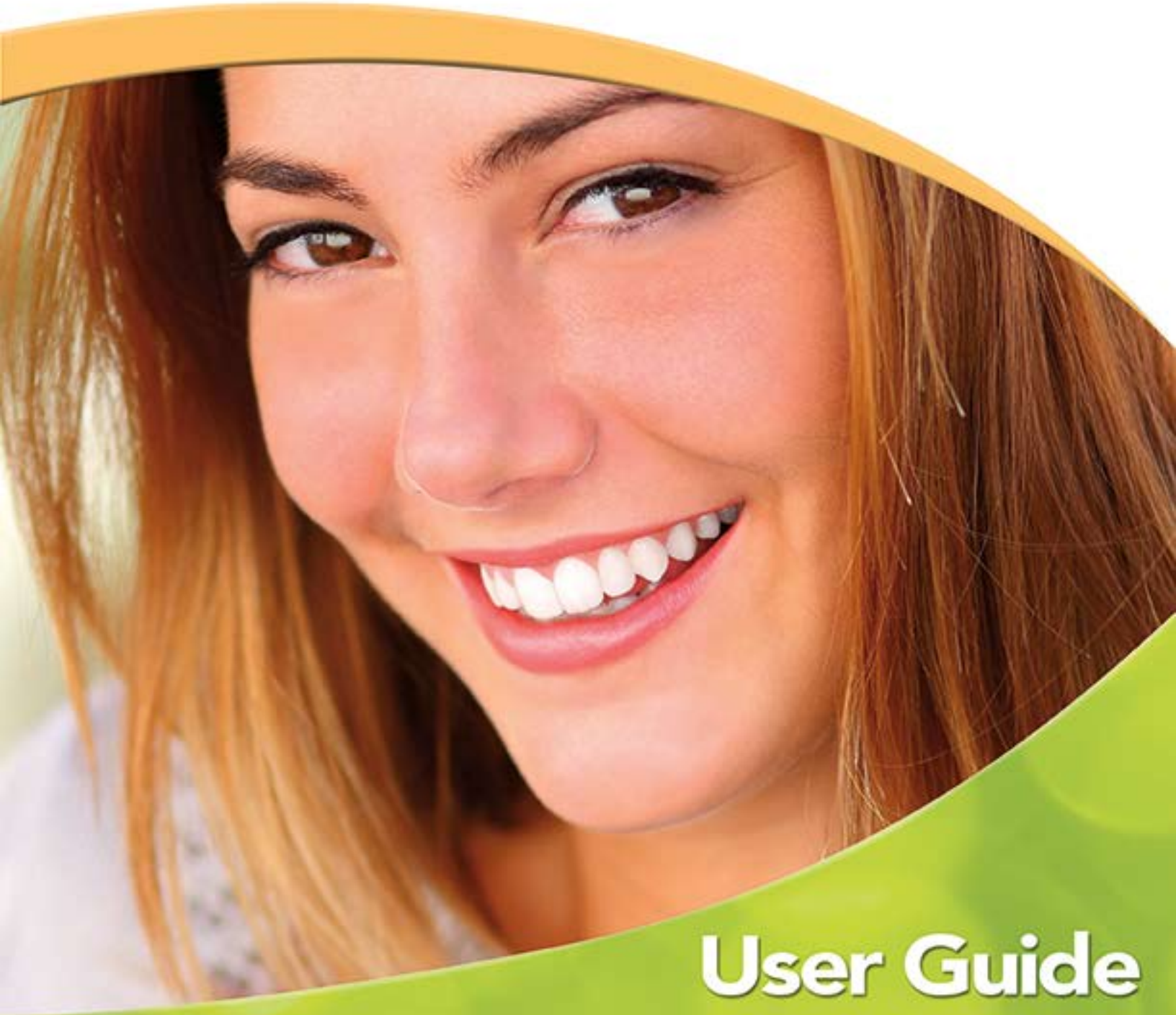
1health care

onecare dental



User Guide

National Small Business Association
www.nsba.net
contactus@nsba.net

Dear New Member,

Welcome to the National Small Business Association (NSBA) and congratulations on your decision to purchase the Nationwide Dental Plan of which the NSBA is the proud sponsor. We hope that you will visit our website www.nsba.net and use the many resources and services available to you.

