Northeast Delta Dental

Certificate of Insurance

Rutland City Public Schools

Group #7123

Notice to Buyer:

This policy provides dental benefits only.

Dental Plan Description

Delta Dental Plan of Vermont, Inc.

Delta Dental National Coverage

Form #: VTDPD 010116 (3CDPDI)

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Welcome

Northeast Delta Dental welcomes you to the growing number of people receiving benefits through our Dental Care programs.

This booklet, together with your Outline of Benefits, describes the benefits of your program and tells you how to use your plan. Please read it carefully to understand the benefits and provisions of your Northeast Delta Dental plan. But, before you turn the page, we'd like you to know something about us.

Northeast Delta Dental is a not-for-profit organization originally established and supported by Dentists to make Dental Care more available to the general public.

Northeast Delta Dental is affiliated with a national association known as the Delta Dental Plans Association (DDPA) which provides Dental Care programs in all states and U.S. territories.

A majority of Dentists in Maine, New Hampshire, and Vermont participate with Northeast Delta Dental through participating agreements. In addition, there is a nationwide network of Participating Dentists available to you.

You are encouraged to take advantage of your Northeast Delta Dental plan since good oral health is an important part of your overall general health. You are also encouraged to participate in Northeast Delta Dental's innovative Health through Oral Wellness® (HOW®) program to be eligible for additional preventive dental benefits based upon a clinical risk assessment by your Dentist. Finally, you are also encouraged to obtain your Dental Care from a Participating Dentist to get the best value from your program.

Your Coverage: The coverage selected for your dental benefits plan uses Delta Dental's PPO and Premier network of Participating Dentists. This Delta Dental network plan allows you to go to any Dentist of your choice and receive a level of benefits for covered services, but you will receive the best value from your plan if you visit a network Dentist.

Delta Dental PPO Dentists are part of a more limited network of Participating Dentists who offer lower fees to their Delta Dental PPO patients. Delta Dental PPO Dentists are reimbursed by Delta Dental based on the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. PPO Dentists agree to accept Delta Dental's payment as payment in full, and further agree not to charge any difference between their fees and the amount paid by Delta Dental back to their Delta Dental patients. Like all Dentists, PPO Dentists are allowed to charge for any applicable Co-payments, Deductibles, or non-covered services.

You will also receive benefits under your dental benefits plan if you choose to visit a Delta Dental Premier Dentist. Delta Dental Premier Dentists are reimbursed by Delta Dental based on the lesser of the submitted charge or Delta Dental's allowance for Premier Dentists in the geographic area in which the services were provided. Like all Dentists, Premier Dentists are allowed to charge for any applicable Co-payments, Deductibles, or non-covered services.

You may also choose to visit Dentists who are not Delta Dental Participating (Non-Participating Dentists) or Other Dental Providers (ODPs). You will receive benefits based on the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. The Non-Participating Dentist or ODP may balance bill up to their submitted charge. When there is not sufficient fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount. You may be requested to bring a claim form to your visit. Claim forms can be downloaded from www.nedelta.com or you may call 1-800-832-5700.

Remember: All Delta Dental Participating Dentists agree to:

- File your claim forms for you.
- Charge you no more than the amount allowed for payment by Delta Dental.
- Accept payment directly from Delta Dental.

Health through Oral Wellness® (HOW®) program: A healthy mouth is part of a healthy life, and Northeast Delta Dental's innovative Health through Oral Wellness (HOW) program works with your dental benefits to help you achieve and maintain better oral wellness. Here's how to participate in the HOW program.

- **REGISTER**

  Go to www.healththroughoralwellness.com and click on "Register Now."

- **KNOW YOUR SCORE**

  After you register, please take the free oral health risk assessment by clicking on "Free Assessment" in the Know Your Score section of the website.

- **SHARE YOUR SCORE WITH YOUR DENTIST**

  The next step is to share your results with your Dentist at your next dental visit. Your Dentist can discuss your results with you and perform a clinical version of the risk assessment. Based on your risk and subject to the provisions of your dental benefits plan, you may be eligible for additional preventive benefits at no cost.

I. Definitions:

1. **Agreement:** the contractual relationship between your group and Delta Dental to provide dental benefits to Eligible Persons, including this document, the contract application, the group contract, and the Outline of Benefits.

2. **Co-payment:** the amount of the Dental Care cost which you are required to pay and the Co-payment Percentage.

3. **Co-insurance:** the amount of the Dental Care cost which you are required to pay after application of Co-insurance Percentages.

4. **Co-insurance Percentage:** the percentage specified in your Outline of Benefits as the amount covered by this dental benefits plan for Coverages A, B, and C, respectively.

5. **Contract Holder:** the group named in the contract application.

6. **Contract Year for Benefits:** the time period specified in the Outline of Benefits.

7. **Coverage:** the Dental Care referred to in the Agreement.

8. **Coverage Period:** the Contract Year for Benefits as defined in the Outline of Benefits.

9. **Delta Dental Plans Association (DDPA):** the association which comprises all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.

10. **Deductible:** the portion of the charge for covered Dental Care which the Subscriber or Eligible Dependent must pay before Northeast Delta Dental's payment responsibility begins. The Deductible for your Coverage is listed in your Outline of Benefits.

11. **Denied:** if the fee for a procedure or service is Denied and chargeable to the patient, the procedure or service is not a benefit of the patient's plan. The approved amount is not payable by Northeast Delta Dental, but is collectable from the patient.

12. **Dental Care:** services ordinarily provided by licensed Dentists or ODPs for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practice at the time the service is rendered.

13. **Dental Plan Description (DPD**): this document which serves as your **Certificate of Insurance**. This DPD is part of the Agreement which provides the terms and conditions under which Northeast Delta Dental shall administer your dental benefit program.

14. **Dentist:** a person duly licensed to practice dentistry in the state in which the Dental Care is provided.

15. **Dependent:**

    (a) The spouse to whom the Subscriber is legally married or a partner in a valid civil union.

    (b) A child of the Subscriber or of the spouse/civil union partner of the Subscriber, by natural birth or legal adoption or a child in the process of adoption or guardianship and in the custody of the Subscriber or the spouse of the Subscriber, a foster child legally placed by order of a court or agency having competent jurisdiction and/or a stepchild, provided such child is under the age of twenty-six (26).

