Reimbursement Plan Summary

Name of Group: Saint Vincent's Catholic Medical Center of NY/USFHP

Group Number: GG-718

Effective Date: January 1, 2019

Plan Number: 100Z100FV0

Benefit Period: Calendar Year

Reimbursement Plan – Covered services can be rendered by any dentist. To use the plan, members should be treated by the dentist of their choice and submit claims to Healthplex. Payments by the plan are subject to the following terms:

Individual Deductible: 0 (Waived for Diagnostic and Preventive Services)

Family Deductible: 0 (Waived for Diagnostic and Preventive Services)

Healthplex Pays:

Category	Services	%	
Category I	Diagnostic Services Preventive Services	100 %	of the maximum allowable amount for In-Network Services.
Category II	Basic Restorative Services Endodontic Services Periodontal Services Oral Surgery Services	0 %	of the maximum allowable amount for In-Network Services.
Category III	Major Restorative Services Prosthetic Services	0 %	of the maximum allowable amount for In-Network Services.
Category IV	Orthodontic Services	0 %	of the maximum allowable amount for In-Network Services.

Individual Maximum (Category I, II, III):	$1,000.00	per benefit period
Family Maximum (Category I, II, III):	N/A	per benefit period
Orthodontic Maximum (Category IV):	N/A	Lifetime

Dependent Eligibility – Dependent Children are covered up to the end of the month of their 26th birthday.

Orthodontics – Dependent Children up to age 19.

Note – The dental coverage described on this Benefit Page is subject to the provisions of the dental agreement between Healthplex Insurance Company and your group. Please refer to the Certificate of Insurance booklet for a summary of the contractual terms that affect your benefits.

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Saint Vincent's Catholic Medical Center of NY/USFHP
Member Reimbursement Schedule - GG-718

Category	Services	In-Network PPO Copayments	Out-of-Network Reimbursement%
Diagnostic & Preventive	Periodic Oral Examination	No Charge	100%
	Full Mouth Series X-Rays	No Charge	100%
	Periapical, First Film	No Charge	100%
	Bitewings, Four Films	No Charge	100%
	Prophylaxis, Adult/Child	No Charge	100%
	Fluoride Treatment	No Charge	100%
	Sealants, Per Tooth	No Charge	100%
Basic	Amalgam, 1 Surface	Discounted Fee	Not Covered
	Amalgam, 2 Surfaces	Discounted Fee	Not Covered
	Amalgam, 3 Surfaces	Discounted Fee	Not Covered
	Amalgam, 4+ Surfaces	Discounted Fee	Not Covered
	Resin-Based Composite, 1 Surface, Anterior	Discounted Fee	Not Covered
	Resin-Based Composite, 2 Surfaces, Anterior	Discounted Fee	Not Covered
	Resin-Based Composite, 3 Surfaces, Anterior	Discounted Fee	Not Covered
	Resin-Based Composite, 4+ Surfaces, Anterior	Discounted Fee	Not Covered
	Pulpotomy	Discounted Fee	Not Covered
	Root Canal Therapy, Anterior	Discounted Fee	Not Covered
	Root Canal Therapy, Bicuspid	Discounted Fee	Not Covered
	Root Canal Therapy, Molar	Discounted Fee	Not Covered
	Apicoectomy, Anterior	Discounted Fee	Not Covered
	Gingivectomy, Per Quad	Discounted Fee	Not Covered
	Osseous Surgery, Per Quad	Discounted Fee	Not Covered
	Scaling/Root Planing, Per Quad	Discounted Fee	Not Covered
	Routine Extraction	Discounted Fee	Not Covered
	Surgical Extraction	Discounted Fee	Not Covered
	Soft Tissue Impaction	Discounted Fee	Not Covered
	Partial Bony Impaction	Discounted Fee	Not Covered
	Full Bony Impaction	Discounted Fee	Not Covered
	Alveolectomy, Per Quad, w/Extraction	Discounted Fee	Not Covered
	Recementation Crown	Discounted Fee	Not Covered
	Recementation Bridge	Discounted Fee	Not Covered
	Stainless Steel Crown (Primary Tooth)	Discounted Fee	Not Covered
	Post and Core, Casted	Discounted Fee	Not Covered
	Palliative Treatment	Discounted Fee	Not Covered
Major	Porcelain with High Noble Metal Crown	Discounted Fee	Not Covered
	Complete Upper or Lower Denture	Discounted Fee	Not Covered
	Partial Upper or Lower Denture, Cast Base	Discounted Fee	Not Covered
	Broken Body of Denture	Discounted Fee	Not Covered
	Replacement of Broken/Missing Teeth	Discounted Fee	Not Covered
	Porcelain with High Noble Metal Pontic	Discounted Fee	Not Covered
	Porcelain with High Noble Metal Abutment	Discounted Fee	Not Covered
Orthodontics		Discounted Fee	Not Covered

In-Network PPO Copayments

You may select any dentist from the Mosaic Directory of Participating Providers. Some services are rendered without any cost, while others have a minimal copayment you pay directly to the dentist. All copayments are based on Healthplex's National Schedule of Allowances. Member copayments will vary based on the location of the provider seen at the time of care.

Out-of-Network Reimbursement

When services are received from an Out-of-Network dentist, you will be reimbursed up to the Maximum Out-of-Network reimbursement and you will be responsible for costs exceeding reimbursement.

This schedule of benefits 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.

Underwritten by:

Healthplex Insurance Company

Administered by

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