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## SCHEDULE OF DENTAL BENEFITS

### Active Covered Members and Dependents

COVERED EXPENSES	DEDUCTIBLE	COPAYMENT	MAXIMUM BENEFITS
<p><b>Preventive and Diagnostic Dental Care</b></p> <p>Periodic oral exams - twice in any calendar year</p> <p>Emergency treatment for pain</p> <p>Routine cleaning and scaling - twice in any calendar year</p> <p>Topical fluoride application - twice in any calendar year, up to age 19</p> <p>X-rays</p> <ul style="list-style-type: none"> <li>- Bitewing series - one set each in any calendar year</li> <li>- Full mouth or panoramic series - one set each in any 36-month period</li> </ul> <p>Space maintainers (nonorthodontic) for Covered Dependents up to age 14</p> <p>Sealants - one per unrestored permanent molar and bicuspids per lifetime for Covered Dependents up to age 19</p> <p>Consultations</p> <p>X-rays of individual teeth - as necessary</p>	NONE	The Plan pays 100% of the Usual and Customary Charge.	UNLIMITED
<p><b>Basic Dental Care</b></p> <p>Fillings</p> <p>Routine extraction</p> <p>Oral surgery, including general anesthesia when medically necessary</p> <ul style="list-style-type: none"> <li>- surgical removal of erupted teeth or impacted or unerupted teeth</li> <li>- incision and drainage of abscess</li> <li>- alveolectomy</li> <li>- alveoplasty with ridge extension</li> </ul> <p>Periodontics - subgingival curettage or root planning and scaling; gingivectomy; osseous surgery with flap entry and closure</p> <p>Endodontics - pulp capping; root canal treatment; apicoectomy</p> <p>Stainless steel crowns - for Covered Dependents up to age 12</p>	\$25 per individual per calendar year, subject to a maximum of \$50 per family. The family Deductible may be satisfied by any combination of covered family members.	Benefits are paid up to the maximum shown on the Dental Fee Schedule, Less the applicable dental plan deductible.	Calendar year maximums apply to the following benefits: <b>Periodontics</b> \$1,000 per individual <b>Prosthodontics</b> \$1,000 per individual.
<p><b>Major Dental Care</b></p> <p>Inlays</p> <p>Onlays</p> <p>Crowns</p> <p>Pontics</p> <p>Fixed or removable bridgework</p> <p>Full and partial dentures</p> <p>Denture repairs (including the addition of a tooth or teeth to an existing denture.)</p> <p>Recement bridge</p>			
<p><b>Orthodontic Care</b></p> <p>Comprehensive full-banded treatment</p> <p>Appliances for tooth guidance - one appliance per individual</p> <p>Retention appliances - one appliance per individual</p> <p>Benefits are payable at the time treatment begins. The full orthodontic benefit will be paid at the time of banding.</p>	NONE	The Plan pays 75% up to the \$1,500 lifetime maximum	Separate \$1,500 lifetime maximum benefit per individual

**IMPORTANT NOTES:**

1. Any non-emergency prosthodontic, periodontic or orthodontic treatment in excess of \$250 should be submitted for pre-determination of benefits.
2. Gold restorations (fillings, inlays, onlays and crowns) are covered only if teeth cannot be restored with a less expensive filling material or if the tooth is an abutment to a covered partial denture or fixed bridge.
3. Members must be covered for at least six consecutive months to be eligible for Orthodontic Care.
4. Benefits will be provided for the replacement of teeth missing prior to the effective date of coverage

## **insert fee schedule**

## **insert fee schedule**

## **insert fee schedule**

# COVERED DENTAL EXPENSES

Your Dental Plan covers “preventive and diagnostic services,” “basic services,” “major services” and “orthodontic services.” Many dental conditions can properly be treated in more than one way. The benefit plan is designed to help pay dental expenses, but not on the basis of treatment that is more expensive than necessary for good dental care. Thus, if a condition is being treated for which two or more services included in the list are suitable under customary dental practices, the benefit will be based on the listed service which, according to a determination made by the Trust, would produce a professionally satisfactory result at the lowest cost.

If a dental service is performed that is not on the list, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, then the listed service(s) that the Trust determines would produce a professionally satisfactory result will be considered to have been performed.

