Certificate of Insurance

Dental Plan Description

Northeast Delta Dental - Vermont Health Connect
Dental with Pediatric High Option

For Individual Contract Holders Only: *This policy may, at any time within ten (10) days after its receipt, be returned by delivering it or mailing it back to Delta Dental and requesting the return of your initial premium payment. If you accept the terms and conditions of the policy, simply continue paying the premium to denote acceptance.*

Term and Renewal of Policy: *This policy is renewable at the option of Delta Dental. If Delta Dental provides written notice of non-renewal at least sixty (60) days prior to the end of the Plan Year, this policy will terminate as of the last day of the Plan Year. The policy will not be renewed if the Enrollees are no longer eligible for coverage under this policy or if this dental program is no longer available.*

Notice to Buyer: This policy provides dental benefits only.

Northeast Delta Dental

Delta Dental Plan of Vermont

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I. Welcome

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

This Certificate of Insurance is issued by Delta Dental Plan of Vermont and delivered in Vermont. It 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 turn the page, we'd like you to know something about us...

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

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

A substantial majority of Dentists in Vermont participate with Delta Dental through Participating Dentist Agreements. In addition, there is a nationwide network of Delta Dental PPO Participating Dentists available to you.

You are encouraged to take advantage of your Delta Dental Plan, because good oral health is an important part of your overall general health. You are also encouraged to obtain your Dental Care from a Delta Dental PPO Dentist to get the best value from your program.

The dental benefits offered by Delta Dental pursuant to this policy are governed by certain policies and procedures of the Department of Vermont Health Access ("DVHA") for certified dental plans offered through the Vermont Health Benefit Exchange known as "Vermont Health Connect" ("VHC"). To the extent applicable, Delta Dental intends to comply with DVHA's policies and procedures in the offering and administration of the dental benefits governed by this policy.

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

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

You will also receive benefits under your dental benefits plan if you choose to visit a Dentist who has signed a Participating agreement to be a Delta Dental Premier Dentist. Delta Dental Premier Dentists are reimbursed by Delta Dental based on the lesser of the actual submitted charge, the Dentist's filed and approved fee, or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Where applicable, Premier Dentists may balance bill up to their filed and approved fee.

You may also choose to visit Dentists who are not Delta Dental PPO Dentists and who do not participate with Delta Dental as a Premier Dentist. Such Dentists are referred to as Non-Participating Dentists or Other Dental Providers (ODPs). You will receive benefits based on the lesser of the actual submitted charge or Delta Dental's allowance for Non-Participating Dentists

or ODPs in the geographic area in which the services were provided. The Non-Participating Dentist or ODP may balance bill up to their submitted charge. When there is not sufficient fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount. You may be requested to bring a claim form for your visit. Claim forms can be downloaded from www.nedelta.com or you may call 1-866-848-2608.

Remember: All Delta Dental PPO Dentists and Delta Dental Premier Participating Dentists agree to:

• File your claim forms for you

• Charge you no more than the amount allowed for payment by Delta Dental

• Accept payment directly from Delta Dental

II. Definitions

1. **Adult Enrollee:** the Subscriber if twenty-one (21) years of age or older on the effective date of your dental benefit plan, and any enrolled Eligible Dependent who is twenty-one (21) years of age or older on the effective date of your dental benefit plan.
2. **Agreement:** the contractual relationship between the Contract Holder and Delta Dental to provide dental benefits to Enrollees. The Agreement includes this document and the contents of VHC's online application ("VHC Application") in the case of an individual Contract Holder. The Agreement includes this document, the contents of VHC's online application ("VHC Application") and the Group Contract in the case of Group Contract Holder.
3. **Coinsurance:** the amount of the Dental Care cost which you are required to pay after application of Coinsurance Percentages.
4. **Coinsurance Percentage:** The percentage specified in the Agreement as the amount covered by this dental benefits plan for Diagnostic and Preventive Benefits (100%), Basic Restorative Benefits (70%) and Major Restorative Benefits (50%), respectively.
5. **Contract Holder:** the individual or Group purchasing this dental benefits plan.
6. **Coverage:** the Dental Care referred to in the Agreement.
7. **Coverage Period:** the Plan Year.
8. **DDPA (Delta Dental Plans Association):** the association which comprises 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 you or the Enrollee must pay before Delta Dental's payment responsibility begins. The Deductible for your Coverage is $50 per Enrollee per Plan Year.
10. **Denied:** If the fee for a procedure or service is denied and chargeable to the patient, the procedure or service is not a benefit of the patient's plan. The approved amount is not payable by Delta Dental, but is collectable from the patient.
11. **Dental Care:** services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practices at the time the service is rendered.
12. **Dental Plan Description (DPD):** this document which serves as your Certificate of Insurance. This Dental Plan Description is part of the Agreement which provides the

