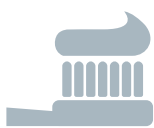


Dentcare Adult/Family (Individual)

Downstate Regions



Bring a smile to your face by joining Healthplex! Healthplex is happy to offer an affordable dental plan for your family. The **Dentcare Adult/Family** dental plan focuses on maintaining good oral health, and reducing dental and oral disease by providing all the Pediatric Dental Essential Health Benefits (EHB) mandated by NY State.



Highlights

- ◆ No deductible
- ◆ \$36 copayment per office visit
- ◆ Annual maximum out-of-pocket:
\$350 Individual
\$700 Family (for covered pediatric benefits only)
- ◆ No additional cost for covered services after your maximum out-of-pocket is met.



Network

- ◆ Over 1,800 provider access points in New York State.
- ◆ All care is provided by your own participating Primary Care Dentist (PCD).
- ◆ To view available dentists, visit healthplex.com/our-dentists and click “**New York State Health Exchange**”.



Coverage

- ◆ Coverage includes all mandated Pediatric Dental Essential Health Benefits in accordance with the Affordable Care Act (ACA).
- ◆ All fees for non-covered services are the patient's responsibility.
- ◆ In-Network coverage only

Monthly Premium

For all prospective members living in the following geographical regions:
New York City, Long Island, Westchester and Rockland counties.

Individual Adult	Individual & Spouse	Parent & Child(ren)	Family
\$11.00	\$22.00	\$28.84	\$39.84

FOR MORE INFORMATION

For New York State of Health Exchange information please call **1-855-355-5777**.

For plan benefit information call us at **1-888-468-1984** (M-F 8am-6pm)

SCHEDULE OF BENEFITS - PEDIATRIC INDIVIDUAL DENTAL

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non- Participating Provider Member Responsibility for Cost-Sharing
Deductible <ul style="list-style-type: none"> One (1) Member under age 19 Two (2) or More Members under age 19 Out-of-Pocket Limit <ul style="list-style-type: none"> One (1) Member under age 19 Two (2) or More Members under age 19 <p>Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit Accumulate on a calendar year ending on December 31 of each year.</p>	None None \$350 \$700	Non-Participating Provider services are not Covered except as required for Emergency Care as described in the Pediatric Dental Care section of this Policy.

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT & CARE	Participating Provider Member Responsibility for Cost-Sharing	Non- Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Emergency Dental Care Preventive Dental Care Routine Dental Care Endodontics Periodontics Prosthodontics Oral Surgery Orthodontics Orthodontia & Major Dental Require Preauthorization; Referral	Copayments \$36 \$36 \$36 \$36 \$36 \$36 \$36 \$36 Orthodontia & Major Dental Require Preauthorization; Referral	\$36 Non-Participating Provider services are not Covered except as required for Emergency Care as described in the Pediatric Dental Care section of this Policy.	One dental exam and cleaning per six (6)month period Full mouth X-rays or panoramic X-Rays at thirty-six (36) month intervals and bitewing X-rays at six (6) month intervals



SCHEDULE OF BENEFITS - ADULT/FAMILY INDIVIDUAL DENTAL

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non- Participating Provider Member Responsibility for Cost-Sharing
Deductible <ul style="list-style-type: none"> Individual Family Out-of-Pocket Limit <ul style="list-style-type: none"> Individual Family <p>Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit Accumulate on a calendar year ending on December 31 of each year.</p>	None None \$350 \$700	Non-Participating Provider services are not Covered except as required for Emergency Care as described in the Adult Dental Care section of this Policy.

ADULT DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non- Participating Provider Member Responsibility for Cost-Sharing	Limits
	Copayments		
Emergency Dental Care	\$36	\$36	One dental exam and cleaning per six (6)month period
Preventive Dental Care	\$36	Non-Participating Provider services are not Covered except as required for Emergency Care as described in the Adult Dental Care section of this Policy.	Full mouth X-rays or panoramic X-Rays at thirty-six (36) month intervals and bitewing X-rays at six (6) to twelve (12) month intervals
Routine Dental Care	\$36		
Endodontics	\$36		
Periodontics	\$36		
Prosthodontics	\$36		
Oral Surgery	\$36		

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under this Policy, You will be responsible for the full cost of the services.



NOTICE OF NON-DISCRIMINATION

Healthplex, Inc., complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age or sex. **Healthplex, Inc.** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthplex, Inc. provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Healthplex, Inc. at 1-888-468-1984. For TTY/TDD services, call 711.

If you believe that **Healthplex, Inc.** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthplex, Inc.** by:

Mail: 333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553-3608
Phone: 1-800-468-9868 (for TTY/TDD services, call 711)
Fax: 1-516-228-1734
In person: Same as Mailing Address (above)
Email: GA@healthplex.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web: Office for Civil Rights Complaint Portal at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>
Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-468-9868; TTY/TDD 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-468-9868 (TTY: 711).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 1-800-468-9868 (TTY: 711)。	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-800-468-9868) (TTY: 711).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 다 1-800-468-9868 (TTY: 711 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-468-9868 (телетайп: 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-468-9868 (TTY: 711).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-468-9868 (ATS : 711).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-468-9868 (TTY: 711).	French Creole
אויפֿמערקזאָם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פֿרײַ פֿון אפצאל. רופט 1-800-468-9868 (TTY: 711).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-468-9868 (TTY: 711).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-468-9868 (TTY: 711).	Tagalog
লক ঙ্গ ক যদি আপনি বা ল কথ্য বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন ক ১-৮০০-৪৬৮-৯৮৬৮ (TTY: ১-৭১১)।	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-468-9868 (TTY: 711).	Albanian
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-468-9868 (TTY: 711).	Vietnamese
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક તમારા માટે ઉપલબ્ધ ફોન કરો 1-800-468-9868 (TTY: 711).	Gujarati
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-468-9868 (TTY: 711).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ (کال کریں 1-800-468-9868) TTY: 711.	Urdu
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-468-9868 (TTY 711).	Portuguese
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-468-9868 (TTY: 711).	Thai
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मु त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-468-9868 (TTY: 711) पर कॉल करें।	Hindi
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-468-9868 (TTY: 711).	German