



NORTHEAST DELTA DENTAL

SUMMARY PLAN DESCRIPTION

GROUP 1775



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

This booklet 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 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 Delta Dental Plans Association (DDPA) which provides dental care programs in all states and territories.
- A substantial majority of Dentists in Maine, New Hampshire, and Vermont participate with Northeast Delta Dental through Participating Dentist Agreements.

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. General Information

This booklet describes the dental benefits available under the University System of New Hampshire dental benefits plan.

The plan has been established with the intention of being maintained indefinitely; however, the University System of New Hampshire reserves the right to amend, modify or terminate the plan. The plan has been established for the exclusive benefit of active benefits-eligible faculty and staff members, their spouses and dependent children, and partners of same gender.

Benefits are subject to modification by the Board of Trustees of USNH; therefore, benefits available at the time of this printing may be significantly different at a later date.

It is the policy of USNH not to discriminate on the basis of race, color, religion, sex, age, national origin, handicap, marital status, or sexual orientation in the recruitment and employment of faculty and staff or in the operation of any of its programs and activities, in accordance with all relevant federal and state laws and regulations.

PLAN INFORMATION

This Summary Plan Description (SPD) contains all of the terms and conditions of the dental plan. Interpretation of this SPD is the responsibility of the Plan Administrator (University System of New Hampshire).

1. **PARTICIPATING EMPLOYER:**
University System of New Hampshire
2. **NAME AND BUSINESS ADDRESS OF PLAN SPONSOR:**
University System of New Hampshire
Dunlap Center
25 Concord Road
Durham, NH 03824-3525
3. **EMPLOYER IDENTIFICATION NUMBER (E.I.N.) ASSIGNED TO SPONSOR BY IRS:**
02-6000937
4. **PLAN NAME, PLAN NUMBER AND TYPE OF PLAN**
University System of New Hampshire Medical Benefits Plan
Plan #501
Group Dental Benefits
5. **PLAN EFFECTIVE DATE:**
Original Effective Date: January 1, 1986; Revised January 1, 1994; Revised January 1, 1997;
Revised April 1, 1998; Revised January 1, 2001; Revised January 1, 2003; Revised November 1, 2005
6. **TYPE OF ADMINISTRATION:** Administration of this plan is supervised by the Plan Administrator. Claims are submitted to the Contract Administrator which acts on behalf of the Plan Administrator. Reimbursements are made according to the terms of the plan document as described in this Summary Plan Description.
7. **NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN:**

PLAN ADMINISTRATOR: University System of New Hampshire Dunlap Center 25 Concord Road Durham, NH 03824-3525 (603) 862-1800	CONTRACT ADMINISTRATOR: Northeast Delta Dental PO Box 2002 Concord, NH 03302-2002 (800) 537-1715 (603) 223-1000
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The Plan Administrator shall have full power to administer the Plan in all of its details, subject, however, to applicable law.
8. **AGENT FOR SERVICE OF LEGAL PROCESS:** The plan administrator. Service may be made on the plan administrator at the above address.
9. The eligibility requirements, termination provisions, and a description of the circumstances which may result in disqualification, ineligibility, denial or loss of any dental benefits are described in the dental plan description which is attached to, and made part of, this Summary Plan Description.

10. ELIGIBILITY INFORMATION:

Eligible Employees

All active faculty/staff members of the University System of New Hampshire who are appointed to a status position of 50% time or more are eligible for dental coverage. If a covered faculty/staff member is not participating in FlexPlus then such covered faculty/staff member and covered Dependents are eligible for dental coverage only under Option B.

The Waiting Period for new faculty and staff members

If enrollment is completed within sixty (60) days of employment, benefits are effective on the first day of the month following completion of enrollment.

Date of Eligibility:

If enrollment is completed within sixty (60) days of employment, benefits are effective on the first day of the month following completion of enrollment. If enrollment is not completed within the first sixty (60) days of employment, employees must wait until the next open enrollment period. You can only change an election at a time other than during the open enrollment period if there is a change in family status, as explained in the "Special Enrollment"

11. FINANCIAL RECORDS OF THE PLAN:

The financial records of the dental plan shall be maintained on the basis of a Coverage Period commencing on January 1 and ending on December 31.

12. CLAIM DISPUTES:

If a covered person has a claim which has been partially or wholly denied and wishes to question the claims decision, he/she should contact the Plan Administrator or the Contract Administrator (named above), who shall provide the reasons for the decision and the procedure to follow to obtain a full review of the claim. These review procedures are outlined in Section X, Disputed Claims Procedure, and Section XI, Disputed Claims Review Procedure, of this Summary Plan Description booklet.

13. DISCRETIONARY AUTHORITY:

The Plan Administrator shall have full discretionary authority to interpret this plan and its provisions and regulations with regard to eligibility, benefit determination and general administrative matters. The Plan Administrator's decisions shall be binding on all plan participants and conclusive as to all questions of coverage under this plan.

