
Dental Plan Description

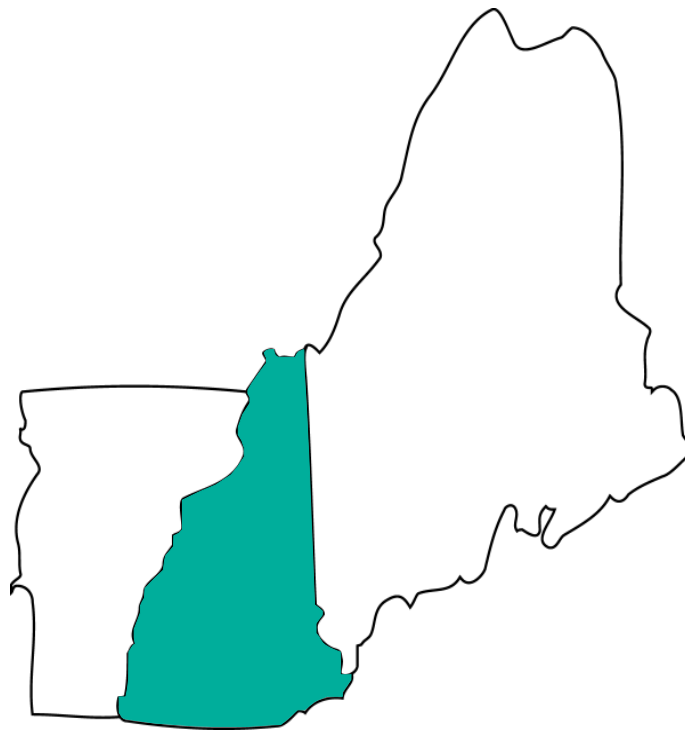


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Delta Dental welcomes you to the growing number of people receiving benefits through our Dental Care programs.

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 Delta Dental Plan. But, before you go on, we would like you to know something about us...

- Delta Dental is a not-for-profit organization established and supported by Dentists to make more Dental Care available to the general public.
- 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 nationwide participate in Delta Dental through Participating Dentist Agreements.

You are encouraged to take advantage of your Delta Dental Plan since good oral health is an important part of your good 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** — means the contract between your group and Delta Dental to provide dental benefits to Eligible Persons.
2. **Co-payment** — is the amount of the Dental Care cost which you are required to pay.
3. **Contract Holder** — means the group named in the application.
4. **Coverage** — means the Dental Care referred to in the Agreement.
5. **Coverage Period** — is the length of time for which you are eligible to receive benefits as specified in the Outline of Benefits.
6. **DDPA (Delta Dental Plan Association)** — means the Association which is made up of all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.
7. **Deductible** — means the portion of the charge for covered Dental Care which the Subscriber or Eligible Dependent must pay before Delta Dental's liability begins.
8. **Delta Dental** — means the Delta Dental Plans in Maine, New Hampshire, and Vermont, collectively known as Northeast Delta Dental.
9. **Dental Care** — means 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** — is this document. The Dental Plan Description together with the Agreement form the terms and conditions under which Delta Dental shall administer your dental benefit program.
11. **Dentist** — means a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
12. **Dependent** — means:
 - a. the spouse to whom the Subscriber is legally married; and/or
 - b. children of the Subscriber by natural birth, legal adoption or guardianship and stepchildren; provided such children are unmarried, are not in military service, and are the Subscriber's dependents for federal income tax purposes unless there is a court decree which awards the dependency exemption(s) to the non-covered parent.

