Exclusions

1. Any dental services not rendered or approved by a participating dentist, except in cases of out-of-area dental emergency.
2. A service not furnished by a dentist unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an x-ray ordered by a dentist.
3. Treatment of a disease, defect, or injury covered by a major medical plan, Workers' Compensation Law, occupational disease law, or similar legislation.
4. General anesthesia, analgesia, or sedation for services rendered in a hospital environment.
5. Dental procedures undertaken primarily for cosmetic reasons *(including composite fillings in molar teeth)*, or dental care to treat accidental injuries, or congenital or developmental malformations.
6. Restorations, crowns, or fixed prosthetics when results can be achieved with alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, the plan will allow for the least costly alternative and the patient is responsible for all additional fees.
7. Services started prior to becoming covered under this plan.
8. Implants, grafts, precision attachments, or other personalized restorations or specialized techniques.
9. Replacement of an existing crown, bridge, or denture that can be made serviceable according to common dental standards.
10. Procedures, appliances, or restorations for which the main purpose is to change vertical dimension, diagnose or treat conditions or dysfunction of the temporomandibular joint, stabilize periodontally involved teeth, or restore occlusion.
11. Treatment of unmanageable children and/or unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or the parent/guardian of the patient.
12. Services not listed in the Schedule of Benefits are not covered.

Limitations

1. Oral exams, bitewing x-rays, prophylaxes, and fluoride treatments: once every 6 months.
2. Full mouth and panoramic x-rays: once every 36 months.
3. Crowns and bridges *(per tooth)*, dentures *(per arch)*, and periodontal surgery *(per quadrant)*: once every 60 months.
4. Orthodontic treatment of Class II/Class III malocclusions: one 24-month case. Dependent children are covered up to age 19 only.
5. Under family coverage, children are covered up to the end of the month of their 26th birthday.

Certain procedures may have age or time limitations. A list of such services is available on request.

Provider may charge up to $30.00 if not notified 24 hours in advance of broken appointment.

This brochure contains a general description of your dental care program for your use as a convenient reference. Due to certain Exclusions and/or Limitations, all member copayments may not be applicable. For Individuals: all benefits are governed by the provisions of Dentcare's dental agreement which can be obtained through our website at healthplex.com. For Groups: prior to receiving any treatment, please obtain the Certificate of Insurance from your benefit administrator for Exclusions and Limitations. A copy of your Certificate of Insurance may also be obtained from our website at healthplex.com. All benefits are governed by the provisions of your group's contract.

Have Any **Questions**?

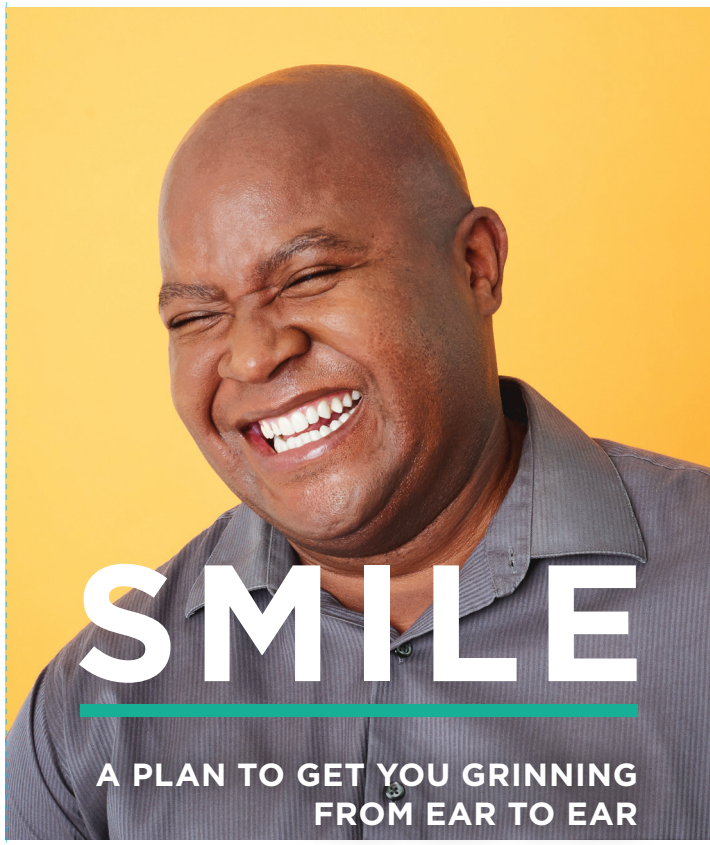
Interested in **Enrolling**?

