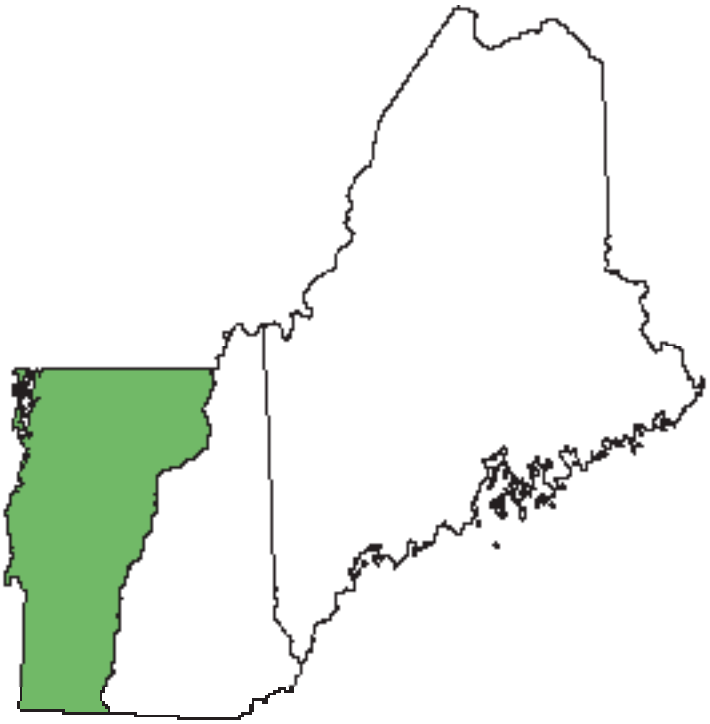
DELTA DENTAL®

Certificate of Insurance

Dental Plan Description



Northeast Delta Dental

Delta Dental Plan of Vermont, Inc.

Form #: VTPD-0511 (3OB001)

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

This Certificate of Insurance, 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 substantial majority of Dentists in Maine, New Hampshire, and Vermont participate with Northeast Delta Dental through Participating Dentist 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 obtain your Dental Care from a Participating Dentist to get the best value from your program.

I. Definitions

1. **Agreement:** the contract 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.
3. **Contract Holder:** the group named in the contract application.
4. **Contract Year for Benefits:** the time period specified in the Outline of Benefits.
5. **Coverage:** the Dental Care referred to in the Agreement.
6. **Coverage Period:** the Contract Year for Benefits as defined above.
7. **DDPA (Delta Dental Plans Association):** the association which is made up of all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.
8. **Deductible:** the portion of the charge for covered Dental Care which the Subscriber or Eligible Dependent must pay before Delta Dental's payment responsibility begins. The Deductible for your Coverage is listed in your Outline of Benefits.
9. **Dental Care:** dental services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with accepted standards of dental practice at the time the service is rendered.
10. **Dental Plan Description (DPD):** this document which serves as your Certificate of Insurance. This Dental Plan Description is part of the Agreement which provides the terms and conditions under which Delta Dental shall administer your dental benefit program.
11. **Dentist:** a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
12. **Dependent:**

    (a) the spouse to whom the Subscriber is legally married or a partner in a valid civil union; and/or

    (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, 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 thirty-one (31) days following birth. Coverage will continue if the child is formally enrolled within the first thirty-one (31) 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 second birthday.

13. **Eligible Dependents:** those Dependents who meet the eligibility requirements of the Agreement and are enrolled by Subscribers in the group's benefit program.

14. **Eligible Persons:** the Subscriber and Dependent(s) (as defined herein).

15. **Maximum:** the dollar amount Northeast Delta Dental will pay per Eligible Person within any Coverage Period (or in a lifetime for orthodontic benefits) for covered benefits. All benefits paid, including benefits for Diagnostic and Preventive services, are counted toward an Eligible Person's Coverage Period Maximum. However, orthodontic payments count only toward the orthodontic Maximum.

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

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

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

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

20. **Participating Dentist:** a Dentist whose fees are filed with and/or accepted by Northeast Delta Dental, and who has signed a participating agreement. A Participating Dentist agrees to abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental. A Dentist who has signed a participating agreement with a Delta Dental company in another state is also a Participating Dentist.

21. **Predetermination:** an administrative procedure by which the Dentist submits the treatment plan to Northeast Delta Dental in advance of performing dental services. 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.