terms and conditions under which Delta Dental shall administer your dental benefit program.

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

14. **Dependent:**

    (a) the spouse to whom the Subscriber is legally married, a partner in a valid civil union, or a domestic partner of the same or opposite sex; and/or

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

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

    A newborn child is automatically covered for the first thirty-one (31) days following birth. Coverage will continue if the child is formally enrolled within the first sixty (60) days following birth or the child may be enrolled thereafter at any open enrollment or special enrollment period established by DVHA.

15. **Disallowed:** If the fee for a procedure or service is disallowed, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist.

16. **DVHA:** the Department of Vermont Health Access.

17. **Eligible Dependent(s):** those Dependents who meet the eligibility requirements of the Agreement and are enrolled by the Subscriber as either Adult Enrollees or Pediatric Enrollees.

18. **Enrollees:** the Adult Enrollee(s) and the Pediatric Enrollee(s) (as defined herein).

19. **Group:** the employer selecting this dental benefits plan for its employees.

20. **Maximum:** the Maximum dollar amount Delta Dental will pay for each Adult Enrollee within any Plan Year for covered benefits. The Maximum for each Adult Enrollee under this dental benefits plan is $1,500 per Plan Year. All benefits paid, including benefits for Diagnostic and Preventive services, are counted toward an Adult Enrollee's Plan Year Maximum. The Maximum does not apply to Pediatric Enrollees.

21. **Medically Necessary Orthodontia:** Orthodontic services to correct handicapping malocclusions caused by either one (1) major diagnostic criteria or two (2) minor diagnostic criteria. Major criteria include: cleft palate; two (2) impacted cuspids; posterior crossbite of three (3) or more teeth; or severe craniofacial syndrome (Treacher-Collins syndrome, Marfan syndrome, Pierre Robin syndrome, etc.). Minor criteria are: One (1) impacted cuspid; two (2) blocked cuspids; three (3) congenital missing teeth; open bite of four (4) or more teeth; crowding, anterior cross bite of three (3) or more teeth; traumatic deep bite impinging on palate; or overjet of 8mm. Prior Authorization is required for all Medically Necessary Orthodontic treatment.

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

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

24. **Out-of-Pocket Maximum:** the maximum amount you are required to pay for deductibles and coinsurance for covered services on behalf of each Pediatric Enrollee. The Out-of-Pocket Maximum for each Pediatric Enrollee under this dental benefits plan is $1,000 per Plan Year. The Out-of-Pocket maximum does not apply to Adult Enrollees.

25. **Participating Dentist:** a Dentist whose fees are filed with and accepted by Delta Dental, and who has signed a Participating agreement. A Dentist who has signed a Participating agreement with a Delta Dental company in another state is also considered a Participating Dentist.

26. **Pediatric Enrollee:** the Subscriber if under the age of twenty-one (21) on the effective date of your dental benefit plan, and any enrolled Eligible Dependent under the age of twenty-one (21) on the effective date of your dental benefit plan.

27. **Plan Year:** the time period commencing with enrollment through the end of the calendar year.

28. **PPO Dentists:** a Participating Dentist who has signed an agreement to participate as a member of the Delta Dental PPO network.