14. The Plan Sponsor reserves the right to amend this plan or to terminate it. If this plan is terminated or if a participant's coverage should terminate, there is no right to obtain an individual (conversion) policy.

II. Definitions

1. **Agreement:** contract between your group and Delta Dental to provide dental benefits to Eligible Persons, including the Outline of Benefits.
2. **Co-payment:** the amount of the Dental Care cost that you are required to pay.
3. **Contract Allowance:** the maximum payment limit for the service set forth in the List of Dental Services (Option B only).
4. **Contract Holder:** the group named in the application.
5. **Contract Year for Benefits:** the time period specified in the Outline of Benefits.
6. **Coverage:** the Dental Care referred to in the Agreement.
7. **Coverage Period:** the Contract Year for Benefits as defined above.
8. **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.
9. **Deductible:** the portion of the charge for covered Dental Care which the Subscriber or Eligible Dependent must pay before Delta Dental's liability begins.
10. **Delta Dental:** the Delta Dental Plans in Maine, New Hampshire, and Vermont, collectively known as Northeast Delta Dental.
11. **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.
12. **Dentist:** a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
13. **Dependent:**
 - a. the spouse to whom the Subscriber is legally married or the Same Sex Domestic Partner of the Subscriber; and/or
 - b. children of the Subscriber or dependent child of a Domestic Partner* by natural birth, legal adoption or in the process of adoption, guardianship, and stepchildren,; provided such children are unmarried, are not in military service, and are the Subscriber's (or Domestic Partner's) dependents for federal income tax purposes unless there is a court decree which awards the dependency exemption(s) to the non-covered parent.

* Dependent children of your Domestic Partner may be eligible for coverage if they reside with you and are listed on your partner's income tax return as Dependents.
14. **Domestic Partner:** Subscriber's unmarried partner of the same sex (and their Dependents) when:
 - a. both parties are each other's sole Domestic Partner;
 - b. are not legally allowed to marry under current laws of the state in which the employee's Domestic Partner resides;
 - c. are not married to anyone;
 - d. are both age eighteen (18) or older and mentally competent;
 - e. share joint responsibility for one another's common welfare and basic needs;
 - f. are not parent, child, sibling, grandparent or any other blood relation which would bar marriage under the laws of the state in which the employee's Domestic Partner resides.
14. **Eligible Dependents:** Dependents who meet the eligibility requirements of the Agreement and are enrolled by Subscribers in the group's benefit program.
15. **Eligible Persons:** the Subscriber and Dependent(s) (as defined herein).

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16. **Maximum:** the dollar amount Delta Dental will pay in any Coverage Period (or lifetime for Orthodontic benefits) for covered benefits.
 17. **Non-Participating Dentist:** a Dentist who has not signed a Participating Dentist Agreement.
 18. **Participating Dentist:** a Dentist whose fees are filed with and/or accepted by Delta Dental, and who has signed a Participating Agreement. A Participating Dentist shall abide by such uniform rules and regulations as are from time to time prescribed by Delta Dental.
 19. **Predetermination:** an administrative procedure by which the Dentist submits the treatment plan to Delta Dental in advance of performing dental services. Delta Dental recommends that you ask your Dentist to request Predetermination of proposed services, which are considered to be other than brief or routine. Predetermination provides an estimate of what Delta Dental will pay for the services, which helps avoid confusion and misunderstanding between you and your Dentist.
 20. **Processing Policies:** are policies approved by Delta Dental, as may be amended from time to time, to be used in processing treatment plans for Predetermination and claims for payment.
 21. **Subscriber:** any person who:
 - a. renders service to the Contract Holder as a paid employee, and
 - b. is certified as being eligible by the Contract Holder as a member of the group specified in the application, and
 - c. enrolls in the group's benefit program.
 22. **Summary Plan Description (SPD):** this document. The Summary Plan Description together with the Agreement form the terms and conditions under which Delta Dental shall administer your dental benefit program.

III. Participation Requirements for Personal and Dependent Coverage

Participation Requirements for Personal Coverage

Eligibility

Only active, benefits-eligible faculty/staff members who are appointed in a status position for at least 50% time and others as designated by USNH are eligible for personal coverage.

Effective Date of Coverage

If enrollment is completed within sixty (60) days of employment, benefits are effective on the first day of the month following completion of enrollment.

If enrollment is not completed within the first sixty (60) days of employment, employees must wait until the next open enrollment period.

You can only change an election at a time other than during the open enrollment period if there is a change in family status, as explained in XIV. General Conditions, "Special Enrollment".

You shall be deemed to have enrolled when you have completed and signed an appropriate enrollment form and have delivered such form to the Human Resource Office.

Deferred Effective Date

If a faculty/staff member is absent from full-time work because of illness or accidental injury on the date he/she would otherwise become eligible for personal coverage, or on the date he/she would otherwise become eligible for an increased amount of personal coverage, the effective date of such coverage shall be deferred until a 30-day period has elapsed since the covered person has received hospital or institutional care of any kind.