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13. **Disallowed** — means a separate fee may not be charged by a Participating Dentist.
 14. **Eligible Dependents** — mean those Dependents who meet the eligibility requirements of the Agreement and are enrolled by Subscribers in the group's benefit program.
 15. **Eligible Persons** — shall mean the Subscriber and Dependent(s).
 16. **Maximum** — means the dollar amount Delta Dental will pay in any Coverage Period (or lifetime for Orthodontic benefits) for covered benefits.
 17. **Non-Participating Dentist** — is a Dentist who has not signed a Participating Dentist Agreement.
 18. **Outline of Benefits** — is the insert to this booklet which describes your dental benefits.
 19. **Participating Dentist** — is a Dentist whose fees are filed with and/or accepted by Delta Dental or any other member of DDPA, 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 and DDPA.
 20. **Predetermination** — is an administrative procedure where 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.
 21. **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 for payment.
 22. **Subscriber** — means 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.
 23. **Usual, Customary, and Reasonable (UCR) Fees** —

Usual: A Usual Fee is the fee regularly charged and received for a given service by a Participating Dentist. If more than one fee is charged for a given service, the fee determined to be the Usual Fee shall not exceed the lowest fee which is regularly charged, or which is offered to patients.

Fees established by a "bona fide arm's length agreement" between a Participating Dentist and a third-party payor for a group prepayment or insurance program shall not be considered to be "regularly" charged and therefore shall not affect a Participating Dentist's "Usual Fees."

Delta Dental may require a Participating Dentist to document the existence of "a bona fide arm's length agreement" between the Dentist and such third-party payor, in order for the Dentist's fees charged to such payor to be considered to be not "regularly charged."

Exceptions may be made by Delta Dental, including but not limited to the fees charged by Participating Dentists to indigents and to patients covered by programs funded by public or charitable funds or primarily intended to assist the poor or disadvantaged, family members, clergy, senior citizens (65 or older, retired and who are not covered by any dental expense benefit program) and for professional courtesy.

Customary: A fee is Customary when it is within the range of Usual Fees charged by Dentists of similar training and experience for the same service within the same geographic area.

Reasonable: A fee is Reasonable when it is Usual and Customary and is justifiable considering the circumstances of the particular case in question. Additionally, a specific fee to a specific patient is Reasonable if it is justifiable considering special circumstances or extraordinary difficulty of the case in question, as may be determined by Delta Dental.

II. How To File a Claim

To Use Your Plan Follow These Steps:

1. Please read this Dental Plan Description carefully to familiarize yourself with the benefits and provisions of your dental plan.
2. You are assured of receiving full benefits under this dental plan if you visit a Participating Dentist (see your Delta Dental Participating Dentist Directory at your group's office or visit the Delta Dental website at www.nedelta.com or DDPA's website at www.deltadental.com).

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.

3. 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 and send a Notification of Benefits form to you which will indicate the amount you should pay, if any, to your Dentist.
4. If you visit a Non-Participating Dentist, you will need to bring a claim form which is available at your group's office. Payment for services rendered will be made directly to you on the basis of the Dentist's fee up to the maximum amount allowed Non-Participating Dentists by the DDPA member operating in the state where services are rendered. It will be your responsibility to make full payment to your Dentist.
5. 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's 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 Year 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.

III. Benefits

Coverage A Benefits

Diagnostic: Evaluations and x-rays to determine required dental treatment

Limited oral evaluation

Oral evaluation — once in any period of six (6) consecutive months. This can be a comprehensive or periodic evaluation provided by a specialist or a general Dentist.

X-rays — Complete series or panoramic film once in any period of three (3) consecutive years, bitewing x-rays once in any period of twelve (12) consecutive months, x-rays of individual teeth as necessary

Pulp vitality tests

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

Prophylaxis (cleaning) one in any period of six (6) consecutive months (child prophylaxis up to 14th birthday; adult prophylaxis thereafter). This can be a routine prophylaxis (Coverage A) or periodontal maintenance procedures (Coverage B).

Full mouth debridement is a covered benefit once in a lifetime.

Fluoride treatment once in any period of twelve (12) consecutive months to the end of the month of the 19th birthday

Space Maintainers

Sealants

NOTE: *The time limitation will be measured from the date the service was last performed. Only those coverage classifications selected by your group 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. Sealant benefit limitation:
 - a. Sealant benefit is provided only to Eligible Dependents fifteen (15) years or younger.
 - b. Sealant benefit is provided no more than once in a lifetime per tooth, only on the occlusal surface of permanent molars, which must be free of caries and/or restorations.
 - c. Sealants are Disallowed within three (3) years of initial placement by the same Dentist. A separate fee may not be charged by a Participating Dentist. Benefits for sealants are denied if performed after three (3) years have elapsed.
3. An evaluation performed in conjunction with periodontal maintenance procedures is not a covered benefit. A separate fee may not be charged by a Participating Dentist.