22. **Processing Policies:** policies approved by Northeast Delta Dental, as may be amended from time to time, to be used in processing treatment plans for Predetermination and claims for payment. 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 DPD.

23. **Subscriber:** any person who:

    (a) renders service to the Contract Holder as a paid employee, and

    (b) is certified by the Contract Holder as a member of the group specified in the application, and

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

    (d) Part-time employees working at least seventeen and one-half (17 1/2) hours per week will be eligible to enroll in this dental plan.

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 plan.

You are assured of receiving full benefits under this dental plan if you visit a Participating Dentist. 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. 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 directly based on their filed fees. An Explanation of Benefits form will be sent to you that will indicate the amount you should pay, if any, to your Dentist.

Non-Participating Dentists or Other Dental Providers: Northeast Delta Dental provides coverage regardless of your choice of Dentist, participating or not. When visiting a Non-Participating Dentist or Other Dental Provider (ODP) (who is a person, other than a Dentist, who provides dental services 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.

Payment to Other Dental Providers: Your Northeast Delta Dental Benefit plan is designed to cover only Dental Care when rendered by, or under the supervision of, a Dentist. However, if services which would otherwise be covered if rendered by, or under the supervision of, a Dentist are provided by an Other Dental Provider ("ODP") within the scope of his or her license, such services will not be considered covered services under this plan unless required to be covered by the state in which the services are provided.

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 on file 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 fee schedule or participating status 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 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: Evaluations and radiographs (x-rays) to determine required dental treatment.

Limited oral evaluations.

Oral cancer screening such as a brush biopsy once in a twelve (12) month period.

Oral evaluations – once in any period of six (6) consecutive months. Evaluations can be comprehensive or periodic and may be provided by a specialist or a general Dentist.

Radiographs – a complete series or a panoramic film once in any period of three (3) consecutive years; bitewing films once in any period of twelve (12) consecutive months; films of individual teeth as necessary.

Preventive: Specific procedures employed to prevent the occurrence of dental disease.

Prophylaxis (cleaning) – once in any period of six (6) consecutive months (child prophylaxis through age twelve (12), adult prophylaxis thereafter). A prophylaxis can be routine or periodontal maintenance under Basic Benefits (Coverage B).

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

Fluoride treatments – once in any period of twelve (12) consecutive months through age eighteen (18).

Space Maintainers through age fifteen (15).

Sealants through age fourteen (14).

NOTE:

- ***Time limitations are measured from the date the service was last performed.***
- ***Only those coverage classifications selected by the Contract Holder shall apply.***

Coverage A Exclusions and Limitations:

1. A panoramic film, with or without accompanying bitewings, is considered the same as a complete series and is paid as such.
2. Cone beam imaging is not a covered benefit.
3. Sealant benefit limitation:
   (a) The sealant benefit is provided only to Eligible Persons through age fourteen (14).
   (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 lifetime per tooth.
4. A limited oral evaluation, when done in conjunction with a procedure (other than radiographs) on the same visit, is considered a part of, and included in the fee for, the procedure and is not a covered benefit. Patient is responsible for any additional fee.
5. One oral cancer screening procedure such as a brush biopsy is covered in a twelve (12) month period. Associated pathological laboratory fees for these services are not a covered benefit. Patient is responsible for any additional fee.

6. Payment for additional periapical radiographs within a thirty-day (30-day) period of a complete series or panoramic film, unless there is evidence of trauma, is subject to consultants' review. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

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

8. Space maintainers are a covered benefit for Eligible Dependents through age fifteen (15) when a space is being maintained for an erupting permanent tooth.

9. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for a periodontal scaling and root planing and a Northeast Delta Dental Participating Dentist agrees not to charge a separate fee for the additional procedure.

Basic Benefits (Coverage B)

Restorative:
- Amalgam (silver) restorations (fillings).
- Resin (white) restorations on anterior (front) teeth.
- If Coverage C (Major Benefits) is not provided, for restorative crowns and onlays, an allowance will be made equal to payment for a four surface amalgam restoration at the selected Co-payment percentage.

Oral Surgery: Extractions and covered surgical procedures.

Periodontics: Treatment of diseased tissue supporting the teeth and periodontal maintenance.