**NOTE:** Any eligible dental expense will be paid based on the scheduled amount for that service, or the Actual Charge, whichever ever is less. A representative list from the Dental Fee Schedule is included in this section. Call the Trust Office directly with any questions you have about the benefits.

## SPECIAL DENTAL PLAN FEATURES

### Estimate of Benefits

Getting an estimate of benefits before getting treatment helps to avoid any misunderstanding between the patient, the dentist and the Plan. Ask your dentist to complete a predetermination form and send it to the Trust for review. An estimate of your benefits will then be sent to your dentist, and a copy will be sent to you. This is only an estimate, not a guarantee of payment. The actual benefit payment will depend on the procedures performed as well as your status and available benefits at the time the service is completed.

Please be advised that a predetermination is not required but recommended for services in excess of \$250.

Here is how it works:

- have your dentist complete a dental claim and describe what work needs to be done — the “treatment plan”
- include periapical x-rays and any other supporting x-rays or charts
- send the pretreatment estimate to the Trust
- the Trust tells you and your dentist the estimated amount the Plan will pay.

You should discuss the treatment plan with your dentist before work is started. If the dentist changes the treatment plan, the amount of payment may change. If the dentist makes a major change, a new dental form should be sent to the Trust.

## FILING CLAIMS

### How to File a Dental Claim

We will accept a claim form from your dental office.

1. The dentist must submit x-rays for all major and adult orthodontic expenses
2. The dentist must mail the completed claim form to the Trust
3. Payment will be based upon the Dental Fee Schedule and Plan Limitations and Exclusions
4. You and your dentist will receive notification of payment amount or denial
5. The claim must be filed within one year of the date of service, after that time no benefits will be payable
6. Please forward claims to: NNEBT, PO Box 4604, Manchester, NH 03108-4604
7. NNEBT does not have contracted dentists. You may go to the dentist of your choice

### Eligible Dental Charges

An eligible dental charge must be all of the following:

- included in the list of covered dental procedures and services
- not excluded by the provisions of the plan

A dental charge is incurred:

- for an appliance or modification of an appliance — on the date the impression is taken
- for a crown, bridge or gold restoration — on the date the tooth is prepared
- for root canal therapy — on the date the pulp chamber is opened
- for orthodontic services — (initial) on the date teeth are banded or the device is placed in the oral cavity
- for all other services — on the date the service is rendered

### **Pre-existing Dental Condition Limitation**

A pre-existing dental condition is a treatment or service which was started or completed before a Covered Person was covered under this Plan. Pre-existing dental conditions include: any treatment or service completed before coverage under this Plan; an appliance or an appliance modification, when the impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered under this Plan. No benefits will be paid for any pre-existing dental condition, except for replacement of missing teeth prior to the effective date of dental coverage.

### **Dental Benefits After Coverage Ends**

Your Plan will not pay for services or supplies furnished after dental coverage ends, even if an estimate of benefits has already been made. Benefits will be payable for the following procedures, only if work is **already in process** when coverage ends and your dentist completes the service within 90 days of the end of coverage:

- an appliance or modification of an appliance
- a crown, bridge or gold restoration
- root canal therapy

**NOTE:** Incomplete information will cause a delay in processing your claim. Receipts, balance forward statements or cancelled checks **cannot** be used in place of itemized bills.

## **DENTAL BENEFIT LIMITATIONS**

Dental Limitations to the Northern New England Benefit Trust Plan include the following:

