SHA Healthy Essentials

Dental Benefits

Dental Plan Provisions	Member Pays
Calendar Year Deductible (Per Person / Per Family) **(Applies to Class II, III and IV)**	$50 / $150
Dental Plan Provisions	**Plan Pays**
Calendar Year Maximum **(Applies to Class I, II and III - Services Combined)**	$1,250
Lifetime Maximum **(Applies to Class IV Services)**	N/A
Dental Services	**Plan Pays**
Class I – Preventive Services	100% - no deductible
Class II – Basic Services (6 month waiting period)	80% - after calendar year deductible
Class III – Major Services (12 month waiting period)	50% - after calendar year deductible
Class IV – Orthodontic Services	N/A

*Eligible benefits based on Usual and Customary at the 90th percentile of the National Dental Advisory Service (NDAS) guidelines.

Vision Benefits

Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery	$250 per year, per covered member, combined benefit maximum

Monthly Rate Schedule

Member Only	$48
Member and Spouse	$89
Member and Child(ren)	$105
Member and Family	$156

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

SHARED HEALTH ALLIANCE

SHA Healthy Essentials Summary of Benefits

DEDUCTIBLE

Individual Deductible
The individual deductible is the dollar amount of ***covered expense*** which each out of area resident must incur during each benefit year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible
When two (2) covered members of the same family have each met their individual deductible amount during a benefit year, the family deductible amount shall be considered satisfied for that benefit year and no further deductible amount shall be taken from the expenses of any covered family member for the remainder of that benefit year.

Coinsurance
The ***Plan*** pays a specified percentage of the ***customary and reasonable amount*** or ***negotiated rate*** for ***covered expenses.*** That percentage is listed on the *Schedule of Benefits.* The ***covered person*** is responsible for the difference.

MAXIMUM BENEFIT

The maximum benefit is the amount payable on behalf of a ***covered person*** for covered dental expense during the benefit year as stated on the *Schedule of Benefits.* If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the benefit year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan.***

The ***maximum benefit*** for orthodontic treatment while a ***covered person*** is covered by this ***Plan*** is also shown on the *Schedule of Benefits.* The “lifetime maximum” applies to all eligible charges paid during the lifetime of a covered member, whether or not coverage is continuous.

DENTAL EXPENSE BENEFIT

MAXIMUM BENEFIT

The maximum benefit is the amount payable on behalf of a ***covered person*** for covered dental expense during the benefit year as stated on the *Schedule of Benefits.* If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the benefit year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan.***

The ***maximum benefit*** for orthodontic treatment while a ***covered person*** is covered by this ***Plan*** is also shown on the *Schedule of Benefits.* The "lifetime maximum" applies to all eligible charges paid during the lifetime of a covered member, whether or not coverage is continuous.

ALTERNATIVE TREATMENT

In the event the ***dentist*** recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the ***covered person's*** choice to obtain the higher-cost treatment will be the ***covered person's*** responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***completed.***

1. For installation of prosthesis, other than a bridge or crown, the date of receipt of the appliance;

2. For a crown, bridge or gold restoration, on the date the crown is cemented;

3. For endodontic treatment, on the date the final service is rendered to complete the therapy.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Class I- Diagnostic and Preventive Dental Services

1. Routine oral examination: Initial or periodic, limited to twice per benefit year.

2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per benefit year.

3. Dental x-rays as follows:

    a. Supplementary bite-wing x-rays, limited to twice per benefit year.
    b. Panorex and/or full mouth series limited to one of each every thirty-six (36) months.
    c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.

4. Topical application of fluoride limited to one (1) treatment per benefit year.

5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments

within six (6) months of installation, limited to ***dependent*** children through the age of fifteen (15). This does not include space maintainers used in orthodontics to create a space between teeth.

6. Topical application of sealant to permanent teeth, for ***dependent*** children through the age of fifteen (15), limited to one treatment per tooth every thirty-six (36) months.

7. ***Emergency*** palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

Class II-Basic Dental Services

1. Sedative fillings covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.

2. Restorations, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or ***injury.***

3. Pin retention when part of the restoration instead of gold or crown retention.

4. Periodontics as follows:

   a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery
   b. Scaling and root planing, limited to twice per quadrant in any benefit year.
   c. Pedicle and free soft tissue grafts, and vestibuloplasty.
   d. Occlusal adjustment, excluding charges for TMJ.
   e. Excision of pericoronal gingiva.
   f. Periodontal prophylaxis, limited to twice per benefit year.
   g. Osseous surgery.

5. Endodontics as follows:

   a. Pulp Capping.
   b. Pulpotomy.
   c. Root canal therapy.
   d. Apicoectomy.
   e. Hemisection.
   f. Retrograde fillings.

6. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:

   a. Simple extraction of one (1) or more teeth.
   b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
   c. Extraction of tooth root.
   d. Incision and drainage of a tumor or a cyst.
   e. Alveolectomy, alveoloplasty, and frenectomy.
   f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
   g. Re-implantation or transplantation of a natural tooth.
   h. General anesthesia, only when provided in conjunction with a surgical procedure.