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

30. **Prior Authorization:** a required administrative procedure by which the Dentist submits a proposed treatment plan to Delta Dental in advance of performing certain specified procedures of Dental Care for approval based upon standardized and valid risk assessment tools or a Delta Dental dental consultant's review.

31. **Processing Policies:** policies approved by Delta Dental, as may be amended from time to time, to be used in processing treatment plans for Prior Authorization, Predetermination and claims for payment or review. Most frequently used Processing Policies are contained in the terms, conditions and limitations described in this DPD.

32. **Subscriber:**

    (a) the individual identified as the applicant in the VHC if said applicant enrolls in the dental benefit plan, or

    (b) any person who:

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

        (ii) is certified by the Group Contract Holder as a member of the Group, and

        (iii) enrolls in the Group Contract Holder's dental benefit plan.

Part-time employees working at least seventeen and one-half (17 1/2) hours per week for the Group Contract Holder will be eligible to enroll in the Group Contract Holder's dental benefit plan.

33. **VHC:** the Vermont Health Connect health benefits exchange.

III. Information About Your Plan

A. The Way Your Plan Works

1. Covered Services: The dental benefits covered by this plan are indicated in Section V of this DPD.

2. Plan Year Deductible: This plan includes a one-time Deductible of $50 per Enrollee per Plan Year. The Deductible applies only to Basic and Major Restorative Services. The Deductible does not apply to Medically Necessary Orthodontic procedures available to Pediatric Enrollees. Expenses incurred for non-covered services shall not apply toward any applicable Deductible.

3. Annual Maximum: This plan has an annual Maximum for each Adult Enrollee per Plan Year in the amount of $1,500. The Annual Maximum does not apply to Pediatric Enrollees.

4. Out-of-Pocket Maximum: The plan includes an annual Out-of-Pocket Maximum that limits the amount you are required to pay for covered services on behalf of Pediatric Enrollees only. The annual Out-of-Pocket Maximum is $1,000 for each Pediatric Enrollee per Plan Year. Excluded from the Out-of-Pocket Maximum are any payments you make to any Dentists who are not Delta Dental PPO Dentists, and any expenses for non-covered services. The annual Out-of-Pocket Maximum does not apply to Adult Enrollees.

The table below summarizes the way your plan works for Pediatric Enrollees and Adult Enrollees, respectively.

High Option			
Benefits	Pediatric Enrollees (under age 21)		Adult Enrollees (over age 21)
	Benefits prior to reaching the out-of-pocket maximum	Benefits after reaching the out-of-pocket maximum	
Plan Year Out-of-Pocket Maximum per Pediatric Enrollee[1]	$1,000	N/A	None
Diagnostic & Preventive (no Deductible)	100%	100%	100%
Basic Restorative (after Deductible)	70%	100	70%
Major Restorative (after Deductible)	50%	100%	50% [2]
Medically Necessary Orthodontia (no Deductible)	50%	100%	N/A
Plan Year Deductible Per Person	$50	$0	$50
Plan Year Maximum Per Adult Enrollee	None	None	$1,500
[1]Only out-of-pocket expenses incurred by enrollees under the age of 21 for covered services received from Delta Dental PPO Dentists are counted toward the plan year Out-of-Pocket Maximum. Enrollees will keep the Under Age 21 benefits through the end of the Plan Year in which they turn 21. [2]After a 6-month waiting period.			

B. What Your Plan Pays

Your plan's payment is based on the "allowed charge" for a covered service received. The allowed charge is determined by whether the provider of the service is a Delta Dental PPO Dentist, participates with Delta Dental as a Premier Dentist, or does not participate with Delta Dental.

1. If the Dentist is a Delta Dental PPO Dentist, the allowed charge will be the lesser of the actual submitted charge, the Dentist's filed and approved fee, or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible and Coinsurance. The Dentist cannot receive in total more than the agreed amount for the service and has agreed not to bill you for more than that amount.