Prophylaxis (cleaning) – once in any period of six (6) consecutive months (child prophylaxis through age twelve (12), adult prophylaxis thereafter). A prophylaxis can be routine or periodontal maintenance under Basic Benefits (Coverage B).

A full mouth debridement under Diagnostic and Preventive Benefits (Coverage A) is covered once in a lifetime and when performed is counted towards your prophylaxis 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, when administered in a dental office and in conjunction with: an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body (only when implant services are specified as a benefit on the Outline of Benefits); biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

NOTE:
- ***Time limitations are measured from the date the service was last performed.***
- ***Only those coverage classifications selected by the Contract Holder shall apply.***

Coverage B Exclusions and Limitations:

1. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for a periodontal scaling and root planing and a Northeast Delta Dental Participating Dentist agrees not to charge a separate fee for the additional procedure.
2. Tooth preparation, bases, copings, sedative fillings, 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. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
3. Resin restorations in posterior teeth (white fillings in bicuspids and molars) are not covered unless specified as a benefit in the Outline of Benefits. If a resin restoration is performed, but is not otherwise a benefit, an allowance will be paid equal to an amalgam (silver) restoration, and the patient will be responsible for any additional fee.
4. 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.
5. Benefits are not paid for the replacement of an amalgam restoration within twelve (12) months of its placement or for a resin restoration within twenty-four (24) months of its placement.
6. 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.

7. Periodontal scaling and root planing is a covered benefit per quadrant once in any period of twelve (12) consecutive months. Benefits are paid for a maximum of two (2) quadrants per office visit.

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

9. 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.

10. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years.

11. 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.

12. Clinical crown lengthening is not a covered benefit when performed on the same day as a crown preparation, restoration or osseous surgery. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

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

14. An indirect pulp cap, when rendered at the same time as the final restoration, is considered a base and is not a benefit when billed as a separate procedure in conjunction with the final restoration. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

15. Recementation of a crown, inlay, onlay, and/or partial coverage restoration is a benefit once in any period of twelve (12) consecutive months.

16. Recementation of a cast or prefabricated post and core is a benefit once in any period of twelve (12) consecutive months.

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

18. A partial pulpotomy is a covered benefit on permanent teeth only.

19. A root canal or apexification procedure that is performed within thirty (30) days of a partial pulpotomy, and is performed by the same Dentist, will have the payment for the procedure reduced by the payment for the partial pulpotomy. A Northeast Delta Dental Participating Provider agrees not to charge a separate fee.

20. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, distal wedge, or soft tissue graft procedure is a benefit once in any period of three (3) consecutive years. A gingivectomy for the removal of hypoplastic tissue is not a covered benefit unless diseased tissue is present.

Please note: **Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any 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 fixed partial denture and crown repairs.
Implant Services:	If implant coverage is specified in the Outline of Benefits, 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 service was last performed.***
- ***Only those coverage classifications selected by the Contract Holder shall apply.***

Coverage C Exclusions and Limitations:

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 benefits for Eligible Dependents under the age of twelve (12).
2. Tissue conditioning is not a covered benefit.
3. Coverage C time limitations:
   - (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of seven (7) consecutive years.
   - (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of seven (7) consecutive years.
   - (c) A removable or fixed partial denture in any period of seven (7) consecutive 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 benefit once per tooth in any period of seven (7) consecutive years.
   - (e) The period of seven (7) consecutive 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.
5. A core buildup or post and core performed on the same day as an inlay or onlay is not a covered benefit. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
6. Removable or fixed partial dentures are not benefits for patients under the age of twelve (12).
7. When covered, an implant body including healing cap is a benefit once in a lifetime per site.
8. Implant services, when covered, are not a benefit for patients under the age of sixteen (16).
9. When implant services are covered, eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. Patient will be responsible for any additional fee.
10. 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.

11. Recementation of a fixed partial denture is a covered benefit once in any period of twelve (12) consecutive months.

12. The relining of a denture is a covered benefit once in any period of three (3) consecutive years.

13. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is not a covered benefit. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a consulting Dentist.

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

Orthodontic Benefits (Coverage D)

Orthodontics: Necessary treatment and procedures required for the correction of malposed (crooked) teeth for Dependent children until the end of the month of their nineteenth (19) birthday or as specified in the Outline of Benefits.

Placement of device to facilitate eruption of an impacted tooth.