Termination Date

Personal coverage shall terminate on the earliest to occur of the following dates:

1. the date on which the plan is terminated;
2. the last day of the period for which contribution has been made, if the faculty/staff member fails to make any contribution which may be required;
3. the day on which the faculty/staff member terminates employment in the classes of persons eligible for coverage. However, if the faculty/staff member is unable to work and has been approved for the USNH Long Term Disability plan, such disabled faculty/staff member's coverage under the plan shall remain in effect for six consecutive months after the commencement of Long Term Disability benefits if the faculty/staff member had been in a benefits-eligible position for up to three years prior to the start of the disability; for 12 consecutive months if the disabled faculty/staff member had been a benefits-eligible position for more than three, but less than six years prior to the start of the disability; or until the faculty/staff member is no longer eligible for Long Term Disability benefits or returns to active service if the faculty/staff member has been in a benefits-eligible position for six or more consecutive years prior to the start of the disability; or reaches retirement age;
4. the faculty/staff member is no longer in an eligible class.

Participation Requirements for Dependent Coverage

Eligibility

Spouses, Same Sex Domestic Partners, unmarried dependent children under age nineteen (19), full time students enrolled at an accredited school or college including regular vacations up to twenty-five years ; disabled dependent.

If a faculty/staff member and spouse or Same Sex Domestic Partner are both eligible for personal eligible to enroll dependent(s).

1. the spouse or Same Sex Domestic Partner shall be deemed to be a faculty/staff member and not a dependent in instances where two person coverage is desired with respect to the parts of this plan which provide both personal coverage and dependent coverage;
2. the spouse or Same Sex Domestic Partner shall be deemed to be a dependent and not a faculty/staff member in instances where family coverage is desired with respect to the parts of this plan which provide both personal coverage and dependent coverage.

An employee cannot be covered as an employee and a dependent.

Effective Date of Coverage

To obtain coverage, an employee must enroll their dependent(s) within sixty (60) days of the dependent's eligibility date. An employee's dependent will be enrolled in the Plan when the employee has completed enrollment. Dependents of employees who are not enrolled within sixty (60) days following the eligibility date will only be eligible to enroll during the open enrollment period or if there is a change in family status, as explained in XIV. General Conditions, "Special Enrollment".

If a dependent child age nineteen (19) to twenty-five (25) is not currently eligible under the Plan and becomes a full-time student at an accredited school or college, the employee may enroll the dependent in the Plan, provided the enrollment form is received within sixty (60) days of the dependent's return to school. The effective date of coverage will be the first day of school.

You shall be deemed to have enrolled when you have completed and signed an appropriate enrollment form and have delivered such form to the Human Resource Office.

Deferred Effective Date

If a dependent is totally disabled by illness or accidental injury on the date coverage or an increase therein would otherwise become effective with respect to that dependent, the effective date of such coverage shall be deferred until a 30-day period has elapsed since the covered person has received hospital or institutional care of any kind.

IV. How to File a Claim

To Use Your Plan Follow These Steps:

Please read this Dental Plan Description 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 Delta Dental's website at www.nedelta.com; refer to your Delta Dental Participating Dentist Directory; or call Delta Dental for information.

When you visit your dental office, inform them that you are covered under a 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 Delta Dental for payment for covered services.

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-payment. Delta Dental will pay the Participating Dentist directly based on their filed fees. A Notification of Benefits form will be sent to you that will indicate the amount you should pay, if any, to your Dentist.

If you visit a Non-Participating Dentist within the Delta Dental operating area of Maine, New Hampshire, and Vermont, you may be requested to bring a claim form that is available by calling Delta Dental or may be downloaded from www.nedelta.com. Payment for services rendered will be made directly to you and will be limited to the lesser of the Dentist's actual submitted charge or the plan's allowance for Non-Participating Dentists located in the tri-state region. It will be your responsibility to make full payment to your Dentist.

If you visit a Dentist outside the operating area of Delta Dental, you may be requested to bring a claim form that is available by calling us or may be downloaded from www.nedelta.com. If your Dentist participates with the local DDPA, payment will be based on their filed fees and sent directly to the Dentist unless it is noted on the claim form that payment should be sent to you. When services are rendered by a Non-Participating Dentist, payment will be sent to the Dentist unless it is noted on the claim form that it should be sent to you. Payment for treatment performed by a Non-Participating Dentist will be limited to the lesser of the actually submitted charge or an amount equal to a selected percentile of a nationally recognized database of dental charges for the geographic area in which the services were provided. When there is not sufficient fee information available for a specific dental procedure, 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 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 benefits based on your current benefits. A new Coverage Period and/or 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). Any changes in a Dentist's fee schedule or participating status may also affect 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 Delta Dental's Customer Service department at 800-832-5700 or 603-223-1234.