2. If the Dentist is not a Delta Dental PPO Dentist, but is a Delta Dental Premier Dentist, the allowed charge will be the lesser of the actual submitted charge, the Dentist's filed and approved fee, or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible and Coinsurance, and any difference between your plan's payment and the Premier Dentist's allowed charge for the service. The Premier Dentist cannot receive more than the agreed Premier amount and has agreed not to bill you for more than that amount.

3. If the Dentist is a Non-Participating Dentist or Other Dental Provider, the allowed charge will be the lesser of the actual submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were rendered. Your responsibility will be any applicable Deductible and Coinsurance, and any difference between your plan's payment and the provider's charge for the service. It is in your best interest to discuss what the charge will be before receiving the service.

C. Paying Your Premiums

This policy is being offered on the Vermont Health Connect ("VHC") exchange operated by DVHA. DVHA will bill and collect the required premiums through a third party service provider. DVHA will distribute the applicable premium to Delta Dental.

For Employees of Group Contract Holders: The Group is responsible to make the premium payment for you in accordance with the terms of the Group Contract and the policies and procedures established by DVHA.

For Individual Contract Holders: Unless you are a recipient of advance payments of premium tax credits from which premiums are paid to Delta Dental in part, you have a ten (10) day premium grace period for any monthly premium payment you must make. If you are a recipient of advance payments of premium tax credits from which premiums are paid to Delta Dental in part, you have a three (3) consecutive month premium grace period for any monthly premium you must make. If you pay your required premium payment in full before the end of the applicable grace period, your coverage will not be affected. If you do not pay your premium in full by the end of your grace period, your coverage will end on the last day of the applicable grace period.

D. Termination of Your Plan

For Employees of Group Contract Holders: Unless otherwise specified in the Agreement, 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.
3. Before the end of the Plan Year for any of the following reasons:
   (a) You or the Enrollee commits, or attempts to commit, fraud or material misrepresentation having to do with this policy;
   (b) This plan terminates or is decertified by DVHA; or
   (c) The Enrollee changes from this policy to another plan that includes minimum essential coverage.

Delta Dental may also terminate coverage for an Enrollee under your policy if we become aware that the Enrollee is no longer eligible for coverage under this policy in accordance with DVHA policies and procedures.

In the event of termination by Delta Dental, it will return promptly the unearned portion of any policy premium on a pro-rata basis.

Under certain circumstances, state or federal law may require that benefits continue 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.

For Individual Contract Holders:

1. Termination by you: When you buy this policy, you are committing to keep it for the Plan Year. However, you may qualify to terminate this policy earlier than the end of the Plan Year, but only for one of the following reasons:

   (a) The Enrollee becomes covered under a group dental policy or obtains minimum essential coverage.

   (b) If the Enrollee dies, the person's coverage will terminate after you provide notice to Delta Dental.

If you want to terminate your policy for either of the events described above, you must notify us in writing at least fourteen (14) days in advance of the requested effective date of termination of coverage for the Enrollee. If you provide the fourteen (14) days notice, coverage under this policy will terminate for the Enrollee on the date you request in the termination notice. If you do not specify an effective date of termination in your notice, the policy will terminate fourteen (14) days after you request termination or an earlier date if you request earlier termination and Delta Dental is able to effectuate the termination in fewer than fourteen (14) days.

Notice of termination of this policy should be submitted in writing to:

Vermont Health Connect
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495
Office: (802) 654-8977
Fax: (802) 879-5962
Website: http://healthconnect.vermont.gov

2. Termination by Delta Dental: By required written notice delivered to you at the last address as shown in the records of Delta Dental, Delta Dental may terminate your policy before the end of the Plan Year for any of the following reasons:

   (a) You do not pay the policy premiums when due, including applicable grace periods;

   (b) You or the Enrollee commits, or attempts to commit, fraud or material misrepresentation having to do with this policy;

   (c) This plan terminates or is decertified by DVHA; or

   (d) The Enrollee changes