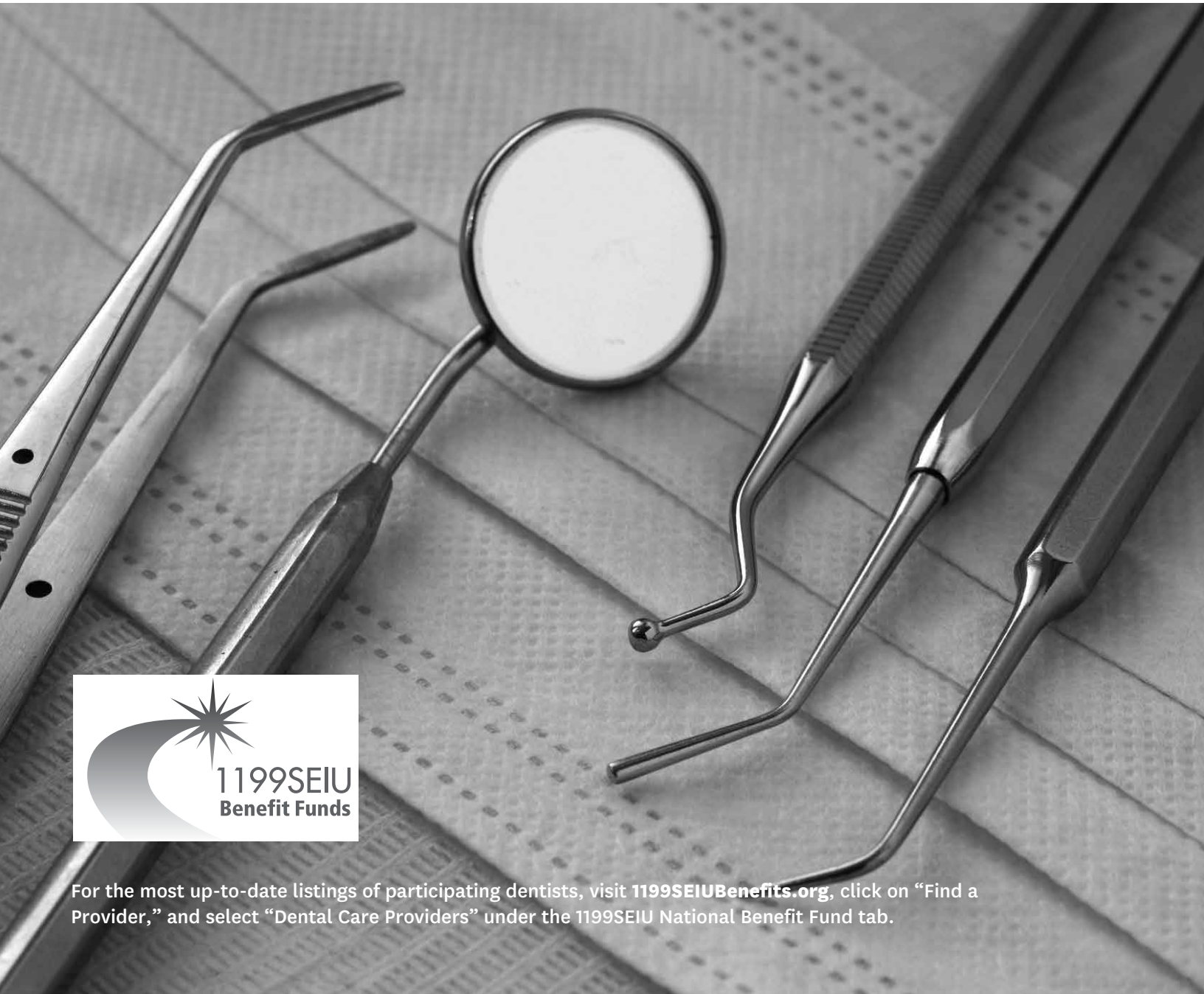
EmblemHealth®

Preferred Premier Dental Benefits Plan

1199SEIU National Benefit Fund



For the most up-to-date listings of participating dentists, visit **1199SEIUBenefits.org**, click on "Find a Provider," and select "Dental Care Providers" under the 1199SEIU National Benefit Fund tab.