NOTE:

- ***Time limitations are measured from the date the service was last performed.***
- ***Only those coverage classifications selected by the Contract Holder shall apply.***

Coverage D Exclusions and Limitations:

1. Orthodontic benefit limitations:
   (a) Orthodontic benefits are provided until the end of the month of the Eligible Dependents nineteenth (19) birthday. Subscribers, spouses, civil union partners and Eligible Dependents aged nineteen (19) and over shall not be eligible for orthodontic benefits unless adult coverage is specified in the Outline of Benefits.
   (b) For treatment commenced while a patient is eligible for orthodontic benefits, Northeast Delta Dental will initiate payment of its liability up to the orthodontic Maximum specified in the Outline of Benefits once bands or orthodontic devices are placed.
   (c) For patients who become eligible after orthodontic treatment has commenced, Northeast Delta Dental will pro-rate its liability based on the number of remaining months of active treatment compared to the total number of months of active treatment.
   (d) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.
2. Clear orthodontic appliances are included in orthodontic benefits provided that upon the consulting Dentist's review of pretreatment radiographs it is indicated that the patient has full adult dentition.

   Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. Patient is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.
3. Northeast Delta Dental's payment for orthodontic benefits shall be limited to the lifetime Maximum per patient specified in the Outline of Benefits. Northeast Delta Dental will make one (1) payment at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of twenty-four (24) months for its total liability.
4. For groups with orthodontic benefits, placement of an appliance must take place for Northeast Delta Dental to make payment on diagnostic records. Diagnostic casts, photographs and other diagnostic records are included in the total case fee. If banding does not take place, Northeast Delta Dental has no liability beyond its share of the allowable fee for a comprehensive oral evaluation.
5. The replacement or repair of an orthodontic appliance is not a covered benefit if done by the same orthodontist who placed the appliance. If performed by an orthodontist who did not originally place the appliance, payment will be made for one repair per lifetime.

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

IV. Waiting Periods and General Exclusions and Limitations

1. Application of Waiting Periods Due to Change in Coverage

   If your group had an effective date on or after September 1, 2011 and you had dental coverage in force with another carrier within thirty (30) days prior to the effective date of your coverage under this dental benefits plan, waiting periods will be applied if your prior coverage did not include Basic, Major or Orthodontic benefits, or any one of those, and your coverage under this plan does, you and any spouse or dependents who were enrolled under your prior coverage will need to satisfy the waiting period or periods for the additional coverage you have under this plan.

   If your group had an effective date on or after September 1, 2011 and you had dental coverage in force with Northeast Delta Dental or another carrier within thirty (30) days prior to the effective date of your coverage under this dental benefits plan, waiting periods will be applied if your prior coverage did not include your spouse, or did not include a dependent or dependents, and you are now enrolling one or more of them for coverage, each must satisfy the waiting period(s) applicable to the coverage you have. Their waiting periods will be based on their respective, individual effective dates of enrollment.

2. 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) started 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) preventive control programs; (iv) periodontal splinting; (v) myofunctional therapy; (vi) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (vii) equilibration; and (viii) 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 (Coverage D) benefits. 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. Patient will be responsible for any additional fee.

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

(t) Pulp vitality tests.

3. 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 selects more expensive Dental Care than is customarily provided, Northeast Delta Dental will pay the selected Co-payment 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 Deductible.

(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. Resin (white) restorations of posterior teeth are not a covered benefit unless elected by the Contract Holder. (See your Outline of Benefits for selected coverages.) If a resin restoration is performed, an allowance of the cost of an amalgam restoration will be paid towards the resin restoration and the patient will be responsible for payment of the balance. 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 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, or as soon as reasonably possible thereafter, 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 except for a demonstrated reason preventing submission within the twenty-four (24) month period.

(k) The Date of Incurred Liability refers to the date a service is subject to the applicable Deductible, Co-payment percentage, Maximum benefit, and limitations. The total cost of the service is applied to the Coverage Period during which the service is incurred, irrespective of the Coverage Period in which the service is completed.

Northeast 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 tooth is prepared.

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

(iii) Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the final impressions are taken for said appliance.

(iv) Endodontics — Total cost for endodontic treatment shall be incurred when the pulp chamber of the tooth is opened.

(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 the final impression is taken for said appliance.

(vii) Orthodontics — Total cost for orthodontic treatment shall be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the patient's mouth.

