Exclusions

1. Any dental services not rendered or approved by a participating dentist, except in cases of out-of-area dental emergency (In-Network plan).
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 (In-Network plan).
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. 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**?

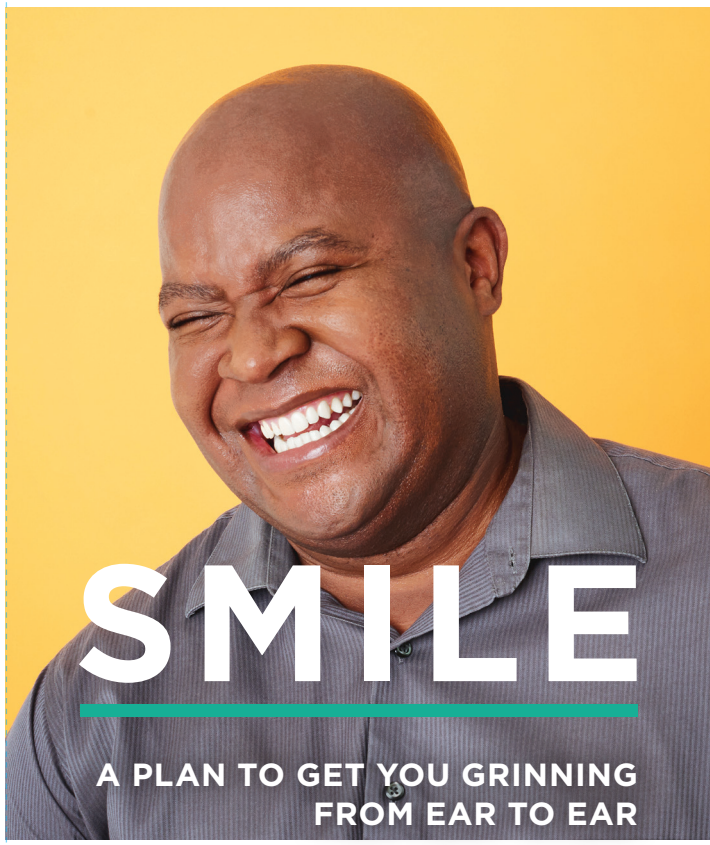
Interested in **Enrolling**?

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

Dentcare®

Select Plus-NY

An Affordable Care Act (ACA) Compliant Dental Plan



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Uniondale, NY 11553-3608
healthplex.com

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The
Select Plus Plan

Whether you are a small or large business, the Select Plus plan offers extensive coverage at an affordable cost that works within any budget.

In-Network Coverage

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 you pay directly to the dentist.

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

Out-of-Network Coverage

If you choose to go Out-of-Network, you will be reimbursed according to the Schedule of Benefits for covered procedures and will be responsible for the difference between the dentist's charge and the reimbursement. This plan requires claim forms to be submitted in order to be reimbursed for covered services rendered.

- $40 Individual/$400 Family Deductible
- $1,200 Individual Maximum
- $720 Orthodontia Maximum

The Select Plus 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	In-Network $5 per Visit/Person	Out-of-Network Reimbursement
Diagnostic & Preventive Services		
Oral Examination	No Charge	$16.50
Full Mouth X-rays	No Charge	$38.50
Single Films	No Charge	$5.00
Bitewing Series	No Charge	$12.00
Prophylaxis	No Charge	$27.50
Fluoride Treatment	No Charge	$16.50
Emergency Treatment	No Charge	$22.00
Restorative Dentistry		
Amalgam, 1 Surface	No Charge	$22.00
Amalgam, 2 Surfaces	No Charge	$33.00
Amalgam, 3+ Surfaces	No Charge	$44.00
Composite Filling, 1 Surface, Anterior	No Charge	$22.00
Composite Filling, 2 Surfaces, Anterior	No Charge	$33.00
Composite Filling, 3+ Surfaces, Anterior	No Charge	$44.00
Oral Surgery		
Routine Extraction	$25.00	$38.50
Surgical Extraction	$50.00	$50.00
Soft Tissue Impaction	$50.00	$65.00
Partial Bony Impaction	$75.00	$100.00
Full Bony Impaction	$100.00	$135.00
Alveolectomy w/o Extraction, Per Quad	$50.00	$65.00
Root Canal Therapy		
Pulpotomy	No Charge	$32.00
Root Canal Therapy - Anterior	$125.00	$215.00
Root Canal Therapy - Bicuspid	$190.00	$250.00
Root Canal Therapy - Molar	$335.00	$300.00
Apicoectomy, Anterior	$125.00	$110.00

Procedure	In-Network $5 per Visit/Person	Out-of-Network Reimbursement
Periodontics		
Scaling/Root Planing of Teeth, Per Quad	$45.00	$32.00
Gingivectomy, Per Quad	$95.00	$80.00
Osseous Surgery, Per Quad	$350.00	$135.00
Prosthetics - Crowns		
Acrylic w/Metal Crown	$150.00	$160.00
Porcelain Crown	$270.00	$160.00
Porcelain w/Metal Crown	$270.00	$215.00
Stainless Steel Crown	$50.00	$55.00
Cast Post	$50.00	$55.00
Recementation, Per Crown	No Charge	$17.00
Prosthetics - Fixed Bridges		
Acrylic w/Metal Abutment or Pontic	$150.00	$160.00[1]
Porcelain w/Metal Abutment or Pontic	$270.00	$215.00[1]
Recementation, Bridge	No Charge	$17.00
Prosthetics - Removable		
Full Upper Denture, inc. Adjustments	$295.00	$275.00[1]
Full Lower Denture, inc. Adjustments	$295.00	$275.00[1]
Partial Upper Denture, Cast Base/Cast	$295.00	$305.00[1]
Partial Lower Denture, Cast Base/Cast	$295.00	$305.00[1]
Prosthetics - Repairs		
Broken Body of Denture	$75.00	$16.50
Replacing Broken/Missing Teeth	$25.00	$16.50
Office Reline	$50.00	$40.00
Lab Reline	$95.00	$82.00
Orthodontics		
Case Fee - 24 Months	$2,910.00	$30.00/mo.[2]

[1]Subject to a 12-month waiting period (other than for single crowns).
[2]Subject to a 24-month waiting period and a lifetime maximum of $720.