1. Periodic oral exams are covered twice in any calendar year
2. Prophylaxis, routine or periodontal, is covered twice in any calendar year
3. Topical application of fluoride is covered twice in any calendar year for Covered Dependents up to age 19
4. Bitewing x-rays are covered once in any calendar year
5. Full mouth x-rays and panoramic x-rays are each covered once in any 36-month period
6. Space maintainers are covered for Covered Dependents up to age 14
7. One sealant treatment per unrestored permanent molars and bicuspids are covered per lifetime for Covered Dependents up to age 19
8. Replacement of an existing partial by a new partial or replacement of an existing full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth are covered only if the existing denture or bridgework was installed at least five years before its replacement and cannot be made serviceable
9. Periodontic services are limited to \$1,000 per calendar year, prosthetic services are limited to another separate \$1000 per calendar year
10. Multiple restorations (fillings) on one surface shall be considered a single procedure
11. Crowns are covered once every five years and only if the tooth cannot be adequately restored with a filling material such as amalgam
12. A full denture is covered in the same arch once every five years
13. Denture relinings are covered once every three years; denture rebasings are covered once every five years
14. Orthodontic appliances are covered to a lifetime maximum of \$1,500 per Covered Person under PLAN A-1.
15. Stainless steel crowns are covered for Covered Dependents up to age 12
16. When scaling and root planing is done on a "per quadrant basis," each quadrant will be covered once in any 12 - month period
17. Root canal therapy is limited to once per lifetime per tooth
18. Mouthguards, nightguards, and occlusalguards are covered once in a five year period

# DENTAL BENEFIT EXCLUSIONS

In addition to the General Plan Exclusions, the dental portion of the Northern New England Benefit Trust Plan does not cover expenses for the following:

1. Services or supplies not described as covered expenses in the Schedule of Dental Benefits
2. Any charge incurred prior to the Plan member or dependent's effective date of coverage under this Plan
3. Pre-existing dental conditions as defined herein
4. Dental services for a child who is not a dependent as defined under this Plan
5. Covered Dental Expenses after the Annual Maximum Benefit/Lifetime Maximum Benefit has been exhausted
6. Any charge incurred after termination of coverage under this Plan (except as specifically provided herein)
7. Any charge for failure to keep a scheduled dentist appointment
8. Any charge for completing claim forms
9. Instruction supplies for dietary or nutritional counseling, oral hygiene or dental plaque control
10. Services or supplies which are not necessary or do not meet accepted standards of dental practice (including experimental procedures)
11. Any duplicate dental service or appliance, including the replacement of lost, missing or stolen devices or appliances
12. Orthodontic treatment while the person is not covered under this dental plan; orthodontic services incurred prior to being covered under the Dental Plan for at least six months
13. Appliances or restoration, other than full dentures, used mainly to alter vertical dimension, stabilize periodontally involved teeth or restore occlusion
14. Diagnosis or treatment of temporomandibular joint (TMJ) dysfunction
15. Care, services, supplies or treatment not prescribed or provided by a dentist (as defined herein) or dental hygienist under the supervision of a dentist
16. Fluoride rinses or any "over-the-counter drug" which can be purchased without a prescription
17. Emergency exam charges when done in conjunction with a procedure (except x-rays) on the same visit
18. Personalization or characterization of teeth or dentures
19. Prescription drugs, premedications and/or related analgesia
20. Denture relining within three months of initial placement
21. A crown not required for the restoration of a tooth
22. Periodontal splinting
23. Gold restorations when a less expensive restorative material can be used satisfactorily
24. Services or supplies received from a hospital are considered medical rather than dental
25. Periodontal scaling and root planing, when provided on the same day of treatment as a prophylaxis, will have benefit payment appropriately adjusted
26. The same surface of a tooth restored during any 12-month period is not covered unless there are extenuating circumstances
27. For a composite resin or acrylic restoration on a posterior tooth, an allowance for an amalgam restoration will be allowed
28. Periodontal postoperative consultations and evaluation
29. Pulp vitality tests
30. Temporary full or partial dentures, bridges and crowns
31. Fixed bridges or removable cast partials for Covered Persons up to age 16
32. Specialized techniques, including precision attachments, implantology or overdentures
33. Only the number of pontics needed to fill an area where abutment teeth have moved to partially close an edentulous area
34. Additional abutments needed due to abnormal conditions
35. Diagnostic models/photographs, except for orthodontic treatment
36. Appliances, procedures or restoration to correct congenital or developmental malformations or dentistry for cosmetic purposes
37. Replacement or repairs of space maintainers and orthodontic appliances
38. Altering or restoring vertical dimension
39. Equalibration/occlusal adjustments
40. Indirect pulp caps

This is not a complete listing of Plan exclusions, more exclusions appear in the "General Exclusions" section.

If an expense is covered under the Northern New England Benefit Trust Dental Plan and also under another part of the Plan, the benefit paid under the dental portion of the Plan will be equal to the excess benefit not paid by any other of our Plans.