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 2 and 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 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.

   (a) Northeast Delta Dental may use reasonable efforts to determine the existence of other benefit programs but shall be under no obligation to do so.

   (b) 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 an Explanation of Benefits form. This notice will explain the benefits that were paid on your behalf, let you know if any services are denied, and give you the reason(s) for the denial.

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, and

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.

You may also contact:

The Vermont Division of HealthCare Administration
(800) 631-7788 (toll free in Vermont)

VIII. 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 90 days after receiving this notice.

Call the Division of Health Care Administration at (800) 631-7788 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.

Division of Health Care Administration
External Appeals Program
Vermont Department of Banking, Insurance, Securities and Health Care Administration
89 Main Street - Drawer 20
Montpelier, Vermont 05620-3601
(800) 631-7788 or (802) 828-2900

The Department of Health Care Ombudsman can provide information and help with appeals.

The Office of Health Care Ombudsman
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

Unless otherwise specified in the Outline of Benefits, 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 employment 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. Conversion and Continuation of Benefits

If your or your Eligible Dependent's coverage under the program terminates for any reason, including at the end of any coverage continuation period, you and your Eligible Dependent(s) will have no right to convert to an individual dental plan. The benefits provided under the program are group benefits and are not convertible to individual plans or coverages. However, when your or your Eligible Dependent's group coverage under your employer's Plan terminates, including at the end of any continuation of coverage period, you may apply for an individual plan with Northeast Delta Dental. Individual policies will be subject to the terms, conditions, and limitations set forth in the individual policy and applications will be subject to Northeast Delta Dental's normal underwriting requirements. If you qualify for an individual policy, the coverage provided will be different from your coverage under this Plan. You may receive application forms and information by calling Northeast Delta Dental at 800-537-1715.

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:

Rights Under the Federal Statute (COBRA)(if applicable):

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under a group health plan would otherwise end. For simplicity, your group dental plan is referred to in this Notice as the "Plan." You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the premium for your continuation coverage. At the end of the maximum coverage period (described below), there is no individual conversion dental plan available under the Plan. This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than those the COBRA statute requires, and this Notice should be construed accordingly.

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

Qualifying Events

If you are an ***employee*** of the employer and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination of your employment (for reasons other than gross misconduct).
2. Reduction in the hours of your employment.

If you are the ***spouse*** of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse.
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the employer.
3. Divorce or legal separation from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your spouse becomes entitled to Medicare benefits.

In the case of a ***dependent child*** of an employee covered by the Plan, he or she has the right to elect continuation coverage if group dental coverage under the Plan is lost because of any of the following five "qualifying events":

(a) The death of the employee parent.

(b) The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the employer.

(c) Parents' divorce or legal separation.

(d) The employee parent becomes entitled to Medicare benefits.

(e) The dependent ceases to be a "dependent child" under the Plan.

Your IMPORTANT Notice Obligations

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child's losing dependent status under the Plan, then under the COBRA statute, you (the employee) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child's losing dependent status. You or your spouse or dependent must provide this notice no later than 60 days after the date coverage terminates under the Plan. (See this summary plan description for details regarding when Plan coverage terminates.) *If you or your spouse or dependent fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or dependent fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child's losing dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of coverage, then the Plan Administrator will notify the affected family member of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member's current mailing address—see the "YOU MUST NOTIFY US…" on page 21).

You (the employee) and your spouse and dependent children will also be notified of the right to elect continuation coverage upon the following events that result in a loss in coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, or death, or the employee's becoming entitled to Medicare.

Election Procedures

You (the employee) and/or your spouse and dependent children must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Plan Administrator is considered to be made on the date of the mailing.

You (the employee) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not (or is not deemed to) elect it.

You (the employee) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group dental plan or entitled to Medicare.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as a divorce. If the coverage is modified for similarly-situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the Employer maintains more than one group health plan, you (or your spouse or dependent children) may elect COBRA coverage under any one or more of those plans in which you have coverage. For example, if you are covered under three separate employer plans, a medical plan, a dental plan, and a vision plan, you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the employer maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

COBRA Premiums You Must Pay

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse or dependent child by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month's premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA can be cut off before the maximum period expires in certain situations described later under the heading "Termination of COBRA Before the End of the Maximum Coverage Period."

