

Healthfirst Pro EPO Dental Benefits

Your family gets access to pediatric dental care.



Dental coverage for children up to age 19

Preventive Care

- Teeth cleaning and polishing every six months
- Topical fluoride application every six months

Routine Care

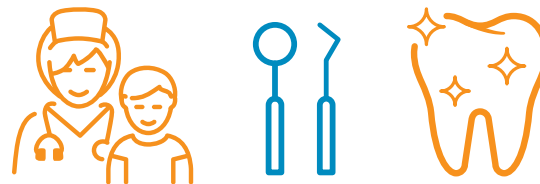
- Dental exams and X-rays every six months
- Fillings (metal and composite)
- Crowns (porcelain, ceramic, and stainless steel)

Emergency Dental Care

- Immediate treatment to ease pain and suffering caused by dental disease or trauma

Major Dental Care

- Teeth scaling and root planing (periodontic services)
- Root canals (endodontic services where hospital stay is not required)
- Complete or partial dentures, plus six months of follow-up care (prosthodontics)
- Orthodontia*



Example of how dental benefits work for Pro EPO plans

Your son or daughter is covered under your Platinum Pro EPO plan. During their yearly dental checkup and cleaning, the dentist needs to take X-rays. The plan has a \$0 medical deductible, so you pay only a \$20 copay for the exam, cleaning, and X-rays.

Health insurance terms you should know:

DEDUCTIBLE – The total annual amount you must pay before your plan will begin to pay for covered services. (Please note that your plan will always pay for services marked “deductible does not apply.”)

COPAY – The fixed amount you will pay for a covered service after you have met your deductible.

COINSURANCE – The percentage of cost that you will pay for a covered service after you have met your deductible.

	Platinum	Silver	Silver 45/75/4300	Bronze 6850 (HSA Compatible)
Deductible (Individual/Family)	\$0/\$0	\$4,300/\$8,600	\$4,300/\$8,600	\$6,850/\$13,700
Preventive Care	\$20 copay	\$35 copay	\$45 copay	0% coinsurance**
Routine Dental Care	\$20 copay	\$35 copay**	\$45 copay**	0% coinsurance**
Major Dental Care	10% coinsurance	40% coinsurance**	40% coinsurance**	0% coinsurance**

*Orthodontia is covered only if medically necessary.

**After deductible is met.

Healthfirst Pro EPO Vision Benefits

Your family gets access to **pediatric vision care.**



Vision coverage for children up to age 19

- **Vision Exam (every 12 months)**
 - Full exam inside and outside of eyes
 - Color vision testing
 - Recommendation for glasses or contacts, if necessary
- **Glasses or Contact Lenses (every 12 months)**
 - One pair of frames and lenses with UV, anti-reflective, anti-scratch, and/or tinted coating
 - A supply of conventional or disposable contact lenses
 - **\$130 yearly allowance** to use on eyeglass frames or contact lenses



Example of how vision benefits work for Pro EPO plans

Your son or daughter is covered under your Platinum Pro EPO plan. When they go in for their annual vision exam, you find out they need glasses. You pay a \$10 copay for the eye exam, a \$25 copay for the lenses, and you have a choice of frames. Collection frames have either a \$0 or \$25 copay, while non-collection (retail) frames from in-network locations come with a \$130 allowance and a 20% discount after that allowance.

If you have any questions, please call **Member Services at 1-855-789-3668 (TTY 1-855-779-1033), Monday to Friday, 8am–6pm.**

	Platinum	Silver	Silver 45/75/4300	Bronze 6850 (HSA Compatible)
Deductible (Individual/Family)	\$0/\$0	\$4,300/\$8,600	\$4,300/\$8,600	\$6,850/\$13,700
Vision Exams	\$10 copay	\$10 copay	\$10 copay	0% coinsurance**
Eyeglass Lenses, Frames, & Contact Lenses*	\$25 copay	\$25 copay	\$25 copay	0% coinsurance**

*A \$130 allowance applies to eyeglass frames or contact lenses; copay applies to contact lens fitting.

**After deductible is met.

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, "Healthfirst").

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Healthfirst Pro Plus EPO Dental Benefits

You get access to both **pediatric** and **adult** dental care.