V. Benefits

Coverage A (Diagnostic & Preventive) Benefits

Diagnostic: Evaluations and radiographs (x-rays) to determine required dental treatment
Limited oral evaluation
Oral evaluation - twice per calendar year. This can be a comprehensive or periodic evaluation provided by a specialist or a general Dentist
Radiographs – complete series or panoramic film once in any period of three (3) consecutive years; bitewing films (x-rays) twice per calendar year
Diagnostic casts

Preventive: Specific procedures employed to prevent the occurrence of dental disease
Prophylaxis (routine cleaning) - twice per calendar year (child prophylaxis through age 12 (twelve), adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement.
Fluoride treatment - twice per calendar year up to the eighteenth (18) birthday
Sealants

Harmful Habit

Appliances: Minor treatment (fixed or removable appliances) to control harmful habits

NOTE: The time limitation will be measured from the date the service was last performed.

Coverage A Exclusions and Limitations :

1. Any services which are not described as covered expenses in the List of Dental Services, any expense which exceeds the Contract Allowance for the services set forth in the List of Dental Services, and expenses which exceed Delta Dental's maximum amounts reimbursable to Non-Participating Dentists.
2. A panoramic film, with or without accompanying bitewings, is considered the same as a complete series and is paid as such.
3. Sealant benefit limitation:
 - a. Sealant benefit is provided only to Eligible Dependents thirteen (13) years of age or younger.
 - b. Sealant benefit includes the application of sealants to caries-free (no decay) and restoration-free permanent molars.
 - c. Sealant benefit is provided no more than once in any thirty-six (36) month period.
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. A separate fee may not be charged by Participating Dentists.
5. 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 accordingly and a separate fee may not be charged by Participating Dentists.

Coverage B (Basic) Benefits

Diagnostic Radiographs:	Films (x-rays) of individual teeth as necessary
Restorative:	Amalgam (silver) and/or resin (white) restorations (fillings) (anterior teeth)
Oral Surgery:	Extractions and covered surgical procedures
Periodontics:	Treatment of diseased tissue supporting the teeth; periodontal maintenance; and clinical crown lengthening, hard tissue
Endodontics:	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy
Denture Repair:	Repair of removable complete or partial denture to its original condition
Crown Repair:	Repair of crown to its original condition
Fixed Partial Denture Repair:	Repair of fixed partial denture to its original condition
Palliative Treatment:	Minor emergency treatment for the relief of pain
Space Maintainers	

Occlusal Guards and Occlusal Adjustments

Anesthesia:	General anesthesia or intravenous sedation, when administered in conjunction with an extraction, tooth reimplantation, surgical exposure of tooth, surgical placement of implant body, biopsy, transseptal fiberotomy, alveoloplasty, vestibuloplasty, incision and drainage of an abscess, frenulectomy and/or frenuloplasty. General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients: (a) A child under the age of six (6) who is determined by a licensed Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or (b) A person who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician, which place the person at serious risk.
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NOTE: The time limitation will be measured from the date the service was last performed.

Coverage B Exclusions and Limitations:

1. Any services which are not described as covered expenses in the List of Dental Services, any expense which exceeds the Contract Allowance for the services set forth in the List of Dental Services, and expenses which exceed Delta Dental's maximum amounts reimbursable to Non-Participating Dentists.

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2. Payment for additional periapical radiographs within a thirty-day (30) period of a complete series or panoramic film, unless there is evidence of trauma, is subject to consultant's review. A separate fee may not be charged by Participating Dentists.
 3. 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 accordingly, and a separate fee may not be charged by Participating Dentists.
 4. 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 separate fee may not be charged by Participating Dentists.
 5. Resin restorations in posterior teeth (white fillings in bicuspids and molars) are optional. An allowance will be paid equal to an amalgam (silver) restoration. If performed, patient is responsible for additional fee.
 6. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A separate fee may not be charged by Participating Dentists.
 7. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A separate fee may not be charged by Participating Dentists.
 8. Periodontal scaling and root planing is a covered benefit per quadrant once per calendar year.
 9. Exploratory surgical services are not a covered benefit. Patient is financially responsible.
 10. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A separate fee may not be charged by Participating Dentists.
 11. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years.
 12. 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 separate fee may not be charged by Participating Dentists.
 13. Recementation of a crown, inlay, and/or a fixed partial denture is a benefit once in any calendar year.
 14. Repairs to crowns and fixed partial dentures are a benefit once in any period of five (5) consecutive years.
 15. Anterior deciduous root canal therapy is not a covered benefit.
 16. 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.
 17. The replacement or repair of space maintainers is not a covered benefit.
 18. Space maintainers are a covered benefit for Eligible Dependents fifteen (15) years or younger when a space is being maintained for an erupting permanent tooth.
 19. Clinical crown lengthening, hard tissue, is a benefit per tooth once in a three (3) year period.

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 Delta Dental's payment and your financial obligation to the Dentist.

