EmblemHealth

Unified Court Systems
Effective Date: August 1, 2026

Dental Benefit Summary
Preferred Premier Network

Dental Cost-Sharing

	In-Network	*Out-of-Network
Annual Individual Deductible - Applies to Type A,B, C, D,E:	$0	$0
Combined Annual Family Maximum - Applies to Type A, B, C:	$0	$0
Coinsurance - Type A:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Coinsurance - Type B:	Plan Pays 100% / Member Pays 0%	Plan Pays 80% / Member Pays 20%
Coinsurance - Type C:	Plan Pays 100% / Member Pays 0%	Plan Pays 80% / Member Pays 20%
Annual Maximum - Includes Type A,B,C:	$8,000 per person, per cal year	$8,000 per person, per cal year
Coinsurance - Type D:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Lifetime Maximum - Applies to Type D:	$6,000-child/$4,000-adult per lifetime	$6,000-child/$4,000-adult per lifetime
Coinsurance - Type E	Plan Pays 100% / Member Pays 0%	Plan Pays 80%/ Member Pays 20%
Implant Annual Maximum - Applies to Type E:	$10,000 per person, per calendar year	$10,000 per person, per calendar year
Dependent Child:	Age 26 end of month	

Type A - Preventive and Diagnostic Services

	Benefit	In-Network	Out-of-Network
Prophylaxes	Three (3) scaling, cleaning and polishing treatments per member per calendar year.	Type A Coinsurance	Type A Coinsurance
Fluoride Treatments	Two (2) fluoride treatments per member per calendar year.	Type A Coinsurance	Type A Coinsurance
Examinations	Three (3) routine examinations per member per calendar year. One (1) initial comprehensive oral evaluation per dentist per member lifetime.	Type A Coinsurance	Type A Coinsurance
X-Rays	Four (4) bitewing x-rays per member per calendar year. One (1) full-mouth series of X-rays or fourteen (14) periapical x-ray films or one (1) panoramic film once every three (3) years.	Type A Coinsurance	Type A Coinsurance
Biopsy & Examination of Oral Tissue	Tests and laboratory exams.	Type A Coinsurance	Type A Coinsurance
Space Maintainers	One (1) space maintainer per lifetime per covered child up to age 19 end of year.	Type A Coinsurance	Type A Coinsurance
Mouth Guards	One (1) athletic mouth guard per lifetime per covered child up to age 19 end of year. One (1) occlusal guard per adult per lifetime, with a lifetime maximum of $1,500 for members 19 or older.	Type A Coinsurance	Type A Coinsurance
Palliative Services	Two (2) emergency service for the relief of pain per member per calendar year.	Type A Coinsurance	Type A Coinsurance
Sealants	One (1) sealant per covered tooth every three (3) years per covered child age 6 until age 14 birthdate.	Type A Coinsurance	Type A Coinsurance

Type B - Basic Services

	Benefit	In-Network	Out-of-Network
Oral Surgery[1]	Surgery for removal of erupted tooth, fractured jaws, impactions, and lesions are covered. Corrective jaw surgery and surgery relating to accidental injury are not covered.	Type B Coinsurance	Type B Coinsurance
Basic Restorations	Fillings covered every 6 months until 12/31/2026. Fillings covered every 12 months as of 1/1/2027. Excludes temporary fillings.	Type B Coinsurance	Type B Coinsurance
Consultations	Visit will count toward Examinations benefit limit.	Type B Coinsurance	Type B Coinsurance
Extractions	Routine removal of a tooth or teeth.	Type B Coinsurance	Type B Coinsurance
Repair of Prosthetic Appliances[1]	One (1) denture reline per denture every five (5) years. Rebase or repair of new dentures covered six (6) months from date of insertion. Repair of dentures includes: replacement of broken teeth or clasps; recementation of inlays, onlays, crowns, bridges, space maintainers; repair of inlays, onlays, crowns, veneers.	Type B Coinsurance	Type B Coinsurance
House/Extended Care Facility Calls	Emergency only.	Type B Coinsurance	Type B Coinsurance
Endodontics (Non-Surgical)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.	Type B Coinsurance	Type B Coinsurance

Surgical Endodontics[1]	Services are covered two (2) months after root canal therapy performed on same tooth by same dentist.	Type B Coinsurance	Type B Coinsurance
Anesthesia & IV Sedation/Analgesia	Covered in connection with a covered service.	Type B Coinsurance	Type B Coinsurance
Periodontal Surgery[1]	Repeated surgeries covered three (3) years from date of service. Periodontal appliances are not covered.	Type B Coinsurance	Type B Coinsurance
Periodontal Treatment (Non-Surgical)	Five (5) treatments of diseases of the gums and jawbone, per member per calendar year. Scaling and root planning covered every three (3) years. Periodontal maintenance procedures covered up to five (5) per year.	Type B Coinsurance	Type B Coinsurance

Type C - Major Services

	Benefit	In-Network	Out-of-Network
Major Restorative Services[1]	Includes: crowns; inlays; onlays; prosthetic services; removable, complete and partial dentures; fixed bridges; crowns, onlays, or inlays used as retainers. Replacements covered after five (5) years from appliance date of service.	Type C Coinsurance	Type C Coinsurance
Fixed & Removable Prosthodontics[1]	Includes: permanent dentures, fixed bridgework and removable partial dentures, posts if evidence of root canal therapy on the tooth, pin retention once every six (6) months. Replacements covered after five (5) years from date of service. Adjustment of appliances is covered after one (1) year of insertion.	Type C Coinsurance	Type C Coinsurance

Type D - Orthodontic Services

	Benefit	In-Network	Out-of-Network
Orthodontics[1]	Up to twenty-four (24) months of treatment covered including: office visits, appliances, follow-up visits and retention. Existing appliances are not covered. Dependents up to age 19 EOY and adults are eligible.	Type D Coinsurance	Type D Coinsurance

Type E - Implant Services

	Benefit	In-Network	Out-of-Network
Implant Services[1]	One (1) surgical implant body per same tooth per lifetime. Abutments are covered.	Type E Coinsurance Implant Body; Maximum $1800 Allowance	Type E Coinsurance

1 - You may obtain a Predetermination of Benefits, refer to Article Five in your Certificate of Insurance

*Out-of-network services reimbursed at 50th percentile of usual, customary, and reasonable fee schedule. You are responsible for any charges that exceed this amount.

Orthodontics are not included in the annual per person maximum.

Implants and occlusal guard (adult night guard) are not included in the annual per person maximum.

Underwritten by EmblemHealth Plan, Inc. Refer to policy form EHPI-PLD-1104B, et al. subject to review and approval by the New York State Department of Financial Services.

This summary provides highlights of coverage only. Coverage is subject to all terms, conditions, limitation and exclusions set forth in the Certificate of Insurance.