



# TWU Local 100 Premier Dental Plan



For the most up-to-date listings of participating dentists, sign in to your member portal at [my.emblemhealth.com](https://my.emblemhealth.com) and select “Find Care.” If you have any questions, call the Customer Service number on your ID card and let us know.

**TWU Local 100 Premier Dental Plan**

This dental plan gives you quality coverage with access to over 13,500\* network dentists and specialists in New York and New Jersey. You can choose a dentist or specialist for services covered under your plan. You don’t have to pick a specific primary care dentist. Benefits are available for covered services received from out of network providers, but you usually will pay more for out of network services.

**Dependent Coverage:** With this dental plan, you can cover your children until the end of the month they turn 26. Children can be covered for orthodontic services as long as they start treatment by the end of the month they turn 26.

**Predetermination of Benefits:** EmblemHealth can let you know what dental services and materials will be paid for before you start treatment. You may 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 is not required, but it is strongly suggested.

**The following are some examples of services that are not covered:**

- Cosmetic surgery and treatment unless it is reconstructive surgery caused by trauma, infection, or disease of the involved part.
- Prescription drugs and medicines.
- Services and appliances for the treatment of temporomandibular joint (TMJ) dysfunction.
- Transplantations.

**Annual Maximum:** \$2,000 individual / \$4,000 family. This is the maximum dollar amount your dental plan will pay during your plan year. You are responsible to pay all costs above the annual maximum. Implant services and orthodontia services are not subject to this annual maximum.

**Lifetime Orthodontic Maximum:** \$4,000 In-network; \$2,000 Out-of-network. This is the maximum dollar amount(s) your dental plan will pay toward the orthodontic services per person per lifetime. You are responsible to pay all costs above the lifetime maximum. Orthodontia benefits are available only to covered children under the age of 26.

**Implant:** EmblemHealth covers implant services for one tooth per rolling 12-month period; one surgical implant per tooth per lifetime. This benefit includes the implant and covered services directly related to the implant procedure (e.g. abutments, crowns, bone grafts). Out-of-network implant services are subject to a dollar maximum of \$1,000 per 12-month period. No dollar maximum applies to in-network implant services.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type A – Preventive and Diagnostic Services		
Base Coverage Level	EmblemHealth will pay 100% of the Preferred Premier Schedule of Allowances for covered services when you see a Preferred Premier Dentist or Specialist.	EmblemHealth will pay 100% of Spectrum fee schedule for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.
Examinations – 2 periodic exams per each person on the plan per calendar year. 1 comprehensive examination per dentist, per lifetime.	Covered  You don’t have to pay for these covered services.	You may have to pay for some of your bill. See above for details.
Prophylaxes (Cleanings) – Prophylaxis is the scaling, cleaning, and polishing of the teeth. 2 per person on the plan per calendar year.		
X-Rays – 4 bitewing x-rays per person on the plan per calendar year. <ul style="list-style-type: none"><li>• 1 full-mouth series of x-rays or 1 panoramic film per person on the plan once every 3 years.</li></ul> If the benefit limit is exceeded and a medically necessary pre-operative film is needed to diagnose dental disease or injury: <ul style="list-style-type: none"><li>• 1 additional panoramic film every 3 years if performed by an oral surgeon.</li><li>• 1 additional bitewing film for posterior teeth, or 1 additional periapical every calendar if performed by a specialist.</li></ul> You are responsible to pay for all additional films that are more than the original and supplemental benefit.		

**NOTE:** This is not a complete benefit comparison or a contract and should only be viewed as a brief summary to assist you in understanding this EmblemHealth benefit program. A detailed benefits description, including limitations and exclusions, is contained within the Certificate of Insurance. The terms, conditions, limits, and exclusions shown in the Certificate of Insurance shall govern.