    Qualified children are eligible regardless of student status and coverage will terminate when a child reaches the age of twenty-six (26). Children incapable of self-support because of physical or mental disability are eligible regardless of age; supporting documentation from a health-care provider may be requested.

    A newborn child is automatically covered for the first sixty (60) days following birth. Coverage will continue if the child is formally enrolled within the first sixty (60) days following birth or the child may be enrolled thereafter at any open enrollment or as of the first day of the month following the month of the child's first birthday.

16. **Disallowed:** if the fee for a procedure or service is Disallowed, it is not payable by Northeast Delta Dental, nor collectable from the patient by a Participating Dentist. The Exclusions and Limitations provisions in Section III. and Section IV. identify services which are Disallowed. In each instance, a Delta Dental Participating Dentist agrees not to charge a separate fee.

17. **Eligible Dependents:** those Dependents who meet the eligibility requirements of the Agreement and are enrolled by Subscribers in the group's benefit program. If enrolling Dependents in the group's benefit program, all Eligible Dependents must be enrolled by the Subscriber for the term of the Agreement.

18. **Eligible Persons:** the Subscriber and Dependent(s) (as defined herein) to the extent eligible in accordance with the eligibility requirements established by the Group (or the employer).

19. **Explanation of Benefits (EOB):** this notice which explains the benefits that were paid on your behalf, lets you know if any services are Denied or Disallowed, and gives you the reason(s) for the denial or disallowance.

20. **Maximum:** the dollar amount Northeast Delta Dental will pay per Eligible Person in total for the Subscriber and all Eligible Persons under this policy within any Coverage Period for covered benefits. All benefits paid, including benefits for Diagnostic and Preventive services, are counted toward an Eligible Person's Coverage Period Maximum.

21. **Non-Participating Dentist:** a Dentist who has not signed a participating agreement with Northeast Delta Dental or another Delta Dental company.

22. **Northeast Delta Dental**: the Delta Dental Plans in Maine, New Hampshire, and Vermont, collectively known as Northeast Delta Dental.

23. **Other Dental Providers (ODP):** a person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are rendered.

24. **Outline of Benefits (OOB):** the insert to this booklet that describes some of the particular provisions of your dental benefits.

25. **Participating Dentist:** a Dentist who has signed a participating agreement with Northeast Delta Dental or another Delta Dental company. A Participating Dentist agrees to abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental.

26. **Predetermination:** an administrative procedure by which the Dentist submits the treatment plan to Northeast Delta Dental in advance of performing Dental Care. Northeast Delta Dental recommends that you ask your Dentist to request a Predetermination of proposed services that are considered to be other than brief or routine. A Predetermination provides an estimate of what Northeast Delta Dental will pay for the services which helps avoid confusion and misunderstanding between you and your Dentist.

27. **Processing Policies:** policies approved by Northeast Delta Dental, as may be amended from time to time, to be used in processing claims for payment or review, and processing treatment plans for Predeterminations. Processing Policies are approved by the Contract Holder by signing the Group Contract. Most frequently used Processing Policies are contained in the terms, conditions and limitations described in this Certificate of Insurance.

28. **Subscriber:** any person who:

    (a) Renders service to the Contract Holder as a paid employee.

    (b) Is certified by the Contract Holder as a member of the group specified in the contract application.

    (c) Enrolls in the group's dental benefit program.

II. How to File a Claim

To Use Your Plan, Follow These Steps:

Please read this Certificate of Insurance carefully to familiarize yourself with the benefits and provisions of your dental benefits plan.

Ask your Dentist if he/she participates with Delta Dental; visit Northeast Delta Dental's website at www.nedelta.com; refer to your Northeast Delta Dental Participating Dentist Directory; or call Northeast Delta Dental for information.

When you visit your dental office, inform them that you are covered under a Northeast Delta Dental program and show your identification card or other means of verifying Delta Dental coverage. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Northeast Delta Dental for payment for covered services.

Participating Dentists: Participating Dentists will have claim forms available in their offices. A Participating Dentist will not charge at the time of treatment for covered services, but may request payment for non-covered services, Deductibles, or Co-payments. Northeast Delta Dental will pay the Participating Dentists based on the lesser of the actual submitted charge or Delta Dental's allowance for Participating Dentists in the geographic area in which the services were provided. An Explanation of Benefits (EOB) form will be sent or accessible to you that will indicate the amount you should pay, if any, to your Dentist.

Non-Participating Dentists or Other Dental Providers (ODPs): Northeast Delta Dental provides coverage regardless of your choice of Dentist, participating or not. When visiting a Non-Participating Dentist or ODP (who is a person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are rendered), you may be required to submit your own claim (available at www.nedelta.com) and pay for services at the time they are provided. All claims should be submitted to Northeast Delta Dental. Payment will be made directly to you. Some states may require that assignment of benefits (directing that payment be sent to the provider) be honored. In these instances, payment will be made directly to the Non-Participating Dentist or ODP when written notice of such an assignment is made on the claim. In either case, payment for treatment performed by a Non-Participating Dentist or ODP will be limited to the lesser of the actual submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which services were provided. It is your responsibility to make full payment to the Dentist or ODP. When there is not sufficient fee information available for a specific dental procedure, Northeast Delta Dental will determine an appropriate payment amount.

You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

Predetermination of Benefits: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist.

Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of payment based on your current benefits. A new Coverage Period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information at the time treatment is provided (the date of service) which may be different than information available at the time the Predetermination estimate was given. Any changes in a Dentist's participating status or Northeast Delta Dental's allowance may also affect Northeast Delta Dental's final payment.

The Predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office. Questions concerning Predetermination should be directed to Northeast Delta Dental's Customer Service department at 1-800-832-5700 or 603-223-1234.

III. Benefits

PLEASE NOTE: Eligible Persons will only be entitled to those benefit coverages selected by the Contract Holder. See your Outline of Benefits for the coverages selected. Section III describes the benefit coverages which may be selected.

Diagnostic & Preventive Benefits (Coverage A)

Diagnostic: Oral evaluations – two (2) times in a period of twelve (12) months.

Radiographic images – a complete series or a panoramic image once in a period of five (5) years; bitewings once in a period of twelve (12) months; images of individual teeth as necessary.

Brush biopsy.

Preventive: Prophylaxis (cleaning) – four (4) times in a period of twelve (12) months (child cleaning through age thirteen (13), adult cleaning thereafter). This can be a routine cleaning, a full mouth debridement or periodontal maintenance under Diagnostic and Preventive Benefits (Coverage A).

