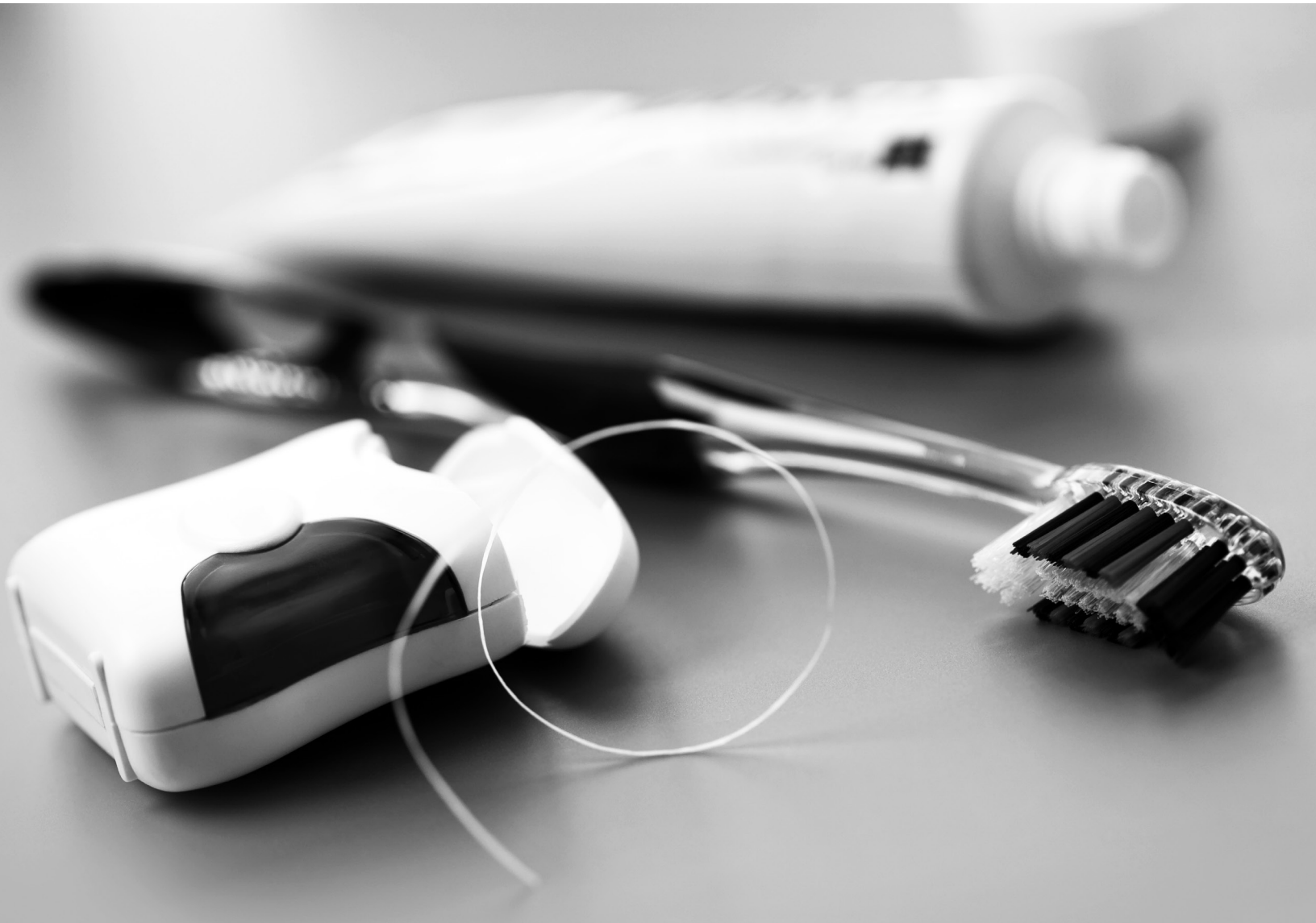
EmblemHealth®

TWU Local 100 Premier Dental Plan



For the most up-to-date listings of participating dentists, sign in to your member portal at **my.emblemhealth.com** and select "Find Care." If you have any questions, call the Customer Service number on your ID card and let us know.

