EmblemHealth

NFTA - Niagara Frontier
Effective Date: January 1, 2023

Dental Benefit Summary
Preferred Network

Dental Cost-Sharing

	In-Network	Out-of-Network
Annual Individual Deductible - Applies to Type B, C:	$0	$0
Combined Annual Family Maximum - Applies to Type B, C:	$0	$0
Coinsurance - Type A:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Coinsurance - Type B:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Coinsurance - Type C:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Annual Maximum - Includes Type A,B,C:	$1,200 per person, per cal year	Subject to InN Annual Maximum
Annual Individual Deductible - Applies to Type D:	$0	$0
Coinsurance - Type D:	Plan Pays 100% / Member Pays 0%	Plan Pays 100% / Member Pays 0%
Lifetime Maximum - Applies to Type D:	$1,998 per person, per lifetime	$1,275 per person, per lifetime
Dependent Student:	Age 23 end of year	
Dependent Child:	Age 23 end of year	

Type A - Preventive and Diagnostic Services

	Benefit	In-Network	Out-of-Network
Prophylaxes	Two (2) scaling, cleaning and polishing treatments per member per calendar year.	Not Subject to Deductible Type A Coinsurance Only	Not Subject to Deductible Type A Coinsurance Only
Fluoride Treatments	One (1) fluoride treatments per covered child until age 19 end of year per calendar year.	Not Subject to Deductible Type A Coinsurance Only	Not Subject to Deductible Type A Coinsurance Only
Examinations	Two (2) routine examination per member per calendar year. One (1) initial comprehensive oral evaluation per dentist per member lifetime.	Not Subject to Deductible Type A Coinsurance Only	Not Subject to Deductible Type A Coinsurance Only
X-Rays	Four (4) bitewing x-rays per member per calendar year. One (1) full-mouth series of X-rays or one (1) panoramic film once every three (3) years.	Not Subject to Deductible Type A Coinsurance Only	Not Subject to Deductible Type A Coinsurance Only
Biopsy & Examination of Oral Tissue	Tests and laboratory exams.	Not Subject to Deductible Type A Coinsurance Only	Not Subject to Deductible Type A Coinsurance Only
Space Maintainers	One (1) space maintainer per lifetime per covered child up to age 19 end of year.	Not Subject to Deductible Type A Coinsurance Only	Not Subject to Deductible Type A Coinsurance Only
Sealants	One (1) sealant per covered tooth every three (3) calendar years per covered child age 6 until age 14 birthdate.	Not Subject to Deductible Type A Coinsurance Only	Not Subject to Deductible Type A Coinsurance Only

Type B - Basic Services

	Benefit	In-Network	Out-of-Network
Mouth Guards	One (1) mouth guard per lifetime per covered child up to age 19 end of year.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Palliative Services	One (1) emergency service for the relief of pain per member per calendar year.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Basic Restorations	Fillings covered every 6 months. Excludes temporary fillings.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Consultations	Visit will count toward Examinations benefit limit. Specialist visit not covered if performed within one (1) month of consultation.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Extractions	Routine removal of a tooth or teeth.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Repair of Prosthetic Appliances[1]	One (1) denture reline per denture every five (5) years. Rebase or repair of new dentures covered six (6) months from date of insertion. Repair of dentures includes: replacement of broken teeth or clasps, broken facings; recementation of inlays, crowns, bridges, space maintainers; repair of inlays, veneers.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Bedside Calls	Emergency only.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Endodontics (Non-Surgical)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Surgical Endodontics[1]	Services are covered three (3) months after root canal therapy performed on same tooth by same dentist.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Anesthesia & IV Sedation/Analgesia	Covered in connection with a covered service.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance

Periodontal Surgery[1]	Five (5) treatments per calendar year. Repeated treatments covered three (3) years from date of service. Periodontal appliances are not covered.	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance
Periodontal Treatment (Non-Surgical)	Five (5) treatments of diseases of the gums and jaw, including two (2) periodontal maintenance procedure, per member per calendar year	Deductible & Type B Coinsurance	Deductible & Type B Coinsurance

Type C - Major Services			
	Benefit	**In-Network**	**Out-of-Network**
Oral Surgery[1]	Surgery for removal of erupted tooth, fractured jaws, impactions, and lesions are covered. Corrective jaw surgery and surgery relating to accidental injury is not covered.	Deductible & Type C Coinsurance	Deductible & Type C Coinsurance
Major Restorative Services[1]	Includes: crowns; inlays; prosthetic services; removable, complete and partial dentures; fixed bridges; crowns or inlays used as abutments. Replacements covered after five (5) years from appliance date of service.	Deductible & Type C Coinsurance	Deductible & Type C Coinsurance
Fixed & Removable Prosthodontics[1]	Includes: permanent dentures, fixed bridgework and removable partial dentures, posts if evidence of root canal therapy on the tooth, pins once every six (6) months. Replacements covered after five (5) years from date of service. Insertion of fixed bridge and partial denture in same arch covered after five (5) years from date of service. Adjustment of appliances is covered after one (1) year of insertion.	Deductible & Type C Coinsurance	Deductible & Type C Coinsurance

Type D - Orthodontic Services			
	Benefit	**In-Network**	**Out-of-Network**
Orthodontics[1]	Up to twenty (20) months of treatment covered including: office visits, appliances, follow-up visits and retention. Existing appliances are not covered. Dependents up to Age 19 EOM are eligible.	Type D Deductible & Coinsurance	Type D Deductible & Coinsurance

1 - You may obtain a Predetermination of Benefits, refer to Article Five in your Certificate of Insurance

Out-of-network services reimbursed using Spectrum Plus fee schedule.

Underwritten by EmblemHealth Plan, Inc. Refer to policy form PLD-1104-D, et al. This summary provides highlights of coverage only. Coverage is subject to all terms, conditions, limitation and exclusions set forth in the Certificate of Insurance.