Coverage C (Major) Benefits

Restorative Onlays, Inlays, and Crowns: Onlays, metallic inlays, and crowns 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 relines of such prosthetic appliances; core buildups; and cast and prefabricated post and cores

Implant Services: Surgical placement of endosteal implant body including healing cap

Implant Supported Prosthetics

NOTE: The time limitation will be measured from the date the service was last performed.

Coverage C Exclusions and Limitations:

1. Any services which are not described as covered expenses in the List of Dental Services, any expense which exceeds the Contract Allowance for the services set forth in the List of Dental Services, and expenses which exceed Delta Dental's maximum amounts reimbursable to Non-Participating Dentists.
2. Onlays, 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).
3. Tissue conditioning is not a covered benefit.
4. Coverage C time limitations:
 - a. One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of five (5) consecutive years.
 - b. One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of five (5) consecutive years.
 - c. A removable or fixed partial denture in any period of five (5) consecutive years unless the loss of additional teeth requires the construction of a new appliance.
 - d. Crowns, inlays, onlays, core buildups, and post and cores are a benefit once per tooth in any period of five (5) consecutive years.
 - e. The period of five (5) consecutive years referred to in (a), (b), (c), and (d) above is to be measured from the date the service was last performed.
5. Removable or fixed partial dentures are not benefits for patients under the age of twelve (12).
6. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are covered benefits. Patient will be responsible for any additional fee.
7. The relining of a denture is a benefit once in any period of three (3) consecutive years.
8. Implantology is not a benefit for patients under the age of sixteen (16).
9. Eposteal and transosteal implants are optional. If performed, patient is responsible for additional fee. An allowance will be paid equal to an endosteal implant.
10. An implant body including healing cap is a benefit once in a lifetime per site.

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 Delta Dental's payment and your financial obligation to the Dentist.

Coverage D (Orthodontics) Benefits

Orthodontics: Necessary treatment and procedures required for the correction of malposed (crooked) teeth.

Placement of device to facilitate eruption of impacted tooth

Correction of malposed teeth for Dependent children until the end of the month of nineteenth (19) birthday or as specified in the Outline of Benefits.

NOTE: The time limitation will be measured from the date the service was last performed.

Coverage D Exclusions and Limitations:

1. Orthodontic benefit limitations:
 - a. Under the Basic Option, orthodontic benefits are provided to children only. An Eligible Dependent is covered until the end of the month of their nineteenth (19) birthday.
 - b. Under the High Option, orthodontic benefits are provided to adults (Subscribers and spouses) and children (Eligible Dependents).
 - c. For treatment commenced while a patient is eligible for orthodontic benefits, 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.
 - d. For patients who become eligible after orthodontic treatment has commenced, 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. Delta Dental will make one (1) payment for its total liability.
2. Delta Dental's payment for orthodontic benefits shall be limited to the lifetime maximum per patient specified in the Outline of Benefits.
3. Banding must take place for Delta Dental to make payment on diagnostic records. If banding does not take place, Delta Dental will apply a benefit for procedure D0150 – comprehensive oral evaluation.
4. The replacement or repair of orthodontic appliances 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 any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.

VI. How Basic Option and High Option Benefits are Paid

BASIC OPTION:

Preventive and Diagnostic (Coverage A)

Expenses for Preventive and Diagnostic services will be payable at actual charge, not to exceed the Contract Allowance for that service set forth in the List of Dental Services. **No deductible is applied.**

Restorative (Coverage B)

Expenses for Restorative services will be payable at actual charge, not to exceed the Contract Allowance for that service set forth in the List of Dental Services, **subject to the deductible.**

Major Restorative (Coverage C)

Expenses for Major Restorative services will be payable at actual charge, not to exceed the Contract Allowance for that service set forth in the List of Dental Services, **subject to the deductible.**

Maximum payment per person per Calendar Year is \$1,000.00 for Coverages A, B and C.

Orthodontia (Coverage D)

Expenses for Orthodontic services for a dependent child who is age 19 or less on the date treatment commences shall be payable at 50% of actual charge, not to exceed the maximum allowable for payment. **No deductible is applied.**

Maximum payment per eligible dependent child per **lifetime** is \$1,000.00 for Coverage D.

HIGH OPTION:

Preventive and Diagnostic (Coverage A)

Expenses for Preventive and Diagnostic services shall be payable at 100% of actual charge, not to exceed the maximum allowable for payment. **No deductible is applied.**

Restorative (Coverage B)

Expenses for Restorative services shall be payable at 80% of actual charge, not to exceed the maximum allowable for payment, **subject to the deductible.**

Major Restorative (Coverage C)

Expenses for Major Restorative services shall be payable at 50% of actual charge, not to exceed the maximum allowable for payment, **subject to the deductible.**

Maximum payment per person per Calendar Year is \$1,500.00 for Coverages A, B and C.

