

**ATTACHMENT TO NEW YORK STATE DENTAL PLAN CERTIFICATE OF  
INSURANCE FOR NEW YORK STATE POLICE BENEVOLENT ASSOCIATION OF  
THE NEW YORK STATE TROOPERS, INC. FOR THE UNIT OF COMMISSIONED  
AND NON-COMMISSIONED OFFICERS IN THE DIVISION OF STATE POLICE (PBA  
SUPERVISORS)**

This Attachment provides important information about Your dental insurance. The State of New York, pursuant to a collective bargaining agreement with **New York State Police Benevolent Association of the New York State Troopers Inc. for the unit of Commissioned and Non-commissioned Officers in the Division of State Police**, has entered into a Group Contract with EmblemHealth Plan, Inc. (“EmblemHealth”) to provide You and Your covered family members with dental insurance.

This Attachment together with the Certificate of Insurance are evidence of Your coverage under the Group Contract. This Attachment sets forth the dental services that We will cover. It sets forth any dollar maximums that apply to Your coverage. It tells You the cost-sharing (i.e. deductible, coinsurance and/or copayment), if any, and reimbursement terms that apply to covered services that You receive from Participating Providers and Non-Participating Providers. It also provides eligibility information about certain types of dependents. Coverage is subject to all terms, conditions, limitations, and exclusions contained in the Certificate of Insurance and this Attachment.

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**ELIGIBILITY:**

<b>Spouse:</b>	Eligible for Coverage
<b>Domestic Partner:</b>	Eligible for Coverage
<b>Children:</b>	Eligible for coverage until the end of the month in which they reach age 19.
<b>Dependent Students:</b>	Eligible for coverage until the earlier of: the end of the month in which they reach age 25 or the last day of the month following a 3-month extension of benefits after the completion of a semester.

Contact Your Health Benefits Administrator for more information on coverage for disabled dependents, military service credits, and for detailed eligibility and enrollment guidelines.

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**BENEFIT WAITING PERIOD:**

You must be employed in an eligible position for 56 days before this plan will pay any dental benefits. This waiting period is determined by Your employer.

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**PROVIDER NETWORK:** Preferred Premier Network

The provider network is a group of providers with whom EmblemHealth has contracted to provide covered services under this Certificate on an in-network basis. These providers are called Participating Providers. The provider network that applies to this Certificate is named above.

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**ANNUAL DEDUCTIBLE(S):** None

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**ANNUAL MAXIMUM:** EmblemHealth will not pay more than \$3,000 per person per calendar year for covered services under this Policy. Orthodontic Services count toward the Annual Maximum.

**ORTHODONTIC  
SERVICES LIFETIME  
MAXIMUM:**

A Lifetime Maximum applies to Orthodontic Services. EmblemHealth will not pay more than \$3,000 per child, per lifetime for covered Orthodontic Services under this Policy. Orthodontic Services count toward the Annual Maximum.

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**TYPE A –**  
**PREVENTIVE & DIAGNOSTIC SERVICES:**

Preventive and Diagnostic  
Services Received from

Preferred Premier  
Participating Providers:

After You meet the annual deductible, if any, EmblemHealth pays 100% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Preventive and Diagnostic Services.

After You meet the annual deductible, if any, You pay 0% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Preventive and Diagnostic Services.

Preventive and Diagnostic  
Services Received from  
Non-Participating Providers:

After You meet the annual deductible, if any, EmblemHealth reimburses You 100% of the Preferred Schedule of Allowances for covered Preventive and Diagnostic Services.

After You meet the annual deductible, if any, You pay 0% of the Preferred Schedule of Allowances for covered Preventive and Diagnostic Services.

You are responsible to pay the difference between EmblemHealth's reimbursement and the Non-Participating Provider's charge.

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**TYPE B –**  
**BASIC SERVICES:**

Basic Services  
Received From EmblemHealth

Preferred Premier  
Participating Providers:

After You meet the annual deductible, if any, EmblemHealth pays 100% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Basic Services.

After You meet the annual deductible, if any, You pay 0% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Basic Services.

Basic Services  
Received From  
Non-Participating Providers:

After You meet the annual deductible, if any, EmblemHealth reimburses You 100% of the Preferred Schedule of Allowances for covered Basic Services.

After You meet the annual deductible, if any, You pay 0% of the Preferred Schedule of Allowances for covered Basic Services.

You are responsible to pay the difference between EmblemHealth's reimbursement and the Non-Participating Provider's charge.

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**TYPE C –**  
**MAJOR SERVICES:**

Major Services  
Received From EmblemHealth

Preferred Premier  
Participating Providers:

After You meet the annual deductible, if any, EmblemHealth pays 100% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Major Services.

After You meet the annual deductible, if any, You pay 0% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Major Services.

Major Services Received from  
Non-Participating Providers:

After You meet the annual deductible, if any, EmblemHealth reimburses You 100% of the Preferred Schedule of Allowances for covered Major Services.

After You meet the annual deductible, if any, You pay 0% of the Preferred Schedule of Allowances for covered Major Services.

You are responsible to pay the difference between EmblemHealth's reimbursement and the Non-Participating Provider's charge.

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**TYPE D –  
ORTHODONTIC  
SERVICES:**

Orthodontic Services  
Received From EmblemHealth

Preferred Premier  
Participating Providers:

EmblemHealth pays 100% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Orthodontic Services.

You pay 0% of the Preferred Premier Schedule of Allowances to the Participating Provider for covered Orthodontic Services.

Orthodontic Services  
Received from  
Non-Participating Providers:

EmblemHealth reimburses You 100% of the Preferred Schedule of Allowances for covered Orthodontic Services.

You pay 0% of the Preferred Schedule of Allowances for covered Orthodontic Services.

You are responsible to pay the difference between EmblemHealth's reimbursement and the Provider's charge.

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### **SPECIAL COVERAGE LIMITS:**

In addition to the other terms, conditions and limits set forth in this Attachment and the Certificate of Insurance, the following additional coverage limits apply to the covered dental services noted below:

#### Prophylaxes

Coverage Limit: EmblemHealth will cover 2 prophylaxes per person per calendar year. Please refer to the Certificate of Insurance for other terms and limits that apply to Prophylaxes.

#### Examinations

Coverage Limit: EmblemHealth will cover 2 examinations per person per calendar year. Please refer to the Certificate of Insurance for other terms and limits that apply to Examinations.

#### Implant Services

Coverage Limit: EmblemHealth will not pay more than \$600 toward the surgical placement of an implant body. Please refer to the Certificate of Insurance for other terms and limits that apply to Implant Services.

Orthodontic Appliance Limit: EmblemHealth provides a one-time benefit of \$550 for the insertion of an orthodontic appliance.

#### Orthodontic Passive

Retention Coverage Limit: EmblemHealth provides a one-time benefit of \$108 for orthodontic retention. Construction of retainers is not covered. Please refer to the Certificate of Insurance for other terms and limits that apply to Orthodontic Services.

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