DENTAL PLAN BENEFITS
NHTA

DENTAL PLAN

1. **Calendar Year** – January 1 through December 31

2. **Eligibility Period -** First day of the month following completion of 1 month of continuous employment

3. **Eligible Persons** – Full-time Employees, their spouses and dependent children are covered under this plan. Children will be covered beginning the first of the month following their 2nd birthday and may remain covered until their 19th birthday; unmarried dependent children who are full-time students are covered until their 25th birthday.

4. **Selected Benefits & Percentage Paid By Delta** –

Coverage A - Diagnostic & Preventive	100%
Coverage B – Restorative	80%
Coverage C – Prosthodontics and Orthodontics	50%

5. **Maximum Contract Year Benefit** - The maximum amount which your plan will pay is $1,000.00 per person per Calendar Year. Any expense incurred during the last 3 months of a calendar year which is applied against an individual's deductible will also reduce his/her deductible for the next year.

6. **Deductible -** There is a $25.00 deductible per person per Calendar Year, applied to Coverage C services only.

7. **Contribution** – There will no contribution on the part of the employee for employee (and dependent) coverage.

COVERAGE A BENEFITS

Diagnostic:

Evaluations to determine required dental treatment

Limited oral evaluation

Comprehensive oral evaluation – one complete comprehensive evaluation per specialist or general Dentist in a lifetime.

Periodic evaluation – once in any period of six (6) consecutive months. This can be by a specialist or a general Dentist.

Preventive:

Specific procedures employed to prevent the occurrence of dental disease

Prophylaxis (cleaning) – once in any period of six (6) consecutive months (child prophylaxis up to thirteenth (13) birthday; adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance procedures (Coverage B).

Fluoride treatment – once in any period of twelve (12) consecutive months up to eighteenth (18) birthday

Space Maintainers

Sealants

NOTE: The time limitation will be measured from the date the service was last performed.

COVERAGE B BENEFITS

Diagnostic:

Radiographs (x-rays) – complete series or panoramic film once in any period of three (3) consecutive years; bitewing films (x-rays) once in any period of six (6) consecutive months; films (x-rays) of individual teeth as necessary.

Palliative Treatment:

Minor treatment for the relief of pain

Restorative:

Amalgam (silver) and/or resin (white) restorations. Resin restorations are a benefit on anterior teeth only.

Endodontics:

Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy

Periodontics:

Treatment of diseased tissue supporting the teeth and periodontal maintenance procedures.
Prophylaxis (cleaning) – once (1) in any period of six (6) consecutive months. This can be a routine prophylaxis or a full mouth debridement (Coverage A) or periodontal maintenance procedures (Coverage B).

Oral Surgery:

Extractions and covered surgical procedures

Injection Drugs

Denture Repair:

Repair of removable denture

Denture Rebase And Reline:

Rebase and Reline of complete and partial dentures

Crown and Fixed Partial Denture Repair:

Repair of crown or fixed partial denture to its original condition

Anesthesia:

General anesthesia administered in conjunction with an extraction, tooth reimplantation, surgical exposure of the tooth, biopsy, transseptal, fiberotomy, alveoloplasty, vestibuloplasty, incision and drainage of an abscess, and/or frenulectomy.

General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients:

(a) A child under the age of four (4) who is determined by a licensed Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or

(b) A person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.

NOTE: The time limitation will be measured from the date the service was last performed.

COVERAGE C BENEFITS

Restorative Crowns and Onlays:

Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations

Prosthodontics:

Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures; core buildups; cast and prefabricated post and cores; and precision attachments.

Implant Supported Prosthetics

Orthodontics

Limited to dependent children and eligible students. $1,200 lifetime maximum.

NOTE: The time limitation will be measured from the date the service was last performed.

GENERAL EXCLUSIONS AND LIMITATIONS

The dental benefits provided by the dental benefit administrator shall not include the following:

a. Services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws.

b. Services that are determined by the dental benefit administrator to be rendered for cosmetic reasons, or to correct congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)

c. Services including, but not limited to, endodontics and prosthodontics (including crowns and removable and fixed dentures), started prior to the date the Subscriber or Dependent became eligible under the Agreement.

d. Prescription drugs, premedications, and/or relative analgesia.

e. Charges for hospitalization, general anesthesia for restorative dentistry (except as noted in Section III. Coverage B Benefits), preventive control programs, periodontal splinting, myofunctional therapy, treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures, equilibration, and gnathological reporting.

f. Charges for failure to keep a scheduled visit with the Dentist.

g. Charges for completion of forms. Such charges shall not be made to a Subscriber or Dependent by Participating Dentists.

h. Dental Care that is not necessary and customary as determined by generally accepted dental practice standards.

i. Dental Care or supplies that are not within the classification of benefits defined in the Agreement.

j. Appliances, procedures, or restorations for: (a) increasing vertical dimension; (b) altering, restoring, or maintaining occlusion; (c) replacing tooth structure lost by attrition or abrasion; (d) correcting congenital or developmental malformations; (e) esthetic purposes; or (f) implantology techniques.

k. Payments of benefits for the Subscriber and/or Dependent(s) terminate on the last day of the month after the date on which the Subscriber becomes ineligible for benefits.

l. Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.

m. Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to act of war, declared or undeclared.

n. Temporary services.

o. A consultation unless performed by a practitioner who is not performing further services.

p. Case presentation and treatment planning. Patient will be responsible for any additional fee.

q. Athletic mouthguards and occlusal guards (night guards).

r. Pulp vitality tests.

s. Incomplete treatment.

Please note: This benefit summary describes some of the benefits, terms of coverage and exclusions under your dental plan. A complete description of the benefits, terms of coverage, exclusions and limitations is provided in the Dental Plan Description.