	KINGSTON TRUST FUND		
Dental Benefits – **Dental Benefits will be paid in accordance with the following schedule with no deductible up to the maximum benefit.**	**Dental Benefits will be paid in accordance with the following schedule with no deductible up to the maximum benefit.** **Class 1—Preventive Benefits…….>** **Class 2—Basic Restorative Benefits…>** **Class 3—Major Restorative Benefits (includes Root Canals & Crowns)...>** **Class 4 - Dentures & Bridges** ……> **Orthodontia (for children to age 19)** **TMJ Treatment (see health plan for coverage.)…>**	NHAI Dental PPO Providers **80%** **70%** **60%** **60%** **50%** **Not covered**	Out of Network Providers **60%** **60%** **50%** **Not covered** **Not covered** **Not covered**
Dental Schedule Prior to 1/1/2008	**Class 1—Preventive Benefits:** **Class 2—Basic Restorative Benefits:** **Class 3—Major Restorative Benefits:** **Class 4 --Benefits**	**N/A prior to 1/1/2008**	**60%** **60%** **60%** **Not covered**
Maximum Benefit	• **$2,000 Annual Limit on total benefits paid in any calendar year for all services, both in and out of network. Except Orthodontia.** • **$2,000 Lifetime Orthodontia limit for children under age 19 *(payable quarterly over treatment* period effective January 1, 2008.**		
Benefit Year	**The Benefit Year for all limits shall be the Calendar Year.**		
Class 1 **Preventive and Basic Services**	1. Two regular prophylaxes (cleanings) during any Benefit Year period, including polishing and scaling. 2. We will pay for two fluoride applications for children age 18 and younger during ay Benefit Year. Sealants shall be covered to age 18 or as medically necessary. 3. Two routine oral examinations during any Benefit Year, or emergency palliative treatments for the purpose of removing or alleviating pain and sedative fillings. 4. If additional dental services are provided on the same day as an emergency examination, we will not make payment for the examination. 5. Two bitewing series of x-rays during any Benefit Year—one preventative and one additional bite wing series will be covered if medically necessary. 6. Occlusal and extra-oral x-rays will not be paid for more than a total of 2 films in any two Benefit Years). 7. Panoramic or full mouth x-rays will not be paid for more than once in every Three Benefit Years. 8. Space maintainers for missing primary teeth.		

Class 1 – cont'd.	9. Emergency exams shall be limited to one per Benefit Year or emergency palliative treatments for the purpose of removing or alleviating pain and sedative fillings. 10. **For persons over age 18, two periodontal prophylaxes shall be covered for those who have been treated for periodontal disease, in addition to the regular cleanings. Periodontal maintenance is limited to twice in any Benefit Year or in conjunction with regular cleanings with no more than 4 visits/cleanings per Benefit Year.**
Class 2 **Basic Repairs**	Class 2 Services shall be covered as follows: **1. Restorations: amalgam and composite fillings, pulp caps and nitrous oxide. The fillings may consist of silver amalgam and or tooth color restorations using synthetic materials.** **2. Benefits for a filling include local anesthesia or direct pulp capping on the same date as the filling.** **3. Only one consultation visit will be covered in any Benefit Year.**

