

Welcome to Your Child's EmblemHealth Dental Benefits

We're happy to offer your child quality dental care through EmblemHealth's Small Group Gold Premier-P Plan. Our goal is to give you access to high quality, low cost care.

As a member of EmblemHealth's Gold Premier-P health plan, your child will:

- Be covered for preventive services like cleanings, X-rays, and exams.
- Be covered for basic services t for fillings, root canals, extractions, and periodontal care based on your dental benefits.
- Be covered until the month they turn 19.

IN-NETWORK COVERAGE

You will be able to choose from our in-network dentists and specialists in New York State. Simply show your child's EmblemHealth 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. Preauthorization is required for major dental care and orthodontics.

YOUR DENTAL BENEFITS

Here are some important things to know about your benefits:

- There may be a deductible. A deductible is the amount you must pay each year before EmblemHealth starts to pay. You can find more information in the table below.
- Your out-of-pocket maximum, the maximum amount you will have to pay each plan year for dental care, is listed in the table below.
- A child is any member under 19 years old. This benefit is a pediatric benefit and can only cover children.
- You do not have out-of-network coverage. This means that your child must see an in-network dentist or dental specialist or you will be responsible for the cost.



| EMBLEMHEALTH GOLD PREMIER-P | |
|------------------------------------|-----------------------------|
| Fee per visit | |
| Emergency and Routine Dental Care | \$25 before deductible |
| Major Dental Care and Orthodontics | \$40 after deductible |
| Preventative Dental Care | \$0 before deductible |
| Deductible | \$500/\$1,000 for Family |
| Out-of-pocket maximum | \$7,500/\$15,000 for Family |

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Welcome to Your EmblemHealth 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 |
| Sealants | Once per tooth per 60 months — up to age 15 |
| 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 |
| ORTHODONTICS — Helps restore oral structures, function, and treats serious medical conditions. | |
| Orthodontia | Under age 19 — when medically necessary |
| 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. |

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your plans 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. 155-OA-NSSGGoldPremierPSch (9/22). This plan is underwritten by Health Insurance Plan of Greater New York (HIP).