36 Months. If you (the spouse or dependent child) lose group dental coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

18 Months. If you (the employee , spouse or dependent child) lose group dental coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period (for the employee, spouse and dependent child) is 18 months from the date of termination or reduction in hours. There are three exceptions:

- If an employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of the termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Administrator within both the 18-month coverage period and 60 days after the date of the determination.
- If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours.
- If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

Children Born to or Placed for Adoption With the Covered Employee During COBRA Period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered a qualified beneficiary provided that, where the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The covered employee or other guardian has the right to elect continuation coverage for the child, provided that the child satisfies the otherwise applicable plan eligibility requirements (for example, regarding age). The covered employee or a family member must notify the Plan Administrator within 30 days of the birth, adoption or placement for adoption to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the employee. (The 30-day grace period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption.) *If the covered employee or family member fails to so notify the Plan Administrator in a timely fashion, then the covered employee will NOT be offered the option to elect COBRA coverage for the child.*

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA (the "Health Insurance Portability and Accountability Act of 1996"), a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children Born to or Placed for Adoption With the Covered Employee After the Qualifying Event," dependents who are added under HIPAA's special enrollment rights do not become qualified beneficiaries - their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the employee, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

1. The employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse or dependent child) become covered under another group dental plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group dental plan. (Note that under HIPAA, an exclusion or limitation of the other group dental plan might not apply at all to the qualified beneficiary depending on the length of his or her creditable dental plan coverage prior to enrolling in the other group dental plan.)
4. After electing COBRA coverage, you (the employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us About Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If your or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or dependent must promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA rights for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

Plan Administrator

The employer is the Plan Administrator. 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 Summary 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.

Assignment:

Benefits of Eligible Persons are personal and cannot be transferred.

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 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.

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. For a copy of Northeast Delta Dental's Notice of Privacy Practices which describes in detail our respective privacy practices, or if you 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

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 assignments 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 assignments 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. Frequently Asked Questions and Answers

1. **May I Choose Any Dentist?**

   Yes. You are free to choose any Dentist as defined in Section I., Definitions.

2. **Will Northeast Delta Dental Make Payment Directly to The Dentist or Will I Receive Payment?**

   If the Dentist is participating, Northeast Delta Dental will make payment directly to the Dentist. If the Dentist does not participate, then payment for services rendered will be made directly to you unless state law requires that payment be sent to the Dentist.

3. **What Difference Does It Make If I Go to A Participating Dentist or A Non-Participating Dentist?**

   Northeast Delta Dental does not restrict you from visiting any Dentist. However, if you go to a Participating Dentist reimbursement may result in a lower out-of-pocket expense for you. Northeast Delta Dental will pay to such Participating Dentist the applicable selected Co-payment percentage of the allowable fee (as such fees are filed with and/or accepted by Northeast Delta Dental), or the billed fee, whichever is less. Such payment, together with the Subscriber's Co-payment, will satisfy in full the claim of the Participating Dentist for the Dental Care provided.

   If you are treated by a Non-Participating Dentist, Northeast Delta Dental will make payment directly to you on the basis of the Dentist's fee up to the maximum amount allowed Non-Participating Dentists unless state law requires that payment be sent to the Dentist. Otherwise, it will be your responsibility to make full payment to the Dentist.

4. **When Does My Dental Coverage Begin?**

   Refer to the Eligibility Period, in the Outline of Benefits. Only dental services received after you become eligible will be covered.

5. **How Much of the Dental Bill Do I Pay?**

   You are responsible for the amount shown on your Explanation of Benefits form that will include any charges for optional treatment or specific exclusions of your program. Your Dentist may request your Co-payment, Deductible, and payment for non-covered services, at the time services are rendered.

6. **Am I Covered for All Dental Services?**

   Not necessarily. Your Coverage is described in this document and in the Outline of Benefits. These covered benefits are governed by the Exclusions, Limitations, and Northeast Delta Dental's current Processing Policies.

7. **What If My Spouse, Civil Union Partner, Is Covered By Another Dental Plan?**

   You may be entitled to as much as (but not more than) 100% of your Dentist's charges for covered benefits. It is important that you inform your Dentist of any dual coverage so that the proper claim filing procedures may be followed and that you get the maximum benefit from your dental program.

8. **Is It Necessary for Me to Have My Dentist Get a Predetermination for My Dental Services?**

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

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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.

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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603-223-1234
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