Orthodontia (Coverage D)

Expenses for Orthodontic services for a dependent child and adult shall be payable at 50% of actual charge, not to exceed the maximum allowable for payment. **No deductible is applied.**

Maximum payment per eligible person per **lifetime** is \$1,500.00 for Coverage D.

VII. General Exclusions and Limitations

1. The dental benefits provided by 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 Delta Dental to be rendered for cosmetic reasons, or to correct 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 Dependent became eligible under the Agreement.
 - d. Prescription drugs, premedications, and/or relative analgesia.
 - e. Charges for: (a) hospitalization; (b) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section III., Coverage B Benefits); (c) preventive control programs; (d) periodontal splinting; (e) myofunctional therapy; (f) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (g) equilibration; and (h) gnathological reporting.
 - f. Charges for failure to keep a scheduled visit with the Dentist.
 - g. Charges for completion of forms. Such charges shall not be made to a Subscriber or Dependent by Participating Dentists.
 - h. Dental Care that is not necessary and customary, as determined by generally accepted dental practice standards.
 - i. Dental Care or supplies which are not within the classification of benefits defined in the Agreement.
 - j. Appliances, procedures, or restorations for: (a) increasing vertical dimension; (b) analyzing, altering, restoring, or maintaining occlusion; (c) replacing tooth structure lost by attrition or abrasion; (d) correcting congenital or developmental malformations; (e) esthetic purposes; or (f) implantology techniques.
 - k. Payments of benefits incurred by the Subscriber and/or Dependent(s) after the date on which the Subscriber becomes ineligible for benefits.
 - l. Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.
 - m. 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.
 - n. Temporary services.
 - o. A consultation unless performed by a practitioner who is not performing further services.
 - p. Case presentation and treatment planning. Patient will be responsible for any additional fee.
 - q. Athletic mouthguards.
 - r. Pulp vitality tests.
 - s. Incomplete treatment.

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2. The dental benefits provided by Delta Dental shall be limited as follows:
- a. Dental Care rendered by other than a Dentist, shall not be a 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.
 - b. Optional Dental Care: In all cases in which the Subscriber or Eligible Dependent selects more expensive Dental Care than is customarily provided, 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 is subject to change dramatically pending payment by 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 Delta Dental's liability.
 - e. When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, 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) 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 or the entire fee for these services.
 - h. Diagnostic casts (study models) and/or photographs are not a covered benefit by 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. Delta Dental programs provide amalgam or resin restorations for treatment of caries. If the teeth can be restored with such materials, any gold foil restorations, crowns, inlays, or onlays are considered optional. Patient will be responsible for additional fee.
 - j. A claim (or satisfactory written proof acceptable to Delta Dental) must be furnished to 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 a claim with dates of service in excess of the twenty-four (24) month limitation.
 - 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.

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

- (i) Restorative Crowns – Total cost for crowns, onlays, and metallic inlays shall be incurred on the date that the tooth is prepared.

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- (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 segment thereof, or a device, is placed in the patient’s mouth.

VIII. 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.

“Plans” means these types of medical/dental benefits:

- Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and
- Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution

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 that 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:

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- a. the plan of the parent with custody;
 - b. the plan of the spouse of the parent with custody (step-parent);
 - c. the plan of the parent without custody.

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 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 Delta Dental is not the first to determine its benefits and there are remaining expenses of the type allowable, 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 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.

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 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, Delta Dental may release information to or obtain it from any party with a legitimate interest in, without consent or notice, such information. 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 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. Delta Dental has the right to recover from the payee excess benefit payments.

IX. General Claims Inquiry

After a claim is submitted by your Dentist and processed by Delta Dental, you will be sent a Notification 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 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 Notification of Benefits form or; if that information is not available, the Subscriber's identification number. This will enable a quick response to your inquiry.

X. 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 Delta Dental and your group, you have the option of using Delta Dental's Disputed Claims Procedure. This may be requested within six (6) months of the issuing of Delta Dental's original Notification of Benefits. Your written request for a review of your claim should 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.

Your request for a review of your claim should reference the claim(s) in question, state your name and address, and the reasons you think the denial should be evaluated, and 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, and
2. the specific reference to the provision 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.

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.

XI. 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 group purchasers/groups.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review before the final appeal date set forth in the Vice President, Professional Relations' notice denying the claim, or, if no date is given, within six (6) months of the notice. Your written request should be sent certified mail, return receipt requested, to the Review Committee at the Northeast Delta Dental address noted previously. It must state specifically the reasons for requesting a review. It should contain issues, comments, and supporting materials stating why you believe the Delta Dental Vice President, Professional Relations' response was incorrect. Not 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 from 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 Agreement and related pertinent documents. The hearing will be scheduled with prompt written notice to you not later than thirty (30) days after your request. A decision will be rendered not 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.