A full mouth debridement under Diagnostic and Preventive Benefits (Coverage A) is covered once in a lifetime and when performed is counted towards your cleaning benefit.

Fluoride treatments – two (2) times in a period of twelve (12) months through age eighteen (18).

Space Maintainers through age fifteen (15).

Sealants through age eighteen (18).

NOTE: ***As a participant in Northeast Delta Dental's Health through Oral Wellness® (HOW®) program, you may be eligible for additional preventive benefits, subject to the annual maximum, deductible, co-insurance and/or co-pays and other standard policy provisions. These additional preventive benefits may include more frequent prophylaxis (cleanings); fluoride treatments; sealants; periodontal maintenance; and full mouth debridement; and availability of caries susceptibility tests; oral hygiene instruction; nutritional counseling; and tobacco cessation counseling.***

Time limitations are measured from the date the services were most recently performed.

Only those coverage classifications selected by the Contract Holder shall apply as shown on the OOB.

Coverage A Exclusions and Limitations:

- If the fee for a procedure or service is "Disallowed," it is not payable by the plan, nor collectable from the patient by a participating dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "Denied," it is not payable by the plan, but is chargeable to the patient as the procedure or service is not a benefit under the plan.

1. Oral evaluations of any kind are Disallowed if performed within ninety (90) days after periodontal surgery by the same Dentist/dental office.
2. Comprehensive oral evaluation and comprehensive periodontal evaluation are a covered benefit once in a lifetime (unless there is history of no care for three (3) years) and is counted toward your oral evaluation benefits. Subsequent comprehensive oral evaluations are covered as a periodic oral evaluation and are subject to frequency limitations.
3. Oral evaluations for patients under age three (3), when performed on the same date of service by the same Dentist/dental office as a comprehensive evaluation, are Disallowed.

4. Pre-diagnostic services, such as screening and assessment of a patient, are not covered benefits. Payment for a screening and assessment is Disallowed if billed with an oral evaluation.

5. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings and/or occlusal), is considered a complete series for time limitations and any fee in excess of the fee for a complete series is Disallowed.

6. Payment for additional periapical radiographic images within a thirty (30) day period of a complete series or panoramic image, unless there is evidence of trauma, is Disallowed.

7. When benefits are requested for a panoramic radiographic image in conjunction with a complete series by the same Dentist/dental office, fees for the panoramic radiographic image are Disallowed as a component of the complete series on the same date of service.

8. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure and separate fees are Disallowed on the same date of service.

9. If the fee for bitewings, periapicals, intraoral occlusal and extraoral radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.

10. Cone beam imaging and interpretation are not covered benefits. Cone beam imaging, when performed by the same Dentist/dental office as an image interpretation, is combined as a cone beam capture and interpretation. Any fees in excess of the combined code are Disallowed.

11. Cephalometric images, oral/facial photographic images and diagnostic casts are not a covered benefit.

12. Oral cancer screening, except brush biopsy, is not a covered benefit.

13. Oral Pathology laboratory services are a covered benefit when accompanied by a pathology report. If more than one of these procedures is billed for the same tooth site on the same day, by the same Dentist/ dental office, payment is allowed for the most inclusive procedure and the less inclusive procedure is Disallowed.

14. A cleaning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Disallowed.

15. Laboratory tests for caries susceptibility are not a covered benefit and are Disallowed when billed with an oral evaluation for children under the age of three (3).

16. Caries risk assessment is a covered benefit once in a period of three (3) years for children between the ages of three (3) and nineteen (19). Benefits for caries risk assessment are Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.

17. Sealant benefit limitation:

    (a) The sealant benefit is provided only to Eligible Dependents eighteen (18) years of age or younger.

    (b) The sealant benefit includes the application of sealants to caries-free (no decay) and restoration-free permanent molars only.

    (c) The sealant benefit is provided no more than once in a three (3) year period per tooth.

    (d) Sealants are Disallowed within two (2) years of initial placement on the same tooth by the same Dentist/dental office. A sealant is Disallowed if performed by the same Dentist/dental office, on the same date of service as a restoration which includes the occlusal surface.

18. Pulp vitality tests are a covered benefit only when done in conjunction with a radiographic image, a limited oral evaluation, a palliative treatment, or a protective restoration. Payment is otherwise Disallowed.

19. Space maintainers are a covered benefit once in a lifetime for Eligible Dependents fifteen (15) years of age or younger when a space is being maintained for an erupting permanent tooth.

20. The replacement or repair of space maintainers is not a covered benefit, unless performed by a Dentist who did not do the original placement.

21. Removal of a space maintainer is included as part of the total treatment. Charges for removal of a space maintainer are Disallowed if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.

22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

23. Genetic test for susceptibility to diseases is not a covered benefit.

Basic Benefits (Coverage B)

Restorative:	Amalgam (silver) restorations (fillings). Resin (white) restorations (fillings).
Oral Surgery:	Routine and complex extractions and covered surgical procedures.
Periodontics:	Prophylaxis (cleaning) – four (4) times in a period of twelve (12) months (child cleaning through age thirteen (13), adult cleaning thereafter). This can be a routine cleaning, a full mouth debridement or periodontal maintenance under Diagnostic and Preventive Benefits (Coverage A). Treatment of Gum Disease. A full mouth debridement under Diagnostic and Preventive Benefits (Coverage A) is covered once in a lifetime and when performed is counted towards your cleaning benefit.
Endodontics:	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.
Denture Repair:	Repair of a removable complete or partial denture to its original condition.
Clinical Crown Lengthening:	Once per tooth per lifetime.
Palliative Treatment:	Minor emergency treatment for the relief of pain.
Anesthesia:	General anesthesia or intravenous sedation, conscious sedation, when administered in a dental office and in conjunction with: an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body; biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy; and/or frenuloplasty.

NOTE: ***Time limitations are measured from the date the services were most recently performed.***

Only those coverage classifications selected by the Contract Holder shall apply as shown on the OOB.

Coverage B Exclusions and Limitations:

- If the fee for a procedure or service is "Disallowed," it is not payable by the plan, nor collectable from the patient by a participating dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "Denied," it is not payable by the plan, but is chargeable to the patient as the procedure or service is not a benefit under the plan.