7. Bacteriologic cultures in connection with a covered dental service.

8. Therapeutic injections administered by a ***dentist.***

9. Repairs and adjustments to full or partial dentures.

10. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.

11. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.

12. Denture adjustment once per twelve (12) consecutive months, only if done more than six (6) months after the initial insertion of the denture.

13. Repair or recementing of crowns, inlays, onlays or bridgework.

14. Specialists consultations and specialty examinations. These consultations and examinations are not restricted to the limitations for routine oral exams

Class III- Major Dental Expenses

1. Post and core.

2. Plastic or stainless steel crowns will be covered for primary teeth only and the five (5) year limitation, as noted below will not be applied.

3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations. Restorations on teeth which are anterior to the first bicuspid are not covered.

4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations. Restorations on teeth which are posterior to the first bicuspid are not covered.

5. Crowns: Covered only when the tooth cannot be restored by a basic restoration. Crowns used to treat temporomandibular joint dysfunction will not be covered.

6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth extracted.

7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth extracted.

8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the "Prosthesis Replacement Rule" below will be covered.

9. Complete dentures for teeth extracted**.**

10. Dental implants: To replace missing teeth with artificial components that function as natural teeth.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following services applies:

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridge cannot be made serviceable and was installed at least five (5) years prior to its replacement.

Covered expenses for a both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Class IV- Orthodontic Services (if applicable, see dental schedule of benefits)

Orthodontic Services (for ***dependent*** children through age 26 only) – No orthodontic benefits are payable until the ***employee*** has completed twelve (12) months of employment.

1. Any dental expense furnished in connection with the orthodontic treatment;

2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment. Includes routine x-rays, local anesthetics, and post-surgical care.

3. Active appliances. Includes diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Orthodontia benefits will be payable upon submission of proof that the orthodontia services have been received. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted.

DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this ***Plan*** for dental expenses ***incurred*** by a ***covered person*** for the following:

1. Charges for any device ordered while the individual was covered under this ***Plan*** and not delivered or installed within thirty (30) days after termination of coverage.

2. Replacement of lost, missing or stolen appliances or prosthetic devices; charges for duplicate prosthetic devices.

3. Any procedure not listed under *Covered Dental Expense*.

4. Any procedure which began before the date the ***covered person's*** dental coverage started to include a service which is:

    a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
    b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
    c. Root canal therapy, for which the pulp chamber was opened before such person became covered.

    X-rays and prophylaxis shall not be deemed to start a dental procedure.

5. Services, supplies or treatment that are cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or porcelains posterior to the second bicuspids are considered optional, and as such, are not ***covered expenses.***

6. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

7. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.

DENTAL EXPENSE BENEFIT

8. Charges for services, supplies or treatment for which benefits are payable under any other employer sponsored group medical or dental plan.

9. A service not furnished by a ***dentist,*** except:

    a. That performed by a licensed dental hygienist under a ***dentist's*** supervision;
    b. X-rays ordered by a ***dentist;*** and
    c. Denturist.

10. Charges for over-dentures, including related root canal therapy and supportive restorations.

11. Replacement of a prosthetic which in the dentist's opinion can be repaired or does not need replacement.

12. Fixed prosthetics and/or partials for children through the age of fifteen (15). An allowance will be made for a temporary acrylic partial.

13. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.

14. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.

15. Charges resulting from changing from one ***dentist*** to another while receiving treatment, or from receiving care from more than one ***dentist*** for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one ***dentist*** had performed all the required dental services.

16. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for children through the age of fifteen (15). An allowance will be made for an acrylic crown.

17. Charges for precision attachments, semi-precision attachments, instruction in dental plaque control, dental hygienics, or nutritional counseling.

18. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

INDEMNITY VISION PROGRAM

SCHEDULE OF VISION CARE BENEFITS

	Self-Funded Vision Opt 1 Maximum Plan Benefit
Indemnity Vision Plan	
Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery	$250 per benefit year, per covered member, combined benefit maximum

Vision benefits will be paid for the charges for covered vision expenses for covered persons as shown on the Schedule of Benefits. The benefits will apply when charges are incurred for vision care by a legally licensed physician or professional provider.

COVERED VISION EXPENSES

Subject to the maximum benefit specified on the Schedule of Benefits, the Plan provides coverage for services, supplies and treatment for the following:

1. Examinations.
2. Lenses.
3. Frames.
4. Contact lenses, including disposable.
5. Lasik surgery.

VISION EXCLUSIONS

In addition to Plan Exclusions, no benefit will be provided under this Plan for vision expenses incurred by a covered person for the following:

1. Services or supplies required as a condition of employment or by any governmental body.
2. Replacing lenses or frames which have been lost, stolen or broken.
3. Safety lenses or goggles.
4. Medical or surgical care of the eye, except as specified above.
5. Artificial eyes.
6. Any lenses not prescribed by a legally licensed physician or optometrist.
7. Any service performed or supplies provided for special procedures such as orthoptics or any aids for sub-normal vision.