XII. Termination

Unless otherwise specified in the Outline of Benefits, benefit entitlement may be automatically terminated:

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

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

Coverage with respect to a Dependent shall terminate upon the earliest to occur of the following dates:

1. the date on which the faculty/staff member's personal coverage terminates;
2. the date on which the faculty/staff member's Dependent coverage under the plan terminates;
3. the date on which the faculty/staff member ceases to be included in the classes of persons eligible for Dependent coverage;
4. the last day of the period for which contribution has been made, if the faculty/staff member fails to make any contribution which may be required; or
5. the date on which the Dependent is no longer within the Definition of Dependent contained herein.

XIII. Conversion and Continuation of Benefits:

If you 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.

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 (New Hampshire RSA 415:18 (g)(1) statutes, law 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:

A. 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 what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the employee) and your spouse 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":

1. The death of the employee parent.
2. 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.
3. Parents' divorce or legal separation.
4. The employee parent becomes entitled to Medicare benefits.
5. 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 "YOU MUST NOTIFY US..." paragraph below).

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 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 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, 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.

B. New Hampshire Continuation Statute (RSA 415:18(g)(1) (if applicable):

Whenever any individual becomes ineligible for continued participation in the group dental plan for any reason including death, except dismissal for gross misconduct, the benefits of such group dental plan shall be available at the same group rate to the individual, the surviving spouse and the dependents covered by the group plan, for an extension period of:

1. 18 months; or
2. 29 months in the case of an individual who is determined, under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of the date such individual becomes ineligible for continued participation in the plan; or
3. Except when the widow, widower, divorced spouse, or legally separated spouse of a covered employee is 55 years of age or older, 36 months in the case of:
 - (i) the death of the covered employee;
 - (ii) the divorce or the legal separation of the covered employee from the employee's spouse;
 - (iii) the covered employee's becoming entitled to benefits under Title XVIII of the Social Security Act or within the 18-month continuation in subparagraph (g)(1)(A);
 - (iv) a dependent child ceasing to be a dependent child; or
 - (v) coverage reduction or termination that takes place within one year of the date the employer files for protection under the bankruptcy provisions of Title 11 of the United States Code.
4. When the surviving spouse, divorced spouse, or legally separated spouse of a covered employee is 55 years of age or older, in the case of the death of the covered employee; or, the divorce or the legal separation of the covered employee from the employee's spouse, then the extension period shall continue until the surviving spouse, divorced spouse, or legally separated spouse becomes eligible for participation in another employer-based group dental plan or becomes eligible for Medicare.
5. Extension coverage need not be provided beyond:
 - (i) the first day of the month following the date the individual becomes eligible for benefits under another group plan;
 - (ii) the date of the first Medicare open enrollment period following the date the individual became ineligible for continued participation under the group plan;
 - (iii) the date on which the group plan terminates; or
 - (iv) the date on which coverage ceases because of a failure to make timely payment of premium as required; however, the payment of any premium shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to the plan.
6. The individual, surviving spouse, divorced spouse, legally separated spouse, or dependent shall elect to

continue the participation in the group dental plan according to rules of the New Hampshire Insurance Commissioner. The individual, surviving spouse, or dependent shall be responsible for payment of premiums which may include an administrative fee not to exceed 2 percent of the monthly premium to the employer or policyholder throughout the extension period. Any divorced spouse or legally separated spouse who is responsible for making a portion of or full payment to the employer shall notify the employer and Delta Dental, in writing within 30 days of the decree of divorce or separation, that coverage under this subparagraph is requested. Any employee who is responsible for making a portion of or full payment to the employer shall likewise notify the employer and Delta Dental, in writing within 30 days of the decree of divorce or separation, that coverage under this subparagraph is requested. The employer shall have the right to terminate coverage for a former dependent spouse who is receiving coverage under this subparagraph if any payment for the coverage is not received from the former dependent spouse within 30 days of the date the premium payments are due. If any payment for the coverage for which the employee is responsible is not received from the employee within 30 days of the date the premium payments are due, the employer shall have the right to terminate coverage for a former dependent spouse; however, no such termination shall occur without 30 days' prior notice to the former dependent spouse, during which time the former dependent spouse shall be given an opportunity to make the payments due or to secure payment from the employee. Upon termination of the extension period, the member, surviving spouse, divorced spouse, legally separated spouse, or dependent shall be entitled to exercise any option which is provided in the group dental plan to elect a converted policy. After timely receipt of the premium payment from the individual, surviving spouse, divorced spouse, legally separated spouse, or dependent, if the employer fails to make payments to Delta Dental, with the result that coverage is terminated, the employer shall be liable for benefits to the same extent as Delta Dental would have been liable if coverage had not been terminated.

XIV. General Conditions

To Change an Election:

Annual Open Enrollment

There shall be an open enrollment period in the Fall of each year. If a faculty/staff member delivers a completed and signed enrollment form to the Human Resource or System Benefits Office during the open enrollment period, the elected coverage shall become effective on the January 1 following this enrollment. Such coverage shall not be subject to any provisions of the plan regarding evidence of medical eligibility or preexisting condition limitations.