1. Restorations are a covered benefit only once per surface in a period of twenty-four (24) months, irrespective of the number or combination of procedures performed. The replacement of amalgam (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office is Disallowed.
2. A cleaning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures and the fee is Disallowed.
3. Tooth preparation, bases, copings, protective restorations, impressions, and local anesthesia, or other services that are part of the complete dental procedure, are considered components of, and included in the fee for, a complete procedure and are Disallowed.

4. Protective restorations are Disallowed if performed on the same date of service as a definitive restoration or palliative treatment by the same Dentist/dental office.

5. Prefabricated stainless steel crowns are a covered benefit once in a period of two (2) years. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Disallowed.

6. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

7. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

8. Exploratory surgical services are not a covered benefit. Patient is financially responsible.

9. Periodontal scaling and root planing is a covered benefit per quadrant once in any period of twenty- four (24) months. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. The fee for periodontal scaling and root planing is Disallowed if performed within four (4) weeks of periodontal surgery by the same Dentist/ dental office.

10. Fees for periodontal maintenance, when billed within three (3) months of periodontal therapy by the same Dentist/dental office, are Disallowed.

11. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. The fee for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.

12. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

13. Clinical crown lengthening is a covered benefit once per tooth per lifetime and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown, or prosthetic device. The fee for clinical crown lengthening is Disallowed if performed on the same date of service by the same Dentist/dental office as the crown placement.

14. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure and is Disallowed.

15. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a dental consultant's review. Payment will be based on the most comprehensive procedure.

16. Direct or indirect pulp caps are a covered benefit once in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure and the fee for the pulp cap is Disallowed.

17. Recementation of a crown, onlay, or partial coverage restoration is a covered benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office.

18. Recementation of a cast or prefabricated post and core is a covered benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.

19. Anterior deciduous root canal therapy is not a covered benefit.

20. A partial pulpotomy is a covered benefit once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within thirty (30) days on the same tooth by the same Dentist/dental office as root canal therapy.

21. Pulpal therapy is a covered benefit once in a three (3) year period on primary first and second molars only. If pulpal therapy is performed on primary anterior or permanent teeth, the procedure will be covered as a palliative treatment.

22. Therapeutic pulpotomy is a covered benefit once in a three (3) year period per tooth on primary teeth only. If the service is provided on permanent teeth, the procedure will be covered as a palliative treatment.

23. Root canal therapy is a covered benefit once in a period of three (3) years. Retreatment of root canal therapy by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed.

24. Root canal therapy is not a benefit in conjunction with overdentures and benefits are Denied.

25. Root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Disallowed.

26. A frenulectomy or frenuloplasty is a covered benefit once per site per lifetime and is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office.

27. Alveoloplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office, in the same surgical area on the same date.

28. The fee for repair of a complete denture cannot exceed half the fees for a new appliance. Any excess fee billed by the same Dentist/dental office is Disallowed on the same date of service.

29. The fee for palliative treatment is Disallowed when submitted with all procedures except radiographic images and diagnostic codes and is performed by the same Dentist/dental office on the same date.

30. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office and a separate fee is Disallowed.

31. General anesthesia is a covered benefit only when administered by a properly licensed Dentist in a dental office in conjunction with covered oral surgical procedures or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is Denied.

32. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure and fees are Disallowed.

33. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office are Disallowed.

34. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Additional pins in the same tooth are Disallowed. Pin retention is Disallowed when billed in conjunction with a core build-up.

35. An apexification or an apicoectomy is a covered benefit once per tooth in a period of three (3) years. Retreatment by the same Dentist/dental office within twenty-four (24) months is Disallowed.

36. An internal root repair is a covered benefit once in a lifetime on permanent teeth only. If performed on a primary tooth the benefit is Denied. The fee for an internal root repair is Disallowed if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.

37. Retrograde fillings are a covered benefit once per root per three (3) years. Retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Disallowed.

38. Periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling and/or root amputation is Disallowed.

39. Pulpal debridement is a covered benefit once in a lifetime. The fee for pulpal debridement is Disallowed if performed within thirty (30) days of a root canal treatment by the same Dentist/dental office.

40. Surgical removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same Dentist/dental office.

41. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered benefit. Payment is Disallowed if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.

42. Adjustment or repair of a denture is a covered benefit twice in a twelve (12) month period for patients age sixteen (16) and older. Fees for an adjustment or repair of a denture is Disallowed if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Disallowed on the same date of service.

43. Cleaning and inspection of a removable complete or partial denture is not a covered benefit. The fee for cleaning and inspection of a removable complete or partial denture is Disallowed when done by the same Dentist/dental office on the same date of service as a reline or rebase of the denture. Otherwise, the fee for cleaning and inspection of a removable complete or partial denture is Denied.

44. A consultation is a covered benefit only if performed by a Dentist that is not performing further treatment. A consultation is Disallowed if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.

45. Gingivectomy; gingival flap procedure; osseous surgery; bone replacement graft with flap surgery; distal wedge; or soft tissue graft procedure is a covered benefit once in a period of three (3) years. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.

46. Interim caries arresting medicament application is not a covered benefit.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist.

Major Benefits (Coverage C)

Restorative Crowns and Onlays:	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and reline of such prosthetic appliances; core buildups; cast and prefabricated posts and cores; and crown and onlay repairs.
Implant Services:	Surgical placement of an endosteal implant body including healing cap.
Implant Supported Prostheses:	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

NOTE: ***Time limitations are measured from the date the services were most recently performed.***

Only those coverage classifications selected by the Contract Holder shall apply as shown on the OOB.

Coverage C Exclusions and Limitations:

- If the fee for a procedure or service is "Disallowed," it is not payable by the plan, nor collectable from the patient by a participating dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "Denied," it is not payable by the plan, but is chargeable to the patient as the procedure or service is not a benefit under the plan.