In order to register your membership and enroll in the NSBA sponsored ABC Card benefits*, go to www.nsba.net, enter the access code "**nsba**" under "NEW MEMBERS" and click "SUBMIT". If you do not have online access, please call your plan administrator at 888-538-9333.

Once you register you will automatically receive the basic NSBA ABC Card membership which includes:

ABC Member Vision Savings of 10% - 30%

ABC Member LASIK Savings of 40% - 50%

ABC Member Rx Savings of 20%

ABC Member Hearing Savings of 35% - 65%

*The ABC Card is NOT INSURANCE but provides discounts at certain providers for health care services.

At www.nsba.net you will find important information on additional benefits available to you.

Go to www.nsba.net and begin using your NSBA resources, information and benefits today!

NSBA Staff
www.nsba.net
contactus@nsba.net

Multiflex Dental Plan Summary of Benefits

Plan: Premier Select 1500 - Calendar Year Maximum: $1,500.00

This plan uses the Maximum Care [TM] network. Members may enjoy discounts by using one of the many dentists within the Maximum Care [TM] network.

Out-of-Network benefits will be paid based on MAC fees which is the Maximum Allowable Charge of a pre-determined fee schedule used to pay out-of-network claims. You may be responsible for the difference between the MAC and the actual dental charge from a Non-Participating Provider.

NOTE: Calendar Year Deductible per member applies across all Classes of Services.

Classes of Services	Description of Services	Multiflex Pays	You Pay
Preventative & Diagnostic Services ***Benefits begin immediately***	• Two routine exams of mouth and teeth per rolling 12 month period • Two cleanings and polishings per rolling 12 month period • Space Maintainers	100% in-network/70% out-of-network of all covered preventative services	0% in-network/30% out-of-network Coinsurance after $50 per member/$150 family calendar year deductible
Basic Restorative Services ***Benefits begin immediately***	• Extraction of teeth • X-Rays • Fillings • Re-cementing	80% in-network/70% out-of-network of all covered minor restorative services	20% in-network/30% out-of-network Coinsurance after $100 per member/$300 family calendar year deductible
Major Dental Services (Oral Surgery, Endodontic/ Periodontal, Prosthodontic) ***Benefits begin after 12 months of enrollment***	• Oral Surgery • Scaling • Endodontic Treatment of Disease • Periodontal services • Crown build up • Denture or bridge • General Anesthesia and analgesic • Restoration services	60% in-network/50% out-of-network of all covered major dental services	40% in-network/50% out-of-network Coinsurance after $100 per member/$300 family calendar year deductible

The benefits matrix above is a summary for informational purposes only. Refer to your official Certificate of Coverage and Schedule of Benefits upon purchase for a detailed description of coverage benefits, limitations, and exclusions. Only the terms and conditions of coverage benefits listed in the policy are binding.

Eligible Expenses

We will pay for eligible expenses you incur for yourself or on behalf of your insured dependent. Expenses must be incurred while the policy is in force and the person is covered by the policy. To be an eligible expense, the dental service or procedure must be performed by a dentist, physician or a dental hygienist.

Deductible Amount

The deductible is an amount of charges you must incur for yourself or on behalf of your insured before we start paying benefits. The Deductible will be waived on in-network preventative services.

Maximum Calendar Year Limit

The maximum limit payable for all eligible expenses in any calendar year is shown in the Brochure. The maximum calendar year limit, if any, will apply to each person covered under the policy.

Maximum Care™ PPO Network

This plan is designed to use the Maximum Care™ dental network. You are free to see any dentist you choose, however, choosing a MaxCare network dentist qualifies you to receive in-network savings on your dental services. To find a Maximum Care™ provider, please visit our website at mbaadmin.com.

