	**EmblemHealth will pay 50% of the set dollar amount for covered services after you meet your deductible under the Preferred Premier Network fee schedule. This is the dollar amount your plan has agreed to pay for covered services. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.***
Endodontics (Root canal therapy) • Pulpotomy covered once per tooth, per lifetime. Not covered if root canal done on same tooth by same dentist within 3 months of the pulpotomy.	**Covered** **You are responsible for paying 50% coinsurance** after you meet the annual deductible.**	**See Type C base coverage level above.**
Periodontics (Treatment of diseases of the gum and jaw) • 5 periodontal treatments per person on the plan per calendar year. • 1 type of periodontal surgery and/or 1 graft per quadrant.		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type C – Major Services (continued)		
Oral Surgery (Surgical removal of an erupted tooth) • Your plan will pay for x-rays taken for surgery, local anesthesia, and post-operative care. • Your plan will pay for surgery on fractured jaws, impactions, lesions in and around the mouth, and reimplantations. • Some types of oral surgery may be covered under your medical plan, not this dental plan.	**Covered** **You are responsible for paying 50% coinsurance** after you meet the annual deductible.**	**See Type C base coverage level above.**
Fixed and Removable Prosthetics – Both temporary and permanent dentures, full or partial, repair, and crowns over implants. **Major Restoration** – Includes crowns, related post and core procedures, and inlays. • Your plan will pay for replacement or substitution of appliances only after 5 years have passed since appliance was inserted. • Your plan will pay for crowns or pontics for attachment or clasp purposes only if tooth cannot be restored by fillings. • When a fixed bridge and partial denture are inserted in the same arch, your plan will only pay for the partial denture unless 5 years have passed since prior insertion of the fixed bridge or partial denture. • No separate allowance for temporary service or appliance. • Your plan will pay for posts only if there is evidence of root canal on the tooth. • Charges for cementation of crown/inlay are included in allowance for the crown/inlay.		

*This refers to the GHI Preferred Premier allowance for the covered service.
**Coinsurance is the percentage you pay at each visit once you have met your deductible.