1. Onlays; or crowns; made of resin-based composite; porcelain; porcelain fused to metal; full cast metal; or resin fused to metal; where the metal is high noble metal; titanium; noble metal; or predominantly base metal; are not covered benefits for Eligible Dependents under the age of twelve (12).
2. Tissue conditioning is a covered benefit two (2) times in a period of three (3) years. The fee for tissue conditioning is Disallowed if performed on the same date of service as a denture rebase or reline by the same Dentist/dental office.
3. Coverage C time limitations:
   (a) One (1) complete or immediate maxillary (upper) and one (1) complete or immediate mandibular (lower) denture in a period of seven (7) years.
   (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in a period of seven (7) years.
   (c) A removable or fixed partial denture in a period of seven (7) years unless the loss of additional teeth requires the construction of a new appliance.
   (d) Crowns, onlays, core buildups, and post and cores are a covered benefit once per tooth in a period of seven (7) years.
   (e) The period of seven (7) years referred to in (a), (b), (c), and (d) above is to be measured from the date the service was last performed.
4. Inlays are not a covered benefit. An allowance will be paid equal to an amalgam (silver) restoration. If an inlay is performed, the patient is responsible for any additional fee.
5. A core build-up is a covered benefit once in a seven (7) year period per tooth for patients age twelve (12) and older. The fees for core build-ups are Disallowed when build-ups are performed in conjunction with inlays, 3/4 crowns or onlays.

6. An indirectly fabricated and prefabricated post and core in addition to a crown is payable only on an endodontically treated tooth and is a covered benefit once in a seven (7) year period for patients age twelve (12) and older. Fees for post and cores are Disallowed when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth.

7. Post removal is Disallowed if performed within thirty (30) days of an endodontic treatment by the same Dentist/dental office performing the endodontic retreatment.

8. A provisional crown is considered part of a crown procedure when performed by the same Dentist/dental as a permanent crown, and a separate fee is Disallowed.

9. Removable or fixed, complete or partial dentures are not covered benefits for patients under the age of sixteen (16).

10. An implant body, including healing cap, is a covered benefit once in a lifetime per site. The fees for an implant are Disallowed if the implant is part of a fixed partial denture on natural teeth.

11. Implant services are not a covered benefit for patients under the age of sixteen (16).

12. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. Patient will be responsible for any additional fee.

13. Bone replacement graft for ridge preservation is not a covered benefit.

14. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are a covered benefit. Patient will be responsible for any additional fee.

15. Recementation of a fixed partial denture is a covered benefit once in a lifetime. Fees for recementation of fixed partial dentures are Disallowed if done within six (6) months of the initial placement by the same Dentist/dental office.

16. An interim complete denture is not a covered benefit. Fees are Disallowed if billed in conjunction with a permanent appliance.

17. An interim partial denture is a covered benefit for Eligible Dependents through age sixteen (16) on anterior, permanent teeth only. The fee for an interim partial denture is Disallowed if billed in conjunction with a permanent appliance on the same day by the same Dentist/dental office.

18. The relining of a denture is a covered benefit twice in a period of twelve (12) months for patients age sixteen (16) and older. The fee for reline of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Disallowed on the same date of service.

19. The rebase of a denture is a covered benefit once in a period of seven (7) years for patients age sixteen (16) and older. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Disallowed on the same date of service.

20. The reline or rebase of a denture is Disallowed if performed within six (6) months of initial placement by the same Dentist/dental office.

21. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is Disallowed. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to a dental consultant's review.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist.

IV. General Exclusions and Limitations

1. Unless otherwise specified in the Outline of Benefits, the dental benefits provided by Northeast Delta Dental shall not include the following:

   (a) Services for injuries or conditions compensable under worker's compensation or employer's liability laws.

   (b) Services that are determined by Northeast Delta Dental to be rendered for cosmetic reasons, such as bleaching or whitening of teeth, placement of veneers, correction of congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)

   (c) Services including, but not limited to, endodontics and prosthodontics (including restorative crowns and onlays) completed prior to the date the Subscriber or Eligible Dependent became eligible under the Agreement.

   (d) Services not provided by a Dentist, or under the supervision of a Dentist, or that are not within the scope of the license of the Dentist or of the license of the person supervised by the Dentist.

   (e) Prescription drugs, premedications, and/or relative analgesia, or the application of anti- microbial agents.

   (f) Charges for: (i) hospitalization; (ii) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section III., Coverage B Benefits); (iii) provisional splinting; (iv) myofunctional therapy; (v) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (vi) equilibration; and (vii) gnathological reporting.

   (g) Charges for failure to keep a scheduled visit with the Dentist.

   (h) Charges for completion of forms. Such charges shall not be made to a Subscriber or Eligible Dependent by Participating Dentists.

   (i) Dental Care which is not necessary and customary, as determined by generally accepted dental practice standards.

   (j) Dental Care or supplies which are not within the classification of benefits defined in the Agreement.

   (k) Appliances, procedures, or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, restoring, or maintaining occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv) correcting congenital or developmental malformations; or (v) esthetic purposes.

   (l) Payments of benefits incurred by the Subscriber and/or Eligible Dependent(s) after the date on which the Subscriber becomes ineligible for benefits.

   (m) Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.

   (n) Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

   (o) All services, including evaluations and radiographs, performed for orthodontic purposes where the group does not have Orthodontic Benefits (Coverage D). If services are rendered they should be done so with the agreement of the patient to assume the additional cost.

   (p) Temporary services or incomplete treatment.

   (q) A consultation unless performed by a practitioner who is not performing further services.

   (r) Case presentation and treatment planning.

   (s) Athletic mouthguards and occlusal guards (nightguards).

2. Unless otherwise specified in the Outline of Benefits, the dental benefits provided by Northeast Delta Dental shall be limited as follows:

(a) Dental Care rendered by other than a Dentist shall not be a covered benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted dental practice standards. All claims for payment for Dental Care received must be submitted under the name and license number of the Dentist rendering treatment or supervising treatment.

(b) Optional Dental Care: In all cases in which the Subscriber or Eligible Dependent agree, after consultation with their Dentist, to more expensive Dental Care than is customarily provided, Northeast Delta Dental will pay based on the applicable Co-insurance Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. The Subscriber or Eligible Dependent shall be responsible for the remainder of the Dentist's fee.

(c) Predetermination does not guarantee payment. Payment is based upon eligibility, benefits selected by the group, and allowable charges at the time the Dental Care is rendered. If Coordination of Benefits is involved, the amount of payment may change dramatically depending on the payment made by the primary carrier.

(d) Services completed or in progress at the Subscriber's or Eligible Dependent's date of death will be paid in full to the limit of Northeast Delta Dental's liability.

(e) When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, Northeast Delta Dental will review the claim to determine the payment, if any, due each Dentist.

