EmblemHealth

Town of Hempstead
Effective Date: January 1, 2026

Dental Benefit Summary
Preferred Premier Network

Dental Cost-Sharing

	In-Network	*Out-of-Network
Annual Individual Deductible - Applies to Type B, C:	$25	$25
Combined Annual Family Maximum - Applies to Type B, C:	$75	$75
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 100% / Member Pays 0%
Coinsurance - Type C:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Annual Maximum - Includes Type A,B,C:	$3,000 per person, per cal year	Subject to InN Annual Maximum
Annual Individual Deductible - Applies to Type D:	$0	$0
Coinsurance - Type D:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Lifetime Maximum - Applies to Type D:	$4,240 per person, per lifetime	$4,240 per person, per lifetime
Dependent Student:	Age 23 end of month	
Dependent Child:	Age 19 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.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Fluoride Treatments	Two (2) fluoride treatments per covered child until age 19 end of month per calendar year.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Examinations	Two (2) routine examination per member per calendar year. One (1) initial comprehensive oral evaluation per dentist per member lifetime.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
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. Cone Beams are covered once every five (5) years.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Biopsy & Examination of Oral Tissue	Tests and laboratory exams.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Space Maintainers	One (1) space maintainer per 60 months per covered child up to age 16 end of year.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Mouth Guards	One (1) athletic mouth guard per lifetime per covered child up to age 19 end of month.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Palliative Services	One (1) emergency service for the relief of pain per member per calendar year.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Sealants	One (1) sealant per covered tooth every three (3) years per covered child age 6 until age 16 birthdate.	Not Subject to Deductible Type A Coinsurance Only	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.

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 is not covered.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Basic Restorations	Fillings covered every 6 months until 12/31/2026. Fillings covered every 12 months as of 1/1/2027. Excludes temporary fillings.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Consultations	Visit will count toward Examinations benefit limit. Specialist visit not covered if performed within one (1) month of consultation.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Extractions	Routine removal of a tooth or teeth.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
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.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Bedside Calls	Emergency only.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Endodontics (Non-Surgical)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.

Surgical Endodontics[1]	Services are covered three (2) months after root canal therapy performed on same tooth by same dentist.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Anesthesia & IV Sedation/Analgesia	Covered in connection with a covered service.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Periodontal Surgery[1]	Repeated surgeries covered three (3) years from date of service. Periodontal appliances are not covered.	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Periodontal Treatment (Non-Surgical)	Five (5) treatments of diseases of the gums and jawbone, including two (2) periodontal maintenance procedure, per member per calendar year	Deductible & Type B Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
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.	Deductible & Type C Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
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.	Deductible & Type C Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
**Implant Services[1]	One (1) surgical implant body per tooth per lifetime. Abutments are covered.	Implant body maximum allowance up to $1,250. Plan pays 100% of the Preferred Premier fee schedule for implant abutments and implant crowns up to the annual maximum limit.	Plan pays 100% of the Preferred fee schedule for implant abutment and implant crowns up to the annual maximum limit. Member is responsible for any charges that exceed this amount.
Type D - Orthodontic Services			
	Benefit	**In-Network**	**Out-of-Network**
Orthodontics[1]	Up to twenty (24) months of treatment covered including: office visits, appliances, follow-up visits and retention (including retainer coverage). Existing appliances are not covered. Adults and dependents are eligible.	Type D Deductible & Coinsurance	Plan Pays 100% of Preferred fee schedule up to the annual maximum limit. Member is responsible for any charges that exceed this amount.

1 - You may obtain a Predetermination of Benefits

*Out-of-network services reimbursed using Preferred fee schedule. You are responsible for any charges that exceed this amount.

**Implant in-network: The plan has an annual maximum of $3,000, and the implant body is covered up to $1,250 within the annual maximum limit. If you have already reached your annual maximum, then you would be responsible for the remaining balance, up to $1,800 when you see an in network provider.

**Implant out-of-network: The plan has an annual maximum of $3,000, and the implant body is covered up to $1,250 within the annual maximum limit. If you have already reached your annual maximum, then you would be responsible for the remaining balance, up to the providers full charge

This summary provides highlights of coverage only. Additional terms, conditions, limitations and exclusions may apply.