EmblemHealth Preferred Premier Dental Plan

This dental plan gives you quality coverage with access to over 8,500 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. Children can be covered for orthodontic services as long as they start treatment by the end of the month they turn 19.

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 tell you and your dentist what is covered.
Please note: Predetermination of Benefits is not required, but it is strongly suggested.

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.

Annual Maximum: $3,000 individual when you visit a dentist in or out of our network. 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.

Lifetime Orthodontic Maximum: $4,000 when you visit an orthodontist in our network; $1,130 when you visit an orthodontist not in our network.

This is the maximum dollar amount your dental plan will pay toward the cost of orthodontic dental care. The orthodontia treatment must begin before the covered child reaches age 19 to be eligible for coverage.

<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 set dollar amount for covered services 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 responsible for paying the difference between what EmblemHealth pays and what the dentist charges.</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><td rowspan="3">Covered
You don't have to pay for these covered services.</td><td rowspan="3">You may have to pay for some of your bill. See above for details.</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.
If the benefit limit is exceeded and a medically necessary pre-operative film is needed to diagnose dental disease or injury:
• 1 additional panoramic film every 3 years if performed by an oral surgeon.
• 1 additional bitewing film for posterior teeth, or 1 additional periapical every calendar if performed by a specialist.
You are responsible to pay for all additional films that are more than the original and supplemental benefit.</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.*

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type A – Preventive and Diagnostic Services (Continued)		
Fluoride Treatments – 1 per person on the plan per calendar year. For children, this benefit applies until the end of the month they turn 14.	**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.**
Space Maintainers – 1 per each child on the plan every 3 years. Coverage provided until the end of the month the child turns 19.		
Athletic and Occlusal Mouth Guards – 1 per each child on the plan until the end of the month the child reaches age 14. 1 additional mouth guard is covered for each covered child who is 14 years of age or older. 1 occlusal mouth guard is covered per lifetime for each covered dependent who is age 14 or older.		
Sealants – Covered once per calendar year per covered tooth until the end of the month the child reaches age 14. First and second permanent molars and bicuspids are considered covered teeth.		
Type B – Basic Services		
Base Coverage Level	**EmblemHealth will pay 100% of the set dollar amount for covered services when you see a Preferred Premier Dentist or Specialist.**	**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 responsible for paying the difference between what EmblemHealth pays and what the dentist charges.**
Simple Extractions	**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.**
Basic Restorations (Fillings)		
Endodontics (Root canal therapy) • Pulpotomy covered once per tooth, per lifetime. Not covered if root canal done on same tooth by 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. 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.		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type B – Basic Services (Continued)		
Repair of Appliances • Replacement of broken teeth or clasps, recementation of inlays, crowns, bridges, and space maintainers. Replacement of broken facings.	**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.**
Tests and Laboratory Exams – Biopsy and examination of oral tissue.		
Type C – Major Services		
Base Coverage Level	**EmblemHealth will pay 100% of the set dollar amount for covered services when you see a Preferred Premier Dentist or Specialist.**	**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 responsible for paying the difference between what EmblemHealth pays and what the dentist charges.**
Fixed and Removable Prosthetics – Both temporary and permanent dentures, removable and fixed partial dentures, full or partial, repair. **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.	**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.**
Type D – Orthodontics		
Orthodontic Base Coverage Level Treatment must begin before the covered child reaches age 19 to be eligible for coverage. The orthodontia lifetime maximum represents the maximum amount that will be paid for orthodontia treatment. This does not include charges for missed appointments or additional cosmetic banding options. You will be responsible for these charges.	**Covered up to the $4,000 maximum benefit.** You don't have to pay for these covered services.	**Covered up to the $1,130 maximum benefit for covered services.** You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.

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