(f) Maximum Payment:

(i) The Maximum amount payable in any Coverage Period, or any portion thereof, shall be limited to the amount specified in the Outline of Benefits.

(ii) Northeast Delta Dental's payment shall be reduced by any applicable Deductible and Co-payments.

(g) Specialized techniques including, but not limited to, precision attachments; overdentures and procedures associated therewith; and personalizations; or characterization; are excluded. Patient will be responsible for part of or the entire fee for these services.

(h) Diagnostic casts (study models) and/or photographs are not a covered benefit by Northeast Delta Dental unless done for orthodontic purposes for those groups that have orthodontic benefits. The charge for such services should be included in the total case fee.

(i) Benefits are paid for amalgam (silver) or resin (white) restorations for the treatment of caries. If a tooth can be restored with amalgam or resin, use of gold, an onlay or a crown is at the option of the patient and the patient will be responsible for any additional cost.

(j) A completed claim (or satisfactory written proof acceptable to Northeast Delta Dental) must be furnished to Northeast Delta Dental at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on claims with dates of service in excess of the twenty-four (24) month limitation.

(k) Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you shall be deemed to have complied with the requirements of this dental benefits plan with the time fixed in the dental benefits plan for filing claims. Notice given by or on behalf of you to Delta Dental, or to any authorized agent of Delta Dental, with information sufficient to identify you, shall be deemed notice to Delta Dental.

(l) The Date of Incurred Liability refers to the date a covered service is subject to the applicable Deductible, Co-insurance Percentage, Maximum benefit, and limitations. The total cost of the service is applied to the Coverage Period during which the service is completed, irrespective of the Coverage Period in which the service is started.

For services covered, Delta Dental's date of incurred liability for multiple visit procedures is as follows:

(i) Restorative Crowns and Onlays — Total cost for crowns and onlays shall be incurred on the date that the crown or onlay is cemented.

(ii) Fixed Partial Dentures (abutment crowns and pontics) — The total cost for fixed partial dentures shall be incurred on the date that the said appliance is cemented.

(iii) Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the said appliance is delivered to the patient.

(iv) Endodontics — Total cost for endodontic treatment shall be incurred when the canal is filled to completion.

(v) Implant Body — Total cost for the implant body, including healing cap, shall be incurred on the date of surgical placement.

(vi) Implant Prosthetics — Total cost for the prosthetic portion of an implant shall be incurred on the date that the said appliance is cemented or delivered to the patient.

(m) You may not bring a legal action against Delta Dental under this dental benefits plan until sixty (60) days after notice of claim. No such action shall be brought after the expiration of two (2) years after the time written notice of claim is required to be furnished.

V. Coordination of Benefits (Dual Coverage)

The Coordination of Benefits provision is designed to provide maximum coverage, but not to exceed 100% of the total fee for a given service. In the event that any Eligible Person is entitled to benefits under any other health care program, the following Coordination of Benefits provision shall determine the sequence and extent of payment. Other health care programs may include any other sponsored plan or group insurance plan. Benefits under this plan will not be coordinated with any state's Medicaid programs.

When an Eligible Person is covered under another health care program, the following rules shall be followed to establish the order of determining liability.

1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.

2. The plan covering an Eligible Person solely as an employee shall determine its benefits before the plan which covers the Eligible Person solely as a Dependent.

3. The plan covering the Eligible Person solely as a Dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the Eligible Person solely as a Dependent of the parent whose birthdate occurs later in a calendar year ("Birthday Rule").

   A parent's year of birth is not relevant. If both parents have the same birthdate (month and day) the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. If the other health care program does not use the Birthday Rule, then that plan's provisions will determine the order of liability.

4. If paragraphs 1 through 3 above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time shall be determined first.

5. The order of payment for the claims of a Dependent child of divorced or legally separated parents will be as follows:

   (a) The plan of the parent with custody.

   (b) The plan of the spouse or civil union partner of the parent with custody (step- parent).

   (c) The plan of the parent without custody.

   (d) If the parents have joint legal custody, paragraph 3 above will apply.

   However, when the parents are separated or divorced and there is a court decree which establishes financial responsibility with respect to the child, the benefits of the plan which cover the child as a Dependent of the parent with financial responsibility pursuant to the decree shall be determined before the benefits of any other plan which covers the child as a Dependent.

6. When Northeast Delta Dental is the first to determine its benefits under the foregoing, benefits hereunder shall be paid without regard to Coverage under any other plan. When Northeast Delta Dental is not the first to determine its benefits and there are remaining expenses of the type allowable, Northeast Delta Dental will pay only the amount by which its benefits exceed the amount of benefits payable under the other plan up to the amount Northeast Delta Dental would have paid without regard to the payment by the other plan or the amount of such remaining expenses, whichever is less. In other words, the combined payment of both plans will not exceed the total cost of the service.

   Northeast Delta Dental may use reasonable efforts to determine the existence of other benefit programs but shall be under no obligation to do so. The Eligible Person is required to furnish Northeast Delta Dental with information relative to any other health care program in order to determine liability.

7. For the purposes of determining the applicability and implementing the terms of this provision in the Agreement, Northeast Delta Dental may release or obtain from any third party, without consent or notice, any information which it deems to be necessary to determine its liability. Northeast Delta Dental shall be free from any liability that might arise in relation to such action.

8. Multiple Coverage: When benefits are coordinated with another Northeast Delta Dental plan, or any other plan providing dental benefits, time limitations and frequency of service limitations will not change. Coverages for services for which a specified number are provided per a specified time period shall not be added together to provide more than the number of services specified per time period under this plan. For example, if each plan covers one prophylaxis (cleaning) in a six month period, the combined Coverages will still only cover one prophylaxis in any six month period. If such a service is covered under this plan, but has been paid for, whether in full or part, by another plan, such service will still be counted toward the maximum number of such services allowed per period under this plan.

9. Right of Recovery: Northeast Delta Dental has the right to recover from the payee excess benefit payments.

10. Subrogation: In the event of any payments for Dental Care under this Agreement, Delta Dental shall be subrogated to all the Subscriber's or Eligible Dependent's right of recovery thereof against any third person or organization who may be liable for such payment. The Subscriber or Eligible Dependents shall execute and deliver such instruments and papers and do whatever else is necessary to secure such rights. Such subrogation shall be on a just and equitable basis and not on the basis of a priority lien.