If a completed and signed enrollment form is not delivered to the Human Resource or System Benefits Office during the open enrollment period, except for the faculty/staff member's initial enrollment, the prior year's Option coverages shall remain in effect, any modification of the Option coverages and provisions shall automatically change and any cost differences shall be automatically instituted.

Special Enrollment

A faculty/staff member can only change an election at a time other than the annual open enrollment period if there is a change in family status.

A change in family status includes:

- birth or adoption of a child
- marriage
- divorce or legal separation
- death of a spouse or dependent child
- addition or loss of a dependent child through a change in legal responsibility for the child's Medical/Dental Coverage
- spouse's termination of employment or commencement of employment
- change of employment status for a faculty/staff member or spouse, from full-time to part-time or from part-time to full-time
- an unpaid leave of absence for a faculty/staff member or spouse
- involuntary loss of Medical/Dental Coverage through spouse's employment

If a faculty/staff member is eligible for a Special Enrollment and wants to change coverage, a revised enrollment form must be received by the Human Resource or System Benefits Office within 30 days of the date of change in family status. The new elections shall be retroactive to the date the family status changed *provided* such enrollment form is received within the 30-day time frame. Federal regulations require changes in elections to be consistent with changes in family status.

Subrogation:

In the event of any payment of benefits under this plan, the plan shall be subrogated to all of the covered person's rights of recovery of those benefits against any person or organization. The covered person shall cooperate with the plan and do whatever is necessary to secure those rights. The covered person agrees to do nothing which would prejudice those rights. It is agreed that if the covered person fails to take the necessary legal action to recover from a responsible party, the plan may proceed in the name of the covered person against the responsible party and will be entitled to the recovery of the amount of benefits paid and the expenses for that recovery. In the event the plan recovers an amount greater than the benefit paid, the excess reduced by the expenses of recovery, will be paid to the covered person. The plan reserves the right to compromise the amount of the claim if, in the opinion of the Plan Administrator, it is appropriate to do so.

Increases/Decreases in Coverage:

Increases: Any increase in the amount of coverage of a covered person shall become effective on the date of such change provided the covered person is actively at work on that date. If he/she is not actively at work on that date, the increase shall be deferred until his/her return to active full-time work.

Decreases: Any decrease in the amount of coverage of a covered person shall become effective on the date of such change.

Assignment:

Benefits of Eligible Persons are personal and cannot be transferred.

Right of Recovery:

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 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 have 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, that 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

XV. Questions and Answers

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

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

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

If the Dentist is participating, 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.

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

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

If you are treated by a Non-Participating Dentist, Delta Dental will make payment directly to you on the basis of the Dentist's fee or the Contract Allowance under Basic Option up to the maximum amount allowed Non-Participating Dentists. It will be your responsibility to make full payment to the Dentist.

If you visit a Dentist outside the geographic area of Northeast Delta Dental, you will need to bring a claim form to the dental office. Payment for services rendered will be made to the Dentist, unless it is noted on the claim form that payment should be sent to you. Delta Dental will pay the lesser of the actually submitted charge or an amount equal to the 90th percentile of a selected national database of dental charges for the geographic area in which you receive such services (or Contract Allowance for Basic Option).

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

Refer to 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 Notification of Benefits form which will include any charges for optional treatment or specific exclusions of your program. Your Dentist may request your Co-payment, Deductible, etc., at the time services are rendered.

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

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

7. **What If My Spouse 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.

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 Delta Dental's payment and your financial obligation to the Dentist.

Exceptional Service Is Our Guarantee

Northeast Delta Dental is committed to providing exceptional service to all of our customers. In fact, we have established the region's first comprehensive guarantee program called *Guarantee of Service Excellence*SM

As a Subscriber, you are very important to us. To emphasize our commitment, we guarantee our service in the following seven major areas.

- Smooth implementation to Northeast Delta Dental
- Exceptional customer service
- Quick processing of claims
- No inappropriate billing by Participating Dentists
- Accurate and quick turnaround of identifications cards
- Timely employee booklets
- Marketing service contacts

For example, if a Dentist charges for more than the appropriate co-payments at the time of service, it's important that we hear from you so that we can resolve it quickly. If you call us with an inquiry, we promise to answer your question immediately or contact you to update our progress within 24 hours. Accurate ID cards and employee booklets will be mailed, generally to your employer, within 15 days of receiving a request, and we're committed to processing 90% of each group's yearly claims within 15 days.

Quality performance has always been an essential component of customer satisfaction. When an area is identified where we did not fulfill our promise, your feedback enables us to enhance our process and, therefore, serve you better. If you are not satisfied with our service, please let us know.

If you would like further information about this program, please call us at 603-223-1234.

Customer Service

603-223-1234

800-832-5700

TTY Hearing Impaired Lines

603-223-1192

800-332-5905

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Corporate Office

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