TWU Local 100 Premier Dental Plan

This dental plan gives you quality coverage with access to over 13,500* dentists and specialists in New York and New Jersey. You can choose a network dentist or specialist for services covered under your plan. You don't have to pick a specific primary care dentist.

Dependent Coverage: With this dental plan, you can cover your children until the end of the month they turn 26. Children can be covered for orthodontic services as long as they start treatment by the end of the month they turn 26.

Predetermination of Benefits: EmblemHealth can let you know what dental services and materials will be paid for before you start treatment. You may ask your dentist to send a Treatment Plan to EmblemHealth before you get oral surgery, prosthetics, or appliances. EmblemHealth will review the Treatment Plan and give you and your dentist an estimate of what is covered. **Please note:** Predetermination of Benefits is not required, but it is strongly suggested.

The following are some examples of services that are not covered:

- Cosmetic surgery and treatment unless it is reconstructive surgery caused by trauma, infection, or disease of the involved part.
- Prescription drugs and medicines.
- Services and appliances for the treatment of temporomandibular joint (TMJ) dysfunction.
- Transplantations.

Annual Maximum: $2,000 individual / $4,000 family when you visit a dentist in or out of our network. This is the maximum dollar amount your dental plan will pay toward the cost of dental care during your plan year. You are personally responsible for paying costs above the annual maximum. Orthodontia is not subject to the annual maximum.

Lifetime Orthodontic Maximum: Lifetime Orthodontic Maximum: $4,000 In-network; $2,000 Out-of-network. This is the maximum dollar amount your dental plan will pay toward the cost of orthodontic dental care per person per lifetime. You are personally responsible for paying costs above the lifetime maximum. Orthodontia benefits are available only to covered children under the age of 26.

<table>
<tr><th>BENEFITS</th><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th></tr>
<tr><td colspan="3">Type A – Preventive and Diagnostic Services</td></tr>
<tr><td>Base Coverage Level</td><td>EmblemHealth will pay 100% of the Preferred Premier Schedule of Allowances for covered services when you see a Preferred Premier Dentist or Specialist.</td><td>EmblemHealth will pay 100% of Spectrum fee schedule for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.</td></tr>
<tr><td>Examinations – 2 periodic exams per each person on the plan per calendar year. 1 comprehensive examination per dentist, per lifetime.</td><td rowspan="3">Covered
You don't have to pay for these covered services.</td><td rowspan="3">You may have to pay for some of your bill. See above for details.</td></tr>
<tr><td>Prophylaxes (Cleanings) – 2 per person on the plan per calendar year.</td></tr>
<tr><td>X-Rays – 4 bitewing x-rays per person on the plan per calendar year.
• 1 full-mouth series of x-rays or 1 panoramic film per person on the plan once every 3 years.
If the benefit limit is exceeded and a medically necessary pre-operative film is needed to diagnose dental disease or injury:
• 1 additional panoramic film every 3 years if performed by an oral surgeon.
• 1 additional bitewing film for posterior teeth, or 1 additional periapical every calendar if performed by a specialist.
You are responsible to pay for all additional films that are more than the original and supplemental benefit.</td></tr>
</table>

NOTE: *This is not a complete benefit comparison or a contract and should only be viewed as a brief summary to assist you in understanding this EmblemHealth benefit program. A detailed benefits description, including limitations and exclusions, is contained within the Certificate of Insurance. The terms, conditions, limits, and exclusions shown in the Certificate of Insurance shall govern.*