VI. General Claims Inquiry

After a claim is submitted by your Dentist and processed by Northeast Delta Dental, you will be sent or have access to an Explanation of Benefits (EOB) form. This notice will explain the benefits that were paid on your behalf, let you know if any services are Denied or Disallowed, and give you the reason(s) for the denial or disallowance.

If you have any questions regarding your benefits, you may call Northeast Delta Dental for an explanation at 603-223-1234. The toll-free number is 800-832-5700. You will be connected directly to our Customer Service Department.

The Customer Service Representative will need to know the claim number that is located on your Explanation of Benefits form or, if that information is not available, the Subscriber's identification number. This will enable a quick response to your inquiry.

VII. Disputed Claims Procedure

After you have followed the General Claims Inquiry procedure and have reason to believe your benefit determination was not in accordance with the Agreement between Northeast Delta Dental and your group, you have the option of using Northeast Delta Dental's Disputed Claims Procedure. This may be requested within six (6) months of the issuing of Northeast Delta Dental's original Explanation of Benefits. It is recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002 but you may also submit your request by standard mail.

Your request for a review of your claim should refer to the claim(s) in question, state your name and address, and the reasons you think the denial should be evaluated, and provide any additional materials you wish to present.

The Vice President, Professional Relations, or his designee, may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is wholly or partially Denied, you will be furnished with a notice of the decision within thirty (30) days after receipt of the disputed claim. The written notice will include:

1. The specific reason(s) for denial, including reference to the evidence, documentation and/or clinical review criteria used in the decision.
2. Specific reference to the provision(s) upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the Vice President, Professional Relations' response. You have the right to request to meet, either in person or by telephone, with one or more of the reviewers before a final decision on your claim review is made.

If you do not receive notice within the thirty day (30-day) period, the claim is considered Denied in order that you may proceed to the Disputed Claims Review Procedure.

If you have any problem securing a review of your claim, contact your group for assistance.

VIII. Disputed Claims Review Procedure

The Disputed Claims Review Procedure allows you to request a review from Delta Dental's Disputed Claims Review Committee after receipt of written notification of the Vice President, Professional Relations' denial of your claim. The Review Committee is composed of Participating Dentists, non-dentist members of the Board of Directors, and representatives of purchasers.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review within one hundred eighty (180) days from receipt of Vice President, Professional Relations' notice denying the claim, or, if no date is given, within six (6) months of the notice. It is recommended that your written request should be sent certified mail, return receipt requested, to the Review Committee at the Delta Dental address noted previously, but you may also submit your request by standard mail. It must state specifically the reasons for requesting a review. It should contain issues, comments, and supporting materials stating why you believe the response of Northeast Delta Dental's Vice President, Professional Relations was incorrect. No later than thirty (30) days after receipt of your request, the Review Committee will render its written decision, including specific reasons for the decision.

In addition, or as an alternative to the written request procedure, you may request a hearing before the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by legal counsel or other duly authorized representatives, to request the presence of a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses, and to cross-examine witnesses. You or your representative may review the policy and related pertinent documents. The hearing will be scheduled with prompt written notice to you no later than thirty (30) days after your request. A decision will be rendered no later than thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

Notice of Right to Appeal Your Health Insurer's Final Decision

You may have a legal right to have our decision reviewed by an organization that is neutral. This is called Independent External Review.

You must ask for this review no later than 120 days after receiving this notice.

Call the Insurance Division of the Vermont Department of Financial Regulation, consumer insurance assistance line at (800) 964-1784 to ask for this review. If it is not an emergency, call between 7:45 a.m. and 4:30 p.m., Monday through Friday. If it is urgent or an emergency, call 24 hours a day, 7 days a week, including holidays. The recording will tell you how to reach the person on call.

Vermont Department of Financial Regulation
Insurance Division
89 Main Street
Montpelier, Vermont 05620-3601
(800) 964-1784

The Department of the Health Care Advocate can also provide information and help with appeals.

The Office of the Health Care Advocate
P.O. Box 1367
264 North Winooski Avenue
Burlington, Vermont 05402
Voice: Toll-free: (800) 917-7787 or (802) 863-2316
TTY: Toll-free: (888) 884-1955 or (802) 863-2473

IX. Termination

Benefit entitlement may be automatically terminated:

1. On the last day of the month for which the group has failed to make a required payment for you.
2. On the last day of the month in which your eligibility is terminated.

Under certain circumstances, state or federal law may require that benefits be continued for terminated or reduced-hour employees, surviving spouses, or surviving partners of civil unions and Dependents of covered employees, divorced or legally separated spouses and children of current employees, and children of employees entitled to Medicare benefits.

X. Continuation of Benefits

A. State and Federal Law Rights to Continue Coverage

Upon termination of coverage under this dental benefits plan, former Subscribers and/or Eligible Dependents may be eligible, under federal (COBRA) and/or state statutes, to continue group coverage benefits, depending upon certain conditions contained in those laws. If a former Subscriber or Eligible Dependent elects to continue coverage under either the federal or state statute, if either is applicable, the Group under which benefits were formerly provided will be responsible to collect the applicable premium from the persons electing coverage. The applicable state or federal law will govern administration of the continuation coverage. Rights under those statutes are provided below.

In addition, there may be other coverage options for you and your family through the Vermont Health Connect ("VHC"). In the VHC, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for Continuation of Coverage does not limit your eligibility for coverage for a tax credit through the VHC. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within thirty (30) days. Last, you may also apply for an individual plan directly with Northeast Delta Dental by applying online at www.deltadentalcoversme.com or by calling 888-910-5667.

Both you (the employee) and your spouse/partner in a civil union should read the summaries carefully and keep it with your records!

B. Rights under Vermont Law (Continuation of Coverage) (if applicable):

Vermont law provides for the continuation of coverage under this dental benefits plan in several circumstances generally described below. For details of your rights under Vermont law, refer to 8 V.S.A. Section 4090a, et seq.

If you lose eligibility for this dental benefits plan due to a "qualifying event" you may be entitled to continue coverage for a period up to 18 months. Pursuant to Vermont law, "qualifying events" include:

1. Loss of employment, including reduction in hours, that results in ineligibility for this dental benefits plan.
2. Divorce, dissolution or legal separation from your spouse or civil union partner.
3. A Dependent child ceasing to be eligible under the requirements of this policy.
4. Death of the employee.

