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, 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 whose 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 parents of the patient.

12. Services not listed in the Schedule of Benefits are not covered.

Limitations

1. Oral exams, bitewing x-rays, prophylaxes, scalings and fluoride treatments: Once every 6 months.

2. Full mouth and panoramic x-rays: Once every 36 months.

3. Crowns, bridges, dentures and periodontal surgery: 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 www.healthplex.com. For Groups: Prior to receiving any treatment, please obtain the Certificate of Insurance from your benefit administrator for Exclusions and Limitations. All benefits are governed by the provisions of your group's contract.

Plans using this network are underwritten by

DENTCARE
DELIVERY SYSTEMS, INC.

Select NY

Dental Health Maintenance Organization

Administered by
Healthplex, Inc.
333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608
www.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, Cleanings and X-rays
- No Deductibles
- Fixed Copayments at Specialty Providers
- No Referrals Required

In this managed care program, you must choose a family dentist from the Select Directory of Participating Providers. You and your dependents will receive all treatment by this dentist or by a Select Participating Specialist. Some services are rendered without any cost, while others have a minimal copayment that you pay directly to the dentist.

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

Do you have questions? Are you interested in enrolling?
Please call our Sales Department at 1-800-468-0466
or visit www.healthplex.com

Are you already a member?
Please call our Customer Service Department
at 1-800-468-0600 or visit www.healthplex.com

All dentists in our network are credentialed by Healthplex, a Credentials Verification Organization certified by the National Committee for Quality Assurance for 10 out of 10 credentialing services. We conduct site visits to ensure all offices are well equipped, adequately staffed and are following proper sterilization techniques.

Schedule of Benefits

Procedure	Patient Copayment
Diagnostic & Preventive Services	
Oral Exam	No Charge
Full Mouth X-rays	No Charge
Single Films	No Charge
Bitewing Series	No Charge
Cleaning of Teeth *(scaling and polishing)*	No Charge
Fluoride Treatment	No Charge
Emergency Treatment	No Charge
Restorative Dentistry	
Silver Amalgam, 1 Surface	$20.00
Silver Amalgam, 2 Surfaces	$35.00
Silver Amalgam, 3 Surfaces	$50.00
Composite Filling, 1 Surface	$25.00
Composite Filling, 2 Surfaces	$40.00
Composite Filling, 3 or more Surfaces	$55.00
Oral Surgery	
Routine Extraction, Per Tooth	$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	$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
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/Acrylic	$395.00
Partial Lower Denture, Cast Base/Acrylic	$395.00
Prosthetics - Repairs	
Broken Body of Denture *(no teeth involved)*	$95.00
Replacing Broken/Missing Teeth	$35.00
Office Reline	$95.00
Lab Reline	$150.00
Orthodontics	
Case Fee - 24 Months	$2,910.00