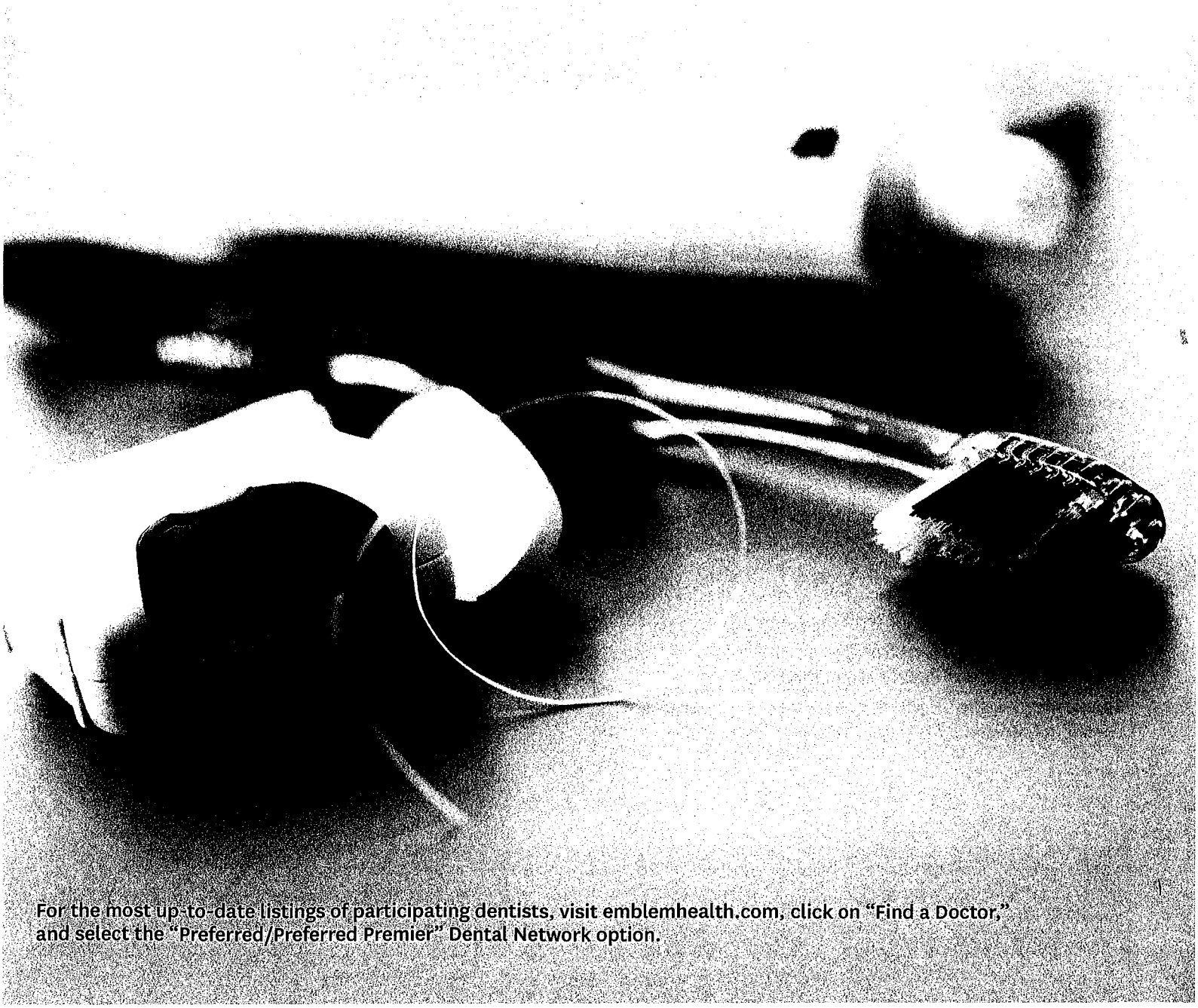
EmblemHealth®

PCTEA Preferred Premier Dental Benefits Plan

Low Plan



For the most up-to-date listings of participating dentists, visit emblemhealth.com, click on "Find a Doctor," and select the "Preferred/Preferred Premier" Dental Network option.

EmblemHealth PCTEA Preferred Premier Dental Benefits Plan

This dental plan gives you quality coverage with access to over 10,000 dentists and specialists in New York and New Jersey. You can choose a network dentist or specialist for services covered under your plan. You don't have to pick a specific primary care dentist.

Dependent Coverage: With this dental plan, you can cover your children until the end of the month they turn 26.

Predetermination of Benefits: EmblemHealth can let you know, before you go to the dentist, what dental services and materials will be paid. 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 tell you and your dentist what is covered. **Please note:** If you are receiving any Type A or basic restorative services (shown in the table below), you do not need to get a Predetermination of Benefits.