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4. A limited oral evaluation, when done in conjunction with a procedure (other than x-rays) 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. 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 separate fee may not be charged by Participating Dentists.
 6. Pulp vitality tests are covered only in conjunction with limited oral evaluations or palliative treatment. When performed in conjunction with definitive treatment, a separate fee may not be charged by a Participating Dentist.
 7. The replacement or repair of space maintainers and orthodontic appliances is not a covered benefit.
 8. Space maintainers are a covered benefit when a space is being maintained for an erupting permanent tooth through age thirteen (13).
 9. One recementation of a space maintainer is allowed per dental office. Subsequent requests for recementation by the same office are denied.

Coverage B Benefits

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| Restorative: | Amalgam (silver) restorations on posterior teeth, resin (white) restorations on anterior teeth and on the buccal (cheek side) surface only of bicusps, and prefabricated stainless steel crowns. If Coverage C is not a covered benefit and unless otherwise specified in the Outline of Benefits, payment for restorative crowns and onlays will be at the selected Co-payment specified in the Outline of Benefits for a four surface amalgam restoration. |
| Oral Surgery: | Extractions and covered surgical procedures. |
| Periodontics: | <p>Treatment of diseased tissue supporting the teeth and periodontal maintenance procedures.</p> <p>Cleaning (prophylaxis) one (1) in any period of six (6) consecutive months. This can be a routine prophylaxis (Coverage A) or periodontal maintenance procedures (Coverage B).</p> |
| Endodontics: | Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy. |
| Denture Repair: | Repair of removable denture to its original condition. |
| Palliative Treatment: | Minor treatment for the relief of pain. |
| Anesthesia: | <p>General anesthesia administered in conjunction with an extraction, tooth reimplantation, surgical exposure of tooth, biopsy, transseptal fibrotomy, alveoloplasty, vestibuloplasty, incision and drainage of an abscess, and/ or frenulectomy. General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients:</p> <ul style="list-style-type: none">(a) A child under the age of four (4) who is determined by a licensed Dentist in conjunction with a licensed primary care physician to have a dental 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. |

NOTE: *The time limitation will be measured from the date the service was last performed. Only those coverage classifications selected by your group shall apply.*

Coverage B Exclusions and Limitations:

1. Periodontal scaling and root planing, when provided in less than three (3) months of treatment as a prophylaxis, a full mouth debridement, or periodontal maintenance procedures, is essentially a duplication of services. Payment is made accordingly and a separate fee may not be charged by Participating Dentists.
2. Tooth preparation, bases, impressions, and local anesthesia, or other services which 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.

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3. Resin restorations in posterior teeth (white fillings in bicuspid and molars) are optional. If performed, patient is responsible for additional fee. An allowance will be paid equal to an amalgam restoration. A buccal (cheek side) single surface resin restoration on a bicuspid is a covered benefit.
 4. 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.
 5. 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.
 6. Periodontal scaling and root planing is a covered benefit once in any period of twenty-four (24) consecutive months per quadrant. Benefits are Disallowed for twenty-four (24) months after initial therapy if the retreatment is performed by the same Dentist. A separate fee may not be charged by a Participating Dentist. If the retreatment is done by a different Dentist within twenty-four (24) months, benefits are denied.
 7. Exploratory surgical services are not a covered benefit. Patient is financially responsible.
 8. An adjustment will be made for two (2) or more surfaces which are normally joined together. A separate fee may not be charged by Participating Dentists.
 9. The replacement or repair of space maintainers and orthodontic appliances is not a covered benefit.
 10. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years. If redone by the same Participating Dentist within twenty-four (24) months of initial treatment, a separate fee may not be charged.
 11. Crown lengthening, when done in conjunction with osseous surgery, crown preparations or restorations, is considered a component of and included in the fee for the complete procedure. A separate fee may not be charged by a Participating Dentist.
 12. A pulp cap, when rendered at the same time as a sedative filling or final restoration, is considered part of the complete procedure and is Disallowed. A separate fee may not be charged by a Participating Dentist.
 13. Recementation of a crown, onlay or inlay is a benefit once in any period of twelve (12) consecutive months. If recementation is provided within six (6) months of initial placement by the same Dentist, it is considered part of the initial procedure. A separate fee may not be charged by a Participating Dentist.
 14. Deciduous root canal therapy is not a covered benefit. When pulpectomy and root canals are performed on primary teeth, the level of benefits is limited to that of a pulpotomy. Patient is responsible for any difference in fee.
 15. Root canal therapy in conjunction with overdentures is not a covered benefit.
 16. Gingivectomy, gingival curettage, 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. The charge for surgical re-entry by the same Participating Dentist within three (3) years is Disallowed. A separate fee may not be charged by a Participating Dentist. The charge for surgical re-entry within three (3) years by a different Dentist is denied.
 17. Alveoloplasties in conjunction with extractions are considered part of the complete procedure. A separate fee may not be charged by a Participating Dentist.