* As of September 2024

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type A – Preventive and Diagnostic Services (Continued)		
Fluoride Treatments – 1 per person on the plan per calendar year. For children, this benefit applies until the end of the month they turn 26.	**Covered** You don't have to pay for these covered services	**You may have to pay for some of your bill. See above for details.**
Space Maintainers – 1 per each child on the plan per lifetime. Coverage provided until the end of the month the child turns 26.		
Athletic and Occlusal Mouth Guards – One (1) mouth guard per lifetime per covered child up to age 26 end of month. Occlusal guards may be covered for member and eligible dependent(s) requires pre-authorization.		
Sealants – One (1) sealant per covered tooth every three (3) calendar years per covered child age 6 until age 14 birthdate.		
Type B – Basic Services		
Base Coverage Level	**EmblemHealth will pay 100% of the Preferred Premier Schedule of Allowances for covered services when you see a Preferred Premier Dentist or Specialist.**	**EmblemHealth will pay 100% of Spectrum fee schedule for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.**
Simple Extractions	**Covered** You don't have to pay for these covered services.	**You may have to pay for some of your bill. See above for details.**
Basic Restorations (Fillings)		
Endodontics (Root canal therapy) • Pulpotomy covered once per tooth, per lifetime. Pulp capping covered as part of root canal.		
Periodontics (Treatment of diseases of the gum and jaw) • 5 periodontal treatments per person on the plan per calendar year including three (3) periodontal maintenance procedures, with one additional treatment if medically necessary. • 1 type of periodontal surgery and/or 1 graft per quadrant.		
Oral Surgery (Surgical removal of an erupted tooth) • Your plan will pay for x-rays taken for surgery, local anesthesia, and post-operative care. • Your plan will pay for surgery on fractured jaws, impactions, lesions in and around the mouth, and reimplantations. • Some types of oral surgery may be covered under your medical plan, not this dental plan.		
Anesthesia & IV Sedation – Your plan will pay for general anesthesia and IV sedation for covered services. Charges for local anesthesia are included in the allowance for the dental procedure. No separate allowance for local anesthesia. Analgesia and monitoring devices will not be paid for by your plan.		
Palliative Services (Relief of pain) • Emergency services covered		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Type B – Basic Services (Continued)		
Repair of Appliances • Replacement of broken teeth or clasps, recementation of inlays, crowns, bridges, and space maintainers. Replacement of broken facings.	**Covered** You don't have to pay for these covered services.	**You may have to pay for some of your bill. See above for details.**
Tests and Laboratory Exams – Biopsy and examination of oral tissue.		
Type C – Major Services		
Base Coverage Level	**EmblemHealth will pay 100% of the Preferred Premier Schedule of Allowances for covered services when you see a Preferred Premier Dentist or Specialist.**	**EmblemHealth will pay 100% of Spectrum fee schedule for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.**
Implants – One (1) surgical implant per year.	**Covered** You don't have to pay for these covered services.	**You may have to pay for some of your bill. See above for details.**
Fixed and Removable Prosthetics – Both temporary and permanent dentures, removable and fixed partial dentures, full or partial, repair. **Major Restoration** – Includes crowns, related post and core procedures, and inlays. • Your plan will pay for replacement or substitution of appliances only after 5 years have passed since appliance was inserted. • Your plan will pay for crowns or pontics for attachment or clasp purposes only if tooth cannot be restored by fillings. • When a fixed bridge and partial denture are inserted in the same arch, your plan will only pay for the partial denture unless 5 years have passed since prior insertion of the fixed bridge or partial denture. • No separate allowance for temporary service or appliance. • Your plan will pay for posts only if there is evidence of root canal on the tooth. • Charges for cementation of crown/inlay are included in allowance for the crown/inlay.		
Type D – Orthodontics		
Orthodontic Base Coverage Level Up to twenty -four (24) months of treatment covered, up to lifetime maximum benefit allowance including one (1) upper and one (1) lower retainer post-orthodontic treatment.	**Covered** You don't have to pay for these covered services.	**Covered up to the $2,000 lifetime maximum benefit for covered services.** You are responsible for paying the difference between what EmblemHealth pays and what the dentist charges.