Dental Coverage

Preventive Care

- Teeth cleaning and polishing every six months
- Topical fluoride application every six months

Routine Care

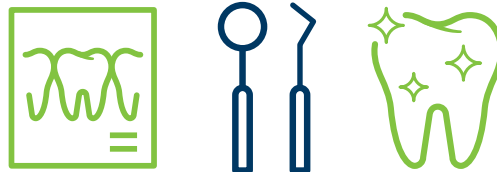
- Dental exams and X-rays every six months
- Fillings (metal and composite)
- Crowns (porcelain, ceramic, and stainless steel)

Emergency Dental Care

- Immediate treatment to ease pain and suffering caused by dental disease or trauma

Major Dental Care

- Teeth scaling and root planing (periodontic services)
- Root canals (endodontic services where hospital stay is not required)
- Complete or partial dentures, plus six months of follow-up care (prosthodontics)
- Orthodontia*



Example of how our dental benefits work

Mary has a Platinum Pro Plus EPO plan. During her yearly dental checkup and cleaning, her dentist tells her she needs X-rays. Mary has a deductible of \$0, so she pays only a \$20 copay for her exam, cleaning, and X-rays.

Health insurance terms you should know:

DEDUCTIBLE – The total annual amount you must pay before your plan will begin to pay for covered services. (Please note that your plan will always pay for services marked “deductible does not apply.”)

COPAY – The fixed amount you will pay for a covered service after you have met your deductible.

COINSURANCE – The percentage of cost that you will pay for a covered service after you have met your deductible.

	Platinum	Gold 1350	Silver	Silver 45/75/4300	Bronze 6850 (HSA Compatible)
Deductible (Individual/Family)	\$0/\$0	\$1,350/\$2,700	\$4,300/\$8,600	\$4,300/\$8,600	\$6,850/\$13,700
Preventive Care	\$20 copay	\$25 copay	\$35 copay	\$45 copay	0% coinsurance**
Routine Dental Care	\$20 copay	\$25 copay	\$35 copay**	\$45 copay	0% coinsurance**
Major Dental Care	10% coinsurance	20% coinsurance**	40% coinsurance**	40% coinsurance**	0% coinsurance**

*Orthodontia is covered only if medically necessary.

**After deductible is met.

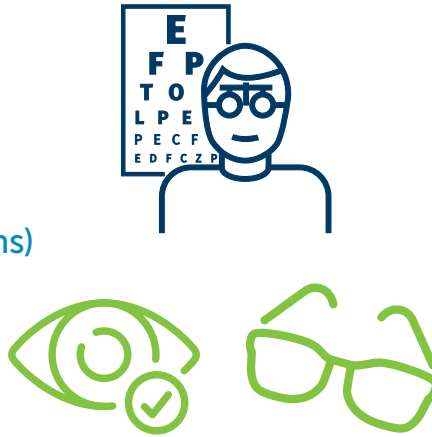
Healthfirst Pro Plus EPO Vision Benefits

You get access to both **pediatric and adult vision care.**



Vision Coverage

- **Vision Exam (every 12 months)**
 - Full exam inside and outside of eyes
 - Color vision testing
 - Recommendation for glasses or contacts, if necessary
- **Glasses or Contact Lenses (every 12 months)**
 - One pair of frames and lenses with UV, anti-reflective, anti-scratch, and/or tinted coating
 - A supply of conventional or disposable contact lenses
 - **\$130 yearly allowance** to use on eyeglass frames or contact lenses



Example of how our vision benefits work

Michael has a Platinum Pro Plus EPO plan. When he went to his eye doctor for his annual vision exam, he found out he needed glasses. He pays a \$10 copay for his eye exam, a \$25 copay for his lenses, and has his choice of frames. Collection frames have either a \$0 or \$25 copay, while non-collection (retail) frames from in-network locations come with a \$130 allowance and a 20% discount after that allowance.

If you have any questions, please call **Member Services at 1-855-789-3668 (TTY 1-855-779-1033), Monday to Friday, 8am–6pm.**

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Deductible (Individual/Family)	\$0/\$0	\$1,350/\$2,700	\$4,300/\$8,600	\$4,300/\$8,600	\$6,850/\$13,700
Vision Exams	\$10 copay	\$10 copay	\$10 copay	\$10 copay	0% coinsurance**
Eyeglass Lenses, Frames, & Contact Lenses*	\$25 copay	\$25 copay	\$25 copay	\$25 copay	0% coinsurance**

*A \$130 allowance applies to eyeglass frames or contact lenses; copay applies to contact lens fitting.

**After deductible is met.

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