Out-of-Network MAC Fees

While you are free to see any dentist you choose, out-of-network benefits will be paid based on MAC fees which is the Maximum Allowable Charge of a pre-determined fee schedule used to pay out-of-network claims. You may be responsible for the difference between the MAC and the actual dental charge from a out-of-network provider. Using an out-of-network provider will result in decreased savings on your dental services.

Eligibility

Coverage is offered to individuals plus their eligible dependents (spouse and unmarried children from birth to age 19; extended to age 25 if child is a full-time student). This may vary based on state requirements.

Termination of Coverage

Coverage terminates on the earliest of the following dates:

(A) the last day of the month in which you cease to be eligible for coverage;

(B) the last day of the month in which your dependent is no longer a dependent as defined;

(C) subject to the grace period, the last day of the month for which a premium has been paid by you or on your behalf;

(D) or the date the master policy ends.

Effective Date

You and your dependents are covered on the later of: the date we accept your enrollment and determine an effective date; or the date you first acquire a dependent, if the date is after your coverage begins. Effective dates will be the first of the month only.

Reasonable and Customary

Reasonable and customary means the usual, customary and regular charges for the area where such expenses are incurred.

Exclusions

No benefits are payable under the policy for the services listed below. In addition, the services listed below will not be recognized toward the satisfaction of any deductible.

1 Any services which are not included in the schedule of covered procedures;

2 Any service started or appliance installed before the effective date or after the termination date, except in those instances noted in this certificate;

3 Any service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least 3 years, as determined by us;

4 Any procedure we determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsements or is experimental in nature;

5 Crowns, inlays, onlays, cast restorations, or other laboratory prepared restorations on teeth, which may be satisfactorily restored with an amalgam or composite resin filling;

6 Any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;

7 Appliances, services or procedures relating to:

a. the change or maintenance of vertical dimension;

b. restoration of occlusion (unless otherwise noted in the schedule of covered procedures - only for occlusal guards);

c. splinting;

d. correction of attrition, abrasion, erosion or abfraction;

e. bite registration; or

f. bite analysis;

8 Replacement of bridges;

9 Replacement of full or partial;

10 Replacement of crowns, inlays, or onlays;

11 For orthodontia services;

12 Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;

13 Charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments.

14 Athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointment; charges for completion of claim forms, infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than us, personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;

15 Prescription drugs, premedication, pharmaceuticals, or analgesia;

16 Dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism or taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;

17 Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;

18 Any charge for a service for which benefits are available under Worker's Compensation or an occupational disease act or law, even if you did not purchase the coverage that is available to you (unless you are not required to be covered under Worker's Compensation);

19 Any charge for a service performed outside of the United States other than for emergency treatment. Benefits for emergency treatment performed outside of the United States are limited to a maximum of $100 per plan year;

20 The initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a natural tooth extracted while the person is insured under the policy;

21 The initial placement of a fixed partial denture including a Maryland bridge, unless it includes the replacement of a natural tooth extracted while the person is insured under the policy, provided that tooth was not an abutment to an existing partial denture.

22 The replacement of teeth beyond the normal complement of 32;

23 The replacement of an existing removable partial denture with a fixed partial denture unless upgrading to a fixed partial denture is essential to the correction of the covered person's dental condition;

24 Local anesthetic, including light anesthetic, as a separate fee;

25 Any treatment plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these services;

26 Services with respect to congenital (hereditary) or developmental (before birth) malformations, except during the 31 day period immediately following the birth of your child, including but not limited to; cleft palate, maxillary and mandibular (upper and lower) malformations, enamel hypoplasia (lack of development), fluorosis, and anodontia;

27 Dental care paid for, required, or provided by or under the laws of a national, state, local or provincial government, or treatment furnished within a hospital or other facility owned or operated by a national or state government unless the insured person has a legal obligation to pay;

28 Dental services performed in a hospital and related hospital fees;

29 Services covered under an existing medical plan;

30 The portion of an expense which is in excess of the reasonable charge;

31 Fees associated with a cancelled or missed appointment;

32 General anesthesia and I.V. sedation, unless deemed medically necessary as determined by a professional consultant.

Missing teeth limitation: We will not pay benefits for replacement of teeth missing on a covered person's effective date of insurance under this certificate for the purpose of the initial placement of a full denture, partial denture or fixed bridge.