Continuation of coverage is not applicable, if you were terminated for gross misconduct, are covered by Medicare, or are covered by a replacement dental benefits plan, among other reasons.

Within 30 days following the occurrence of a "qualifying event," the Group is required to provide notice of your rights to continued coverage. The notice will include instructions for electing continued coverage and the premium amount to be paid. The monthly premium you will pay shall not be more than 102% of the Group premium amount for your coverage. You must provide the Group (or its designated agent) with your election to continue coverage in writing within 60 days of receipt of notice from the Group. With your written election, you are responsible to submit payment of the premium to the Group (or its designated agent) for the period from the qualifying event to the end of the month in which you make the election. Thereafter, the monthly premium shall be paid in advance as directed by the Group (or its designated agent).

If you have any questions about your continuation rights under Vermont law, please contact the Plan Administrator or Delta Dental.

C. Continuation Coverage Rights Under COBRA:

Introduction

You are receiving this information because you recently gained coverage under a group dental plan (the Plan). This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group dental coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this policy or contact the Plan Administrator.

You may have other options available to you when you lose group dental coverage. For example, you may be eligible to buy an individual plan through the Vermont Health Connect. By enrolling in coverage through the VHC, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group dental plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost

because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

Qualified beneficiaries will be offered COBRA continuation only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the employee.
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Vermont Health Connect, Medicaid, or other group dental plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthconnect.vermont.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about Vermont Health Connect, visit www.healthconnect.vermont.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Plan Administrator

The Plan Administrator is the individual(s) designated by the employer or other plan sponsor, and if no one is designated, the employer itself. All notices and other communications regarding the Plan and regarding COBRA must be directed to the individual who is acting on behalf of the Plan Administrator.

For More Information

If you, your spouse or Dependent children have any questions about this notice or COBRA, please contact the Plan Administrator. Also, please contact the Plan Administrator if you wish to receive the most recent copy of the Plan's Dental Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

XI. General Conditions

Change of Status:

The Subscriber shall notify his or her group of any event causing a change in the status of an Eligible Person. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, etc.

Transfer of Benefits Prohibited:

Benefits of Eligible Persons are personal and cannot be transferred.

Physical Examinations:

In consideration of waiving physical examination of you or your eligible Dependent(s) and as a condition precedent to the approval of claims hereunder, Delta Dental shall be entitled to receive, to such extent as may be lawful and at its own expense, from any attending or examining Dentist or from hospitals in which a Dentist's service is rendered, such information and records relating to attendance of, or examination of, or treatment rendered to such person as may be required in the administration of such claim. At its own expense, Northeast Delta Dental shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim for the insured is pending hereunder. However, Northeast Delta Dental shall, in every case, preserve the confidentiality of such information except as is necessary for the proper administration of Delta Dental programs.

Right of Recovery:

Northeast Delta Dental will succeed to the Eligible Person's right of recovery against any third person or organization that may be liable. The Eligible Person will authorize Northeast Delta Dental to do whatever is necessary to secure such rights.

Doctor-Patient Relationship:

The Eligible Person has the freedom to choose any Dentist. Dentists rendering service under the Agreement are independent contractors and will maintain the traditional doctor-patient relationship. The Dentist or ODP will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment:

If an Eligible Dependent loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment. Someone enrolled under your policy may lose eligibility if such person ceases to be an Eligible Person in accordance with the provision of Section I. 18.of this DPD.

Maintaining Your Privacy:

Northeast Delta Dental has always respected and carefully preserved the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

By receiving coverage pursuant to this dental benefits plan, each Eligible Person, including a parent or guardian in the case of a minor Dependent, agrees that, except as restricted by applicable state and federal laws, Northeast Delta Dental may have access to all dental and health records, and medical data from Dentists, ODPs, and other health care providers providing services covered under this dental benefits plan.

For a copy of Northeast Delta Dental's Notice of Privacy Practices which describes in detail our respective privacy practices, please visit our website www.nedelta.com. If you wish to have a copy mailed to you or have any questions about the privacy of your health information, please contact:

Privacy Officer Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
(800) 537-1715

Entire Agreement; Amendment:

This Certificate of Insurance, together with the group contract application, Group Contract and OOB constitute the entire contract of insurance. As referenced in this COI, the provisions of this COI are subject to the jurisdiction and requirements of the Department of Financial Regulation. Additionally, we reserve the right to implement changes in American Dental Association (ADA) dental terminology and CDT codes and Delta Dental internal processing policies which do not materially affect the provisions of this COI. Any material modification in this COI shall be valid only if approved by DFR and an executive officer of Northeast Delta Dental and evidenced by a written, signed amendment hereof or endorsement hereto. Any such amendment or endorsement will be provided to you at least sixty (60) days in advance of its effective date. No broker or agent has authority to change this COI or waive any of its provisions.

Governing Law:

This policy is governed by and shall be construed according to the laws of the state of Vermont and its regulations.

XII. Assignment of Benefits

Benefits will be paid directly to the Dentist if the Dentist is a Participating Dentist with the local Delta Dental member company. If the Dentist does not participate with the local Delta Dental member company, payment will be made to the Subscriber unless the state in which the services are rendered requires that assignment of benefits be honored and Northeast Delta Dental receives written notice of an assignment on the claim form before payment for benefits is made.

For services rendered by Other Dental Providers which are required to be considered covered services by the law of the state in which the services were rendered, payment will be made to the Subscriber unless the state in which the services are rendered requires assignment of benefits to such Other Dental Providers be honored and Northeast Delta Dental receives written notice of an assignment on the claim form before payment for benefits is made.

XIII. Statement of ERISA Rights

The following statement is applicable to those dental plans subject to the provisions of the Employees Retirement Income Security Act of 1974 (ERISA):

Your Rights: As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits: Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employees Benefits Security Administration.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report.

COBRA and HIPAA Rights: Continue dental coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a benefit is Denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is Denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employees Benefits Security Agency, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employees Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employees Benefits Security Administration.

XIV. Vermont Mandatory Civil Unions Endorsement

Purpose:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract or certificate to comply with Vermont law.

Definitions, Terms, Conditions, and Provisions:

The definitions, terms, conditions, and any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a civil union established according to Vermont law.

"Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

"Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

Caution: Federal Law Rights May or May Not Be Available

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

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800-832-5700
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800-332-5905

Corporate Office
603-223-1000
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