Refer to Policy Forms PLD-1104-C and PLD-1103-C

Underwritten by EmblemHealth Plan, Inc., refer to policy form EHPI-PLD-1103, et al.

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

EmblemHealth®

Dental Enrollment Form

EMPLOYER INFORMATION

Group Name (Group Number)	Effective Date (Required)
☐ TWU Local 100 (1141809 1001) ☐ Liberty Lines/Westchester (1141809 1003)	

MEMBER INFORMATION

BSC# (ID#)	Social Security Number (optional)	
Last Name	First Name	M.I.
Address		Apt
City	State	ZIP Code
Home Phone	Email Address	Gender / D.O.B.
Other Dental Coverage ☐ Yes ☐ No	Name of other plan (if applicable)	

MEMBER MARITAL STATUS

☐ Single ☐ Domestic Partner ☐ Married ☐ Divorced/Widow

DEPENDENTS TO BE COVERED – Spouse/Domestic Partner and Dependent Children (covered up to their 26th birthday).

Dependent (Last Name, First Name)	Date of Birth (DOB)	Gender	Social Security Number (optional)	Relationship to Member

In order for TWU Local 100 to complete the processing of your benefits, you must provide us with copies of the following documents:

- Marriage certificate for spouse
- Social Security cards for all dependents
- Birth certificate for all dependents
- Adoption/Legal Guardianship papers for dependent children

By signing below, I affirm that I am employed by the above-referenced employer/group. I understand that my employer is responsible for the payment of monthly premium due to EmblemHealth Plan, Inc. for dental coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any act material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed a thousand dollars and stated value of the claim for each violation.

Member Signature	Date

Return completed form to:

Transport Workers Union, Local 100
149 Pierrepont Street, Room 1.100
Brooklyn, N.Y 11201

Email: **member.services@twulocal100.org** -or- Fax: **347-916-0629**

PRINT RESET

EMB_PR_FRM_66963_TWU_DentalOptionEnrollmentForm 10/24

EmblemHealth®

Member/Dependent Change Form

MEMBER INFORMATION

Member Name		
Member BSC# (ID#)	EmblemHealth K ID#	Effective Date of Indicated Change (Required)

TYPE OF CHANGE

☐ Termination (Check box and sign.)	☐ Name Change (Go to section A.)	☐ Address Change (Go to section B.)	☐ Add or remove Dependant (Go to section C.)	☐ Reinstatement

A. CHANGE OF NAME

Last Name	First Name	M.I.
Address		Apt #
City	State	Zip Code	Phone Number

B. CHANGE OF ADDRESS

Address	Apt #
City	State	ZIP

C. CHANGE DEPENDENTS – Spouse/domestic partner and dependent children (covered up to their 26th birthday).

☐ Add Dependents ☐ Remove Dependents ☐ Reinstate Dependents

Dependent (Last Name, First Name)	Date of Birth (DOB)	Social Security Number (optional)	Gender	Relationship to Member	Reason and Date of Occurrence
Dependent (Last Name, First Name)	Date of Birth (DOB)	Social Security Number (optional)	Gender	Relationship to Member	Reason and Date of Occurrence
Dependent (Last Name, First Name)	Date of Birth (DOB)	Social Security Number (optional)	Gender	Relationship to Member	Reason and Date of Occurrence
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In order for TWU Local 100 to complete the processing of your benefits, you must provide us with copies of the following documents:

- Marriage certificate for spouse
- Social Security cards for all dependents
- Birth certificate for all dependents
- Adoption/Legal Guardianship papers for dependent children

☐ I hereby apply to change my insurance coverage and/or records, as set forth herein.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any act material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed a thousand dollars and stated value of the claim for each violation.

Member Signature	Date

Return completed form to:

Transport Workers Union, Local 100
149 Pierrepont Street, Room 1.100
Brooklyn, N.Y 11201

PRINT RESET