Dental Services 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.
- Implants.
- Orthodontics.

Annual Deductible: This is the amount you pay each year before your plan starts to pay: $50 per individual; $150 per family for Type B and C.

Annual Maximum: This is the maximum dollar amount your dental plan will pay toward the cost of dental care during your benefit period. You are personally responsible for paying costs above the annual maximum: $1,500.

<table>
<tr><th>BENEFITS</th><th>IN-NETWORK*</th><th>OUT-OF-NETWORK*</th></tr>
<tr><td colspan="3">Type A – Preventive and Diagnostic Services</td></tr>
<tr><td>Base Coverage Level</td><td>EmblemHealth will pay 100% of the bill when you see a Preferred Premier dentist or specialist.</td><td>EmblemHealth will pay 100% of the set dollar amount for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.</td></tr>
<tr><td>Sealants: Coverage provided for teeth not already filled, for children up to the end of the year they turn 17.</td><td rowspan="7">Covered
You don't have to pay for these services.</td><td rowspan="7">You may have to pay for some of your bill.
See above for details.</td></tr>
<tr><td>Examinations – 2 periodic exams per each person on the plan per calendar year. 1 comprehensive examination per dentist, per lifetime.</td></tr>
<tr><td>Prophylaxes (Cleanings) – 2 per person on the plan per calendar year.</td></tr>
<tr><td>X-rays – 4 bitewing x-rays per person on the plan per calendar year.
• 1 full-mouth series of x-rays or 1 panoramic film per person on the plan once every 3 years.</td></tr>
<tr><td>Fluoride Treatments – 1 per person on the plan per calendar year. Coverage provided until the end of the calendar year the child turns 19.</td></tr>
<tr><td>Space Maintainers – 1 per each child on the plan per lifetime. Coverage provided until the end of the calendar year the child turns 19.</td></tr>
<tr><td>Athletic Mouth Guards – 1 per each child on the plan per lifetime. Coverage provided until the end of the calendar year the child turns 19.</td></tr>
</table>

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.*

Payment amounts shown apply after you have met the applicable annual deductible.

BENEFITS	IN-NETWORK*	OUT-OF-NETWORK*
Type B – Basic Services		
Base Coverage Level	**EmblemHealth will pay 80% of the set dollar amount for covered services when you see a Preferred Premier dentist or specialist.**	**EmblemHealth will pay 50% of the set dollar amount for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.**
Simple Extractions	**You will have to pay 20% of the cost of covered services after the $50- $150 deductible.**	**You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.**
Endodontics (Root canal therapy) • Pulpotomy covered once per tooth, per lifetime. Not covered if root canal is done on the same tooth by the same dentist within 3 months of the pulpotomy.		
Periodontics (Treatment of diseases of the gum and jaw) • 5 periodontal treatments per person on the plan per calendar year. • 1 type of periodontal surgery and/or 1 graft per quadrant.		
Oral Surgery (Surgical removal of an erupted tooth) • Your plan will pay for x-rays taken for surgery, local anesthesia, and post-operative care. • Your plan will pay for surgery on fractured jaws, impactions, lesions in and around the mouth, and reimplantations. • Some types of oral surgery may be covered under your medical plan, not this dental plan.		
Anesthesia & IV Sedation – 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. There is no separate allowance for local anesthesia. Analgesia and monitoring devices will not be paid for by your plan.		
Palliative Services (Relief of pain) • 1 service per person on the plan per calendar year. This is for emergencies only.		
Repair of Appliances • Replacement of broken teeth or clasps, recementation of inlays, crowns, bridges, and space maintainers. Replacement of broken facings.		
Tests and Laboratory Exams – Biopsy and examination of oral tissue.		

BENEFITS	IN-NETWORK*	OUT-OF-NETWORK*
Type C – Major Services		
Base Coverage Level	**EmblemHealth will pay 50% of the bill when you see a Preferred Premier dentist or specialist.**	**EmblemHealth will pay 50% of the set dollar amount for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.**
Fixed and Removable Prosthetics – Temporary services are not covered. Dentures, full or partial, repair, and crowns over implants. **Major Restoration** – Includes crowns, related post and core procedures, and inlays. • Your plan will pay for replacement or substitution of appliances only after 5 years have passed since appliance was inserted. • Your plan will pay for crowns or pontics for attachment or clasp purposes only if tooth cannot be restored by fillings. • 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. • No separate allowance for temporary service or appliance. • Your plan will pay for posts only if there is evidence of root canal on the tooth. • Charges for cementation of crown/inlay are included in allowance for the crown/inlay.	**You will have to pay 50% of the cost of covered services after the $50-$150 deductible.**	**You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.**

Refer to Policy Forms PLD-1104-C and PLD-1103-C