\* As of September 2024

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type A – Preventive and Diagnostic Services (Continued)		
<b>Fluoride Treatments</b> – 1 per person on the plan per calendar year. For children, this benefit applies until the end of the month they turn 26.	<b>Covered</b>  You don't have to pay for these covered services	<b>You may have to pay for some of your bill. See above for details.</b>
<b>Space Maintainers</b> – 1 per each child on the plan per lifetime. Coverage provided until the end of the month the child turns 26.		
<b>Athletic and Occlusal Mouth Guards</b> – One (1) mouth guard per lifetime per covered child up to age 26 end of month.  Occlusal guards may be covered for member and eligible dependent(s) requires pre-authorization.		
<b>Sealants</b> – One (1) sealant per covered tooth every three (3) calendar years per covered child age 6 until age 14 birthdate.		
Type B – Basic Services		
<b>Base Coverage Level</b>	<b>EmblemHealth will pay 100% of the Preferred Premier Schedule of Allowances for covered services when you see a Preferred Premier Dentist or Specialist.</b>	<b>EmblemHealth will pay 100% of Spectrum fee schedule for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.</b>
<b>Simple Extractions</b>	<b>Covered</b>  You don't have to pay for these covered services.	<b>You may have to pay for some of your bill. See above for details.</b>
<b>Basic Restorations (Fillings)</b>		
<b>Endodontics (Root canal therapy)</b> <ul style="list-style-type: none"><li>Pulpotomy covered once per tooth, per lifetime. Pulp capping covered as part of root canal.</li></ul>		
<b>Periodontics (Treatment of diseases of the gum and jaw)</b> <ul style="list-style-type: none"><li>5 periodontal treatments per person on the plan per calendar year including three (3) periodontal maintenance procedures, with one additional treatment if medically necessary.</li><li>1 type of periodontal surgery and/or 1 graft per quadrant.</li></ul>		
<b>Oral Surgery (Surgical removal of an erupted tooth)</b> <ul style="list-style-type: none"><li>Your plan will pay for x-rays taken for surgery, local anesthesia, and post-operative care.</li><li>Your plan will pay for surgery on fractured jaws, impactions, lesions in and around the mouth, and reimplantations.</li><li>Some types of oral surgery may be covered under your medical plan, not this dental plan.</li></ul>		
<b>Anesthesia &amp; IV Sedation</b> – 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.		
<b>Palliative Services (Relief of pain)</b> <ul style="list-style-type: none"><li>Emergency services covered</li></ul>		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type B – Basic Services (Continued)		
<b>Repair of Appliances</b> <ul style="list-style-type: none"><li>Replacement of broken teeth or clasps, recementation of inlays, crowns, bridges, and space maintainers. Replacement of broken facings.</li></ul>	<b>Covered</b>  You don't have to pay for these covered services.	<b>You may have to pay for some of your bill. See above for details.</b>
<b>Tests and Laboratory Exams</b> – Biopsy and examination of oral tissue.		
Type C – Major Services		
<b>Base Coverage Level</b>	<b>EmblemHealth will pay 100% of the Preferred Premier Schedule of Allowances for covered services when you see a Preferred Premier Dentist or Specialist.</b>	<b>EmblemHealth will pay 100% of Spectrum fee schedule for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.</b>
<b>Implants</b> – One (1) surgical implant and related services per rolling twelve-month period beginning on initial treatment date. One (1) surgical implant per tooth per lifetime.	<b>Covered</b>  You don't have to pay for these covered services.	<b>You may have to pay for some of your bill. See above for details.</b>
<b>Fixed and Removable Prosthetics</b> – Both temporary and permanent dentures, removable and fixed partial dentures, full or partial, repair.		
<b>Major Restoration</b> – Includes crowns, related post and core procedures, and inlays. <ul style="list-style-type: none"><li>Your plan will pay for replacement or substitution of appliances only after 5 years have passed since appliance was inserted.</li><li>Your plan will pay for crowns or pontics for attachment or clasp purposes only if tooth cannot be restored by fillings.</li><li>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.</li><li>No separate allowance for temporary service or appliance.</li><li>Your plan will pay for posts only if there is evidence of root canal on the tooth.</li><li>Charges for cementation of crown/inlay are included in allowance for the crown/inlay.</li></ul>		
Type D – Orthodontics		
<b>Orthodontic Base Coverage Level</b>  Up to twenty -four (24) months of treatment covered, up to lifetime maximum benefit allowance including one (1) upper and one (1) lower retainer post-orthodontic treatment.	<b>Covered</b>  You don't have to pay for these covered services.	<b>Covered up to the \$2,000 lifetime maximum benefit for covered services.</b>  You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.

Underwritten by EmblemHealth Plan, Inc., refer to policy form EHPI-PLD-1103, et al.

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