Please note: Exclusion language may not be applicable in all states. Please refer to the Certificate of Coverage for a complete list of exclusions in your state.

MultiFlex Dental & Vision- State Availability Chart

State	Dental - Availability	PPO Available	Vision - Availability
Alabama	Approved	Y	Approved
Alaska	Pending	Y	Pending
Arizona	Approved	Y	Approved
Arkansas	Approved	Y	Approved
California	Approved	Y	Approved
Colorado	Approved	Y	Approved
Connecticut	Approved	Y	Approved
Delaware	Approved	Y	Approved
District of Columbia	Approved	Y	Approved
Florida	Approved	Y	Pending
Georgia	Approved	Y	Pending
Hawaii	Approved	Y	Approved
Idaho	Approved	Y	Approved
Illinois	Approved	Y	Approved
Indiana	Approved	Y	Approved
Iowa	Approved	Y	Approved
Kansas	Approved	Y	Approved
Kentucky	Approved	Y	Approved
Louisiana	Approved	Y	Approved
Maine	Pending	Y	Pending
Maryland	Approved	Y	Pending
Massachusetts	Approved	N	Approved
Michigan	Approved	Y	Approved
Minnesota	Pending	Y	Approved
Mississippi	Approved	Y	Approved
Missouri	Approved	Y	Approved
Montana	Pending	Y	Pending
Nebraska	Approved	Y	Approved
Nevada	Approved	Y	Approved
New Hampshire	Pending	Y	Pending
New Jersey	Approved	N	Pending
New Mexico	Approved	Y	Approved
New York	Approved	Y	Approved
North Carolina	Approved	N	Pending
North Dakota	Approved	Y	Approved
Ohio	Approved	Y	Approved
Oklahoma	Approved	Y	Approved
Oregon	Approved	Y	Approved
Pennsylvania	Approved	Y	Approved
Rhode Island	Approved	Y	Approved
South Carolina	Approved	Y	Approved
South Dakota	Pending	Y	Approved
Tennessee	Approved	Y	Approved
Texas	Approved	Y	Approved
Utah	Approved	Y	Approved
Vermont	Pending	Y	Pending
Virginia	Approved	N	Approved
Washington	Approved	Y	Pending
West Virginia	Approved	Y	Approved
Wisconsin	Approved	Y	Approved
Wyoming	Approved	Y	Approved

Nationwide®
is on your side

As of 4/26/2016

Nationwide Life Insurance Company

SCHEDULE OF BENEFITS

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy. Final interpretation of all provisions and coverages will be governed by the Group Policy on file with Nationwide Life Insurance Company at its administrative office and with the Policyholder.

Policyholder: National Small Business Association

Eligible Class(es): All Association Members

Eligibility Waiting Period: 0 days

Plan Year: Calendar Year

Plan Type: Participating Provider Program: In and Out-of-Network Benefits

Participating Provider Network: Maximum Care

Procedure Classes:
A Preventative
B Basic
C Major

Deductible:
Combined In-Network and Out-of-Network Deductible:
$100 Individual Deductible.
Maximum Deductible per Family: 3 times the Individual Deductible.
Applies to Procedure Classes: A, B, C.
The Deductible is waived for In-Network Preventative services for Procedure Class A.