T: 800-468-0466
E: sales@healthplex.com
healthplex.com

Dentcare®

Select-NY

An Affordable Care Act (ACA) Compliant Dental Plan



Underwritten by:
Dentcare Delivery Systems, Inc.

Administered by:
healthplex®
333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608
healthplex.com

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The

Select Plan

The Select Plan offers extensive coverage at an affordable cost that works within any budget for an individual, family, or business. Benefits of the Select Plan include:

- No Annual Maximums
- No Charge for Exams, Prophylaxes, and X-rays
- No Deductibles
- Fixed Copayments at Specialty Providers
- No Referrals Required

General Dentistry

You must choose a family dentist from the Select Network. You and your dependents will receive all Diagnostic, Preventive, Restorative, and Prosthetic Services from this dentist. Some services are rendered without any cost, while others have a minimal copayment that you pay directly to the dentist.

Specialty Care

You and your dependents may see any participating Select Network specialist without a referral. Covered specialty services will have fixed copayments paid directly to the specialist. For all covered non-specialty services, members pay 100% of the reduced scheduled PPO fees directly to the specialist.

The Select Plan is ACA compliant and includes the Pediatric Dental Essential Health Benefits, as defined in the Patient Protection Affordable Care Act for all dependent children under the age of 19.

Schedule of Benefits

Procedure	Patient Copayment
Diagnostic & Preventive Services	
Oral Examination	No Charge
Full Mouth X-rays	No Charge
Single Films	No Charge
Bitewing Series	No Charge
Prophylaxis	No Charge
Fluoride Treatment	No Charge
Emergency Treatment	No Charge
Sealants	No Charge
Specialty Consultation	$50.00
Restorative Dentistry	
Amalgam, 1 Surface	20.00
Amalgam, 2 Surfaces	35.00
Amalgam, 3 Surfaces	50.00
Composite Filling, 1 Surface, Anterior	25.00
Composite Filling, 2 Surfaces, Anterior	40.00
Composite Filling, 3+ Surfaces, Anterior	55.00
Oral Surgery	
Routine Extraction	45.00
Surgical Extraction	75.00
Soft Tissue Impaction	95.00
Partial Bony Impaction	125.00
Full Bony Impaction	160.00
Alveolectomy w/o Extraction, Per Quad	95.00
Root Canal Therapy	
Pulpotomy	35.00
Root Canal Therapy - Anterior	225.00
Root Canal Therapy - Bicuspid	290.00
Root Canal Therapy - Molar	395.00
Apicoectomy, Anterior	175.00

Procedure	Patient Copayment
Periodontics	
Scaling/Root Planing of Teeth, Per Quad	25.00
Gingivectomy, Per Quad	125.00
Osseous Surgery, Per Quad	425.00
Perio Maintenance	72.50
Prosthetics - Crowns	
Acrylic w/Metal Crown	295.00
Porcelain Crown	385.00
Porcelain w/Metal Crown	425.00
Stainless Steel Crown	95.00
Cast Post	95.00
Recementation, Per Crown	35.00
Prosthetics - Fixed Bridges	
Acrylic w/Metal Abutment or Pontic	295.00
Porcelain w/Metal Abutment or Pontic	425.00
Recementation, Bridge	35.00
Prosthetics - Removable	
Full Upper Denture, inc. Adjustments	395.00
Full Lower Denture, inc. Adjustments	395.00
Partial Upper Denture, Cast Base/Cast	395.00
Partial Lower Denture, Cast Base/Cast	395.00
Prosthetics - Repairs	
Broken Body of Denture	95.00
Replacing Broken/Missing Teeth	35.00
Office Reline	95.00
Lab Reline	150.00
Orthodontics	
Case Fee - 24 Months	$2,910.00