EmblemHealth®

Smile!
Your coverage offers value and access through DentaQuest.

Welcome to Your EmblemHealth Dental Benefits

We're happy to offer you quality dental care through EmblemHealth's Essential Plan. Our goal is to give you access to high-quality, low-cost care.

As a member of EmblemHealth's Essential Plan, you will:

- Be covered for preventive services like cleanings, x-rays, and exams.
- Be covered for basic services through our network for fillings, root canals, extractions, and periodontal care.

IN-NETWORK COVERAGE

You will be able to choose from our in-network dentists and specialists in New York state. Simply show your member ID card at your dental visit. You do not have out-of-network coverage. If you choose to visit an out-of-network dentist, you will be responsible for the cost.

YOUR DENTAL BENEFITS

Here are some important things to know about your benefits:

- Your out-of-pocket maximum, the maximum amount you will have to pay each year for in-network dental care, is listed in the table below.
- You do not have out-of-network coverage. This means that you must see an in-network dentist or specialist or you will be responsible for the cost.

	ESSENTIAL PLAN 200-250	ESSENTIAL PLAN 1	ESSENTIAL PLAN 2	ESSENTIAL PLAN 3	ESSENTIAL PLAN 4
Copay	$0	$0	$0	$0	$0
Deductible	$0	$0	$0	$0	$0
Out-of-pocket maximum	$2,000	$360	$200	$200	$0

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EMBLEMHEALTH ESSENTIAL PLAN DENTAL BENEFITS

CATEGORY/PROCEDURE	BENEFIT LIMITATIONS
In-network only	
DIAGNOSTIC — Helps to determine your treatment needs.	
Periodic oral exam	Once every 6 months
Comprehensive oral exam	Once per location
Full mouth x-rays	Once every 36 months
Bitewing x-rays	Once every 6 months
Single tooth x-rays	Once every 6 months
PREVENTIVE — Procedures to help prevent oral disease from occurring.	
Routine cleaning	Once every 6 months
Fluoride varnish application	Four times in 12 months
Topical fluoride treatment	Once every 6 months
BASIC RESTORATIVE — Routine dental procedures to stabilize oral health.	
Silver fillings	Twice per 24 months per tooth
White fillings	Twice per 24 months per tooth
Porcelain crowns	Once per 60 months per tooth
Stainless steel crowns	Once per 24 months per tooth
Re-cement or re-bond crown	Once per 24 months per tooth
MAJOR RESTORATIVE — Complex dental procedures to stabilize oral health.	
ENDODONTICS* — Treatment involving the pulp of your tooth.	
Root canal treatment	Once per tooth per lifetime
Pulpotomy (removing a portion of the pulp of your tooth)	Once per tooth per lifetime on primary teeth only
PERIODONTICS* — Prevention and treatment of gum disease.	
Periodontal maintenance (for gum disease)	Twice per 12 months
Scaling and root planing (removing dental plaque and tartar)	Once per 24 months per quadrant
DENTURES*	
Complete or partial dentures	Services are covered
Repair of dentures or fixed bridges	Services are covered
Rebase/reline of dentures	Once per 12 months
ORAL SURGERY* — Surgical treatment or repair of various problematic or extreme conditions of the mouth or jaws.	
Simple tooth extraction	Once per tooth per lifetime
Surgical tooth extraction	Once per tooth per lifetime
EMERGENCY DENTAL CARE	
Palliative treatment for dental pain — minor procedure	Twice per 12 months
ANESTHESIA — A drug used by a dentist to numb your mouth or put you to sleep so no pain is experienced during dental procedures.	
General anesthesia	Deep sedation/general anesthesia — each 15-minute increment. Anesthesia time begins when the doctor gives you the anesthetic and ends when you can be safely left alone. For billing purposes, it is measured in 15-minute increments.
Intravenous anesthesia	Intravenous moderate (conscious) sedation/analgesia — each 15-minute increment. Anesthesia time begins when the doctor gives you the anesthetic through an IV and ends when you can be safely left alone. For billing purposes, it is measured in 15-minute increments.

*Service requires preauthorization and is covered as long as clinical criteria is met.

The information on this coverage summary should be used only as a guideline for your dental benefits. For detailed information on your plan's terms and conditions, or limitations and exclusions, refer to your Certificate of Coverage. If you receive a treatment from an out-of-network dentist you will not have benefits and you will be billed at the dentist's normal rate.

This summary provides only benefit highlights. Coverage is subject to all terms, conditions, limits, and exclusions set forth in the Certificate of Coverage. Refer to policy forms: 155-23-EPP1AIAN (01/25), 155-23-EPP1NONAIAN (01/25), 155-23-EPP2AIAN (01/25), 155-23-EPP2NONAIAN (01/25), 155-23-EPP3Aliessa (01/25), 155-23-EPP4Aliessa (01/25). Refer to HIP policy form numbers for Essential Plan 200-250: 155-23-EPP200-250NONAIAN (01/25), 155-23-EPP200-250AIAN (01/25)