Plan Year Benefit Maximum:
Combined In-Network and Out-of-Network Maximum:
Each Plan Year: 1500.00

Percentages of Covered Expenses:

Each Plan Year:

Procedure Class	Covered % In-Network	Covered % Out-of-Network	Subject to Plan Year Benefit Max
A	100%	70%	Yes
B	80%	70%	Yes
C	60%	50%	Yes

SCHEDULE OF COVERED PROCEDURES

What is Covered? The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable Frequency Limitations. We will not pay benefits for expenses incurred for any Procedure not listed in this Schedule of Covered Procedures.

Procedure Class	Benefit Waiting Period
A Preventive/Diagnostic	0 Months
B Basic	0 Months
C Major	12 Months
NC Not Covered	N/A

Type of Maximum Reimbursement

In-Network	MAC - Participating Provider Maximum Allowable Charge
Out-of-Network	MAC - Participating Provider Maximum Allowable Charge

Frequency Limitations

a. Maximum of 1 procedure per 12 months
b. Maximum of 1 procedure per 24 months
c. Maximum of 1 procedure per 36 months
d. Maximum of 1 procedure per 4 year period
e. Maximum of 1 procedure per 5 year period
f. Maximum of 1 procedure per 7 year period
g. Maximum of 1 procedure per 10 year period
h. Maximum of 1 procedure per lifetime
i. Maximum of 2 procedures per 12 months
j. Maximum of 2 procedures per 24 months
k. Maximum of 2 procedures per 36 months

1. Limited to Dependent Children under age 12
2. Limited to Dependent Children under age 14
3. Limited to Dependent Children under age 16
4. Limited to Dependent Children under age 19
5. Limited to Participants age 17+
6. Limited to Participants age 19+
7. Limited to Participants age 25+

l. Applications made to permanent molar teeth only.
m. Benefits are based on the benefit for the corresponding non-cosmetic restoration.
n. Only in conjunction with listed complex oral surgery procedures and subject to review.
o. Premature loss of primary tooth.
p. Replacement of existing only if in place for 24 months.

COVERED PROCEDURES

Diagnostic and Preventive	Procedure Class	Frequency Limitation	Benefit Waiting Period Months
Bitewing - Single, Two, Three, or Four Films	A	a	0
Emergency Palliative Treatment	B	a	0
Film(s) - Single, Additional, or Intra-Oral Occlusal	A	a	0
Full Mouth X-Ray or Panoramic Film	B	e	0
Oral Exam - Comprehensive or Periodic	A	i	0
Problem Focused Exam	B	a	0
Prophylaxis	A	i	0
Sealant	A	h,l,3	0
Space Maintainer	A	o,3	0
Topical Application of Fluoride	A	a,3	0

Fillings			
Amalgam Restorations	B	p	0
Anterior Restorations	B	p	0
Posterior Restorations	B	p	0
Sedative Fillings (per Tooth)	B	b	0

Oral Surgery			
Alveolectomy - With or Without Extraction (per Quadrant)	C		12
Coronal Remnants	C		12
Extraction - Erupted Tooth or Exposed Root	B		0
General Anesthesia / Intravenous Sedation	C	n	12
Impacted - Complete Bony, Partial Bony, or Soft Tissue	C		12
Incision and Drainage of Abscess – Intraoral	C		12
Surgical Extraction	C		12
Surgical Removal of Root	C		12

Periodontics (Non-Surgical)			
Periodontal Debridement (Full Mouth)	C	h	12
Periodontal Maintenance Procedure	C	i	12
Scaling and Root Planing (per Quadrant)	C	b	12

Periodontics (Surgical)			
Gingival Flap Surgery (per Quadrant)	C	c	12
Gingivectomy (per Quadrant)	C	c	12
Osseous Surgery (per Quadrant)	C	c	12
Soft Tissue Grafts (per Tooth)	C	c	12
Subepithelial Graft (per Tooth)	C	c	12

Endodontics

Apicoectomy - Anterior, Bicuspid, or Molar (per Tooth)	C	h	12
Retrograde Filling (per Tooth)	C	h	12
Root Amputation (per Tooth)	C	h	12
Root Canal - Anterior, Bicuspid, or Molar (per Tooth)	C	b	12
Vital Pulpotomy (Primary Teeth Only)	C	2	12