Class 3 **Major Periodontics, Endodontics & repair and Root Canal Services**	Class 3 - covered services include— 1. **Surgical periodontics examination; gingival curettage; gingivectomy and gingivoplasty; osseous surgery including flap entry and enclosure; mucogingivoplastic surgery; and management of acute infections and oral lesions.** 2. **Oral surgery to extract teeth. The oral surgery may consist of treatment of fractures and dislocations and diagnosis and treatment of cysts, abscesses and impaction.** 3. **Periodontics treatment (scaling/planning) of the same portion of the mouth (quadrant) is limited to once in any Benefit Year..** 4. **Periodontal surgery if you were covered under this Plan on the date the surgery is actually performed.** 5. **Space maintainers for children up to age 14 and any adjustments, which are made within six months of the installation of the space maintainers. The apicectomy may include flap surgery, apical curettage, local anesthesia, x-rays and post-operative care.** 6. **Inlay/onlay services are covered when the teeth cannot be restored by filling, local anesthesia, direct pulp capping on the same date as cementation, indirect pulp capping, lab charges, base, pins, gum preparation and temporary restoration. Replacement of inlays is limited to once every five years.** 7. **For child crowns (up to age 14), covered services include pulpotomy, including local anesthesia, x-rays, pulp capping, temporary fillings and post-operative care.** 8. **Repairs or adjustments to bridges or dentures.** 9. **Root canal therapy, including anesthesia, x-rays, pulpotomy, temporary fillings and post-operative care is covered. Any post and crown following a root canal would not be covered unless it is only to "repair" an existing crown (see Class 4) prior to 1/1/2008. After 12/31/2007, crowns shall be covered as a Class 4 service.** 10. **Crowns are covered when the teeth cannot be restored by other means and when the crown is not part of a bridge. Crowns can be replaced once every five years if medically necessary.** 11. **Crowns for the purpose of periodontal splinting is covered, including services for local anesthesia, direct pulp capping done on the same date as cementation, indirect pulp capping, lab charges, base, pins, gum preparation and temporary restoration are also covered.**
Class 4 **Major Services** *Only covered if provided by an NHAI provider.*	**Class 4 Major Services provided by PPO Providers shall include the following effective January 1, 2008 provided the Member has been covered under this Plan or another dental plan covering such major services for the previous 12 months prior to the date of service *(HIPAA Certificate or proof of prior dental coverage is required)*:** 1. **Bridges** 2. **Dentures.**

Orthodontia *(Covered at 50% for Network Providers only and for children to age 19 only.)*	**Orthodontia shall be covered for any child to age 19 who has been covered under this plan or who has had continued orthodontia coverage under any other dental *plan* of at least 12 months *(HIPAA Certificate or proof of coverage is required*) will be covered.** **Payments shall be made on a quarterly basis while an eligible covered member under this plan. Payments will be made over the treatment program with the first payment payable upon insertion of the devise. Payments will be subject to the lifetime limit for Orthodontia Treatment for each covered dependent under age 19.** Only orthodontic treatment that begins after the effective date of this amendment will be covered. **Example: If the treatment period is 2 years. You will receive the second quarterly payments in Month 4, the third payment in month 8 and the 4th payment in month 12 following the initial insertion of the appliances.** **Orthodontic expenses include the following:** ♦ **Radiographs or cephalometric film** ♦ **Minor or interceptive treatment for tooth guidance, including removable appliance therapy and fixed or cemented appliance therapy.)** ♦ **Treatment of Transitional Dentition, including Class I, II and III Malocclusion.** ♦ **Treatment of Permanent Dentition, including Class I, II and III Malocclusion.**
Extended Benefits (*must be completed within 30 days of termination)*	**Benefits will be extended for a dental procedure that began before the date a person's coverage terminated and which was completed within 30 days after the termination date, if the covered charge is for any of the following:** 1. A removable appliance or modification of an appliance for which an impression is made. 2. A fixed bridge, crown, gold or cast restoration when the tooth or teeth are fully prepared. **Root canal therapy when the pulp chamber is opened and explored to the apex, provided you or your dependents do not become covered under any other Group Dental Plan for that dental procedure.**
Treatment Started Before Coverage Begins	**Charges for the following are not covered if the services were begun prior to the member becoming covered under the Dental Plan unless the member provides proof of prior continuous creditable dental coverage with no break in coverage according to HIPAA rules. The member must supply the plan with a copy of the HIPAA Certificate for any prior dental coverage or other proof of prior coverage before any consideration will be give to coverage for any treatment which began prior to coverage under this plan.** ♦ **Dentures, if the impression for the denture was taken prior to coverage;** ♦ **Crowns, bridges, or gold restorations if preparation of the teeth was begun prior to coverage;** ♦ **Root canal therapy;** ♦ **Orthodontic charges.**

In addition to the above changes to the Dental Schedule of Benefits, the following clarification is made to the Vision Benefit under the Group Health Plan effective January 1, 2008.

1. **The Eye Exam benefit is limited to one exam during each Calendar Year.**
2. **The benefits for Eye Glasses and/or contacts is limited to $150 during any two Benefit Years.**

I hereby certify that the above restatement of the Dental Schedule of Benefits, as recommended by NHAI with the addition of a Dental PPO network, was amended, approved, and adopted by a majority vote at a Quarterly Meeting of the Board of Trustees on January 22, 2008.

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Hugh M. Spoljaric, Executive Director