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18. Frenulectomies in conjunction with any other surgical procedure in the same site are considered part of the complete procedure. A separate fee may not be charged by a Participating Dentist.
 19. Palliative treatment, when done in conjunction with definitive treatment, is not a covered benefit. A separate fee may not be charged by a Participating Dentist.
 20. Prefabricated stainless steel crowns are a benefit once per tooth in any period of five (5) consecutive years. If replaced on a primary tooth by the same Dentist within twenty-four (24) months of initial placement, a separate fee may not be charged by a Participating Dentist.
 21. Restorations are a covered benefit only once per surface in any period of twenty-four (24) consecutive months, irrespective of the number or combination of procedures performed. The replacement of amalgam or composite restorations within twenty-four (24) months by the same Dentist is not a covered benefit. A separate fee may not be charged by a Participating Dentist.
 22. Root amputation performed in conjunction with an apicoectomy is Disallowed. A separate fee may not be charged by a Participating Dentist.
 23. Therapeutic pulpotomy is limited to primary teeth. When a pulpotomy is performed on a permanent tooth as an emergency procedure, benefits may be allowed as a palliative treatment. The fee in excess of the palliative treatment is Disallowed. A separate fee may not be charged by a Participating Dentist.
 24. When more than one surgical procedure is provided on the same teeth on the same day, benefits will be based upon, but not limited to, the most inclusive procedure. Benefits for surgical retreatment within three (3) months of the initial surgery are Disallowed. Periodontal surgical procedures by the same Dentist include all necessary postoperative care, finishing procedures and evaluations for three months. A separate may not be charged by a Participating 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 Delta Dental's payment and your financial obligation to the Dentist.

Coverage C Benefits

Prosthodontics: Crowns and onlays when a tooth cannot be adequately restored with amalgam or resin restorations; removable and fixed partial dentures; complete dentures, including rebase and relines of such prosthetic appliances; core buildups; cast and prefabricated post and cores; fixed partial denture and crown repairs; and (if indicated on the Outline of Benefits) endosteal implantology.

NOTE: *The time limitation will be measured from the date the service was last performed. Only those coverage classifications selected by your group shall apply.*

Coverage C Exclusions and Limitations:

1. Porcelain crowns, porcelain fused to metal, full cast metal or resin fused to metal-type crowns are not benefits for Eligible Dependents under the age of sixteen (16).
2. Prefabricated resin crowns are a covered benefit per tooth once every five (5) years on anterior primary teeth only. If provided on a posterior primary tooth, an allowance will be paid equal to a prefabricated stainless steel crown. Patient is responsible for the additional fee.
3. A prefabricated stainless steel crown with a resin window is a benefit only on anterior primary teeth.
4. Tissue conditioning is a covered benefit, twice per denture in a thirty-six (36) month period. If performed in conjunction with initial placement, rebase or relines, a separate fee may not be charged by a Participating Dentist.
5. Prosthodontics (Coverage C) benefit 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, onlays and core buildups are a benefit once per tooth in any period of five (5) consecutive years.
 - e. Post and cores for endodontically treated teeth only are a benefit once per tooth in any period of five (5) consecutive years. If the tooth is not endodontically treated, a separate fee may not be charged by a Participating Dentist.
 - f. The period of five (5) consecutive years referred to in (a), (b), (c), (d) and (e) above is to be measured from the date the service was last performed.
6. When covered, implant body and implant abutment are benefits once in a lifetime per site.
7. Removable or fixed partial dentures are not benefits for patients under the age of sixteen (16).
8. Implantology, when covered, is not a benefit for patients under the age of sixteen (16).

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9. When implantology is covered, 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. 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.
 11. Recementation of a fixed partial denture is a benefit once in any period of twelve (12) consecutive months. If performed within six (6) months of initial placement by the same Participating Dentist, a separate fee may not be charged.
 12. The relining of a denture is a benefit once in any period of three (3) consecutive years. If performed within six (6) months of initial placement or rebase, a separate fee may not be charged by a Participating Dentist.
 13. Two adjustments per complete and removable partial denture are a covered benefit in any period of twelve (12) consecutive months. If performed within six (6) months of initial placement or reline/rebase, a separate fee may not be charged by a Participating Dentist.
 14. Complete or partial dentures include any reline/rebase, adjustment or repair required within six (6) months of delivery; except in the case of immediate dentures. Reline/rebase, adjustment or repair of dentures is Disallowed if performed by the same Dentist/dental office within six (6) months of initial placement. A separate fee may not be charged by a Participating 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 Delta Dental's payment and your financial obligation to the Dentist.

Coverage D Benefits

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

Correction of malposed teeth, surgical exposure of a tooth for orthodontic reasons and transseptal fiberotomy for Dependent children up to age nineteen (19) or as specified in the Outline of Benefits.

NOTE: *The time limitation will be measured from the date the service was last performed. Only those coverage classifications selected by your group 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 Dependent's 19th birthday. Subscribers, spouses, 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, 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, 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. For groups with Orthodontic benefits, banding must take place for Delta Dental to make payment on diagnostic records. If banding does not take place, Delta Dental has no liability beyond its share of UCR Fee, or table allowance, for procedure 00150—comprehensive oral evaluation.
4. The replacement or repair of space maintainers and 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.

IV. General Exclusions and Limitations

1. Unless otherwise specified in the Outline of Benefits, 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 which 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, completed after the date the Subscriber's or Dependent's coverage was terminated under this Agreement.
 - d. Prescription drugs, application of desensitizing medicaments, premedications, and/or relative analgesia.
 - e. Charges for hospitalization, office visits after scheduled hours, general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section III. Coverage B Benefits), preventive control programs, periodontal splinting, myofunctional therapy, treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures, equilibration, and gnathological reporting.
 - f. Charges for failure to keep a scheduled visit with the Dentist.
 - g. Charges for completion of forms is not a benefit nor shall a charge be made to a Subscriber or Dependent by Participating Dentists.
 - h. Dental Care which 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. All services, including evaluations and radiographs, performed for orthodontic purposes where the group does not have Orthodontic (Coverage D) benefits are not covered benefits. If services are rendered they should be done so with the agreement of the patient to assume additional cost.
 - o. Temporary services are not a covered benefit.

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- p. A consultation is not a covered benefit unless performed by a practitioner who is not performing further services. Consultations and evaluations are not covered benefits for procedures that are normally non-covered services. The charge for a consultation should be included in the evaluation fee. It is Disallowed in conjunction with an evaluation. A separate fee may not be charged by a Participating Dentist.
 - q. The fee for consultation, diagnosis and treatment planning is included in the fee for the evaluation and/or diagnostic procedure(s). A separate fee may not be charged by a Participating Dentist.
 - r. Athletic mouthguards and occlusal guards (nightguards) are not covered benefits.
 - s. The fee for isolation of a tooth with a rubber dam is included in the procedure performed. A separate fee may not be charged by a Participating Dentist.
 - t. Canal preparation and fitting of a preformed dowel or post is included in the fee for the post or root canal therapy. A separate fee may not be charged by a Participating Dentist.
 - u. Root amputation performed in conjunction with an apicoectomy is Disallowed. A separate fee may not be charged by a Participating Dentist.
 - v. Benefits are based on the most comprehensive treatment performed. A separate fee may not be charged by a Participating Dentist.
2. Unless otherwise specified in the Outline of Benefits, the dental benefits provided by Delta Dental shall be limited as follows:
- a. Dental Care rendered by other than a Dentist, 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, if 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 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.

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- g. Specialized techniques including, but not limited, to precision attachments, implantology, overdentures and procedures associated therewith, personalizations or characterization, are excluded. Patient will be responsible for part or all of the fee for these services.
 - h. Diagnostic models/photographs are not a covered benefit by Delta Dental unless done for orthodontic purposes for those groups which have Orthodontic (Coverage D) benefits. The charge for such services should be included in the total case fee.
 - i. Delta Dental programs provide amalgam, synthetic, or plastic restorations for treatment of caries. If the teeth can be restored with such materials, any gold 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 completed, irrespective of the Coverage Period in which the service is started.

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

- (i) Restorative Crowns — Total cost for crowns and onlays shall be incurred on the date that the crowns or onlays are cemented.
- (ii) Fixed Partial Dentures (abutment crowns and pontics) — The total cost for fixed partial dentures shall be incurred on the date that the said appliance is cemented.
- (iii) Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the said appliance is delivered to the patient.
- (iv) Endodontics — Total cost for endodontic treatment shall be incurred when the canal(s) is filled to completion.
- (v) Implant Body — Total cost for the implant body, including healing cap, shall be incurred on the date of surgical placement.
- (vi) Implant Abutment — Total cost for the implant abutment shall be incurred on the date of placement.
- (vii) Implant Prosthetics — Total cost for the prosthetic portion of an implant shall be incurred on the date the said appliance is cemented or delivered to the patient.
- (viii) 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.

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.

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 the party to a civil union) 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.

The Eligible Person is required to furnish Delta Dental with information relative to any other health care program in order to determine liability.

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7. For the purposes of determining the applicability and implementing the terms of this provision in the Agreement, 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. Delta Dental shall be free from any liability that might arise in relation to such action.
 8. Multiple Coverage. If an Eligible Person has benefits under two or more Delta Dental programs and both provide coverage for a particular service, the cost of such service will be distributed pro-rata between the applicable programs.
 9. Time limitations and frequencies of service do not change because of the dual coverage. For example, if each plan allows two cleanings in a year, the combined coverage will allow two cleanings in a year.
 10. Right of Recovery. Delta Dental has the right to recover from the payee excess benefit payments.

VI. 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 which is located at the top of your Notification of Benefits form, or if that information is not available, the Subscriber's social security 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 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 forty-five (45) 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 forty-five-day (45-day) period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

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

VIII. Disputed Claims Review Procedure

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

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 parties to civil unions, and Dependents of covered employees, divorced or legally separated spouses or parties to civil unions and children of current employees, and children of employees entitled to Medicare benefits.

X. Conversion and Continuation of Benefits:

1. Former Subscribers and Eligible Dependents whose benefits have been terminated, for any reason, will have no right to convert to an individual plan or coverage with Delta Dental. The benefits provided are group benefits and are not convertible to individual plans or coverages.
2. A former Subscriber and/or his/her Eligible Dependents may be eligible for continuation of benefits under applicable federal or state law, depending upon various qualifying events. If the former Subscriber and/or Eligible Dependents elect to continue benefits in accordance with applicable federal and/or state law, the group providing the benefits will be responsible to collect the applicable dues from the electing former Subscriber and/or Eligible Dependents.

XI. General Conditions

The Subscriber shall notify their 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:

Delta Dental will succeed to the Eligible Person's right of recovery against any third person or organization who 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.

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.

**One Delta Drive
PO Box 2002
Concord, NH 03302-2002
www.nedelta.com**

**Customer Service
603-223-1234
800-832-5700**

**Corporate Office
603-223-1000
800-537-1715**