Miscellaneous

Occlusal Guard	NC		

Bridge

Abutment Crown - Cast Metal (per Tooth)	C	f	12
Abutment Crown - Porcelain (per Tooth)	C	f,n	12
Abutment Crown - Porcelain to Metal (per Tooth)	C	f,n	12
Abutment Crown - Resin to Metal (per Tooth)	C	f,n	12
Pontic -Cast Metal (per Tooth)	C	f	12
Pontic - Porcelain to Metal (per Tooth)	C	f,n	12
Pontic - Resin to Metal (per Tooth)	C	f,n	12
Prefabricated - Post and Core (In Addition to Fixed Partial Denture Retainer) (per Tooth)	C	f	12

Crown

Cast or Prefabricated - Post and Core (In Addition to Crown) (per Tooth)	C	f	12
Core Build-up - With or Without Retainer (Including any Pins) (per Tooth)	C	f	12
Crown - Full Cast (per Tooth)	C	f	12
Crown - Porcelain (per Tooth)	C	f,n	12
Crown - Prefabricated Stainless Steel (per Tooth)	C	f	12
Crown - Resin (per Tooth)	C	f,n	12
Inlay or Onlay (per Tooth)	C	f,n	12
Veneers - Excluding Cosmetic (restorative Only)(per Tooth)	C	f,n	12

Crown and Bridge Repair

Recementation - Bridge, Crown or Onlay	B		0
Repair - Bridge or Crown	C		12

Dentures

Complete Denture (per Arch)	C	e	12
Immediate Denture (per Arch)	C	e	12
Partial Cast Metal Base (per Arch)	C	e	12
Partial Resin Base (per Arch)	C	e	12
Removable Unilateral Partial Denture (per Arch)	C	e	12

Denture Repair

Add Clasp to Existing Partial Denture	C	a	12
Add Tooth to Existing Partial Denture	C	a	12
Denture Adjustment - Complete or Partial (per Arch)	C	i	12
Rebase Denture - Complete or Partial (per Arch)	C	c	12
Reline Denture - Complete or Partial (per Arch)	C	c	12
Reline Denture - Complete or Partial (Lab) (per Arch)	C	c	12
Repair Broken Clasp	C	a	12
Repair Denture Base	C	a	12
Repair Partial Denture	C	a	12
Repair Partial Framework	C	a	12
Repair Teeth (per Tooth)	C	a	12
Replace Teeth (per Tooth)	C	a	12
Tissue Conditioning (per Arch)	C	j	12

Dental Provider Search

http://www.careington.com/co/maxcare/

Provider Directory/Fee Schedule Explanation

The PPO, CPPO , and DTMX are simply the sub-network within the Maxcare network these dentists are a part of. It ends up determining what fees schedule they are on but to a member signing up on one of our plans, it wouldn't make a difference. The Maxcare network combines all 3 of these sub-networks. Essentially, every plan we offer accepts all of these sub-networks as "In Network".

MAXIMUM™ CARE

Care PPO		Care Platinum PPO		DenteMax	
General Dentists	**Specialists**	**General Dentists**	**Specialists**	**General Dentists**	**Specialists**
Fee Schedule/Discounts		**Fee Schedule/Discounts**		**Fee Schedule/Discounts**	
Uses Fee Schedule; 20% Discount on non-listed procedures	Does Not Use Fee Schedule; 20% Discount on all procedures	Uses Fee Schedule; 15% Discount on non-listed procedures	Does Not Use Fee Schedule; 5-15% Discount on all procedures based on percentage listed in provider file code	Uses Fee Schedule; No discount on non-listed procedures. (Should not be an issue with DenteMax since schedule is so robust.)	Uses Fee Schedule; No discount on non-listed procedures. (Should not be an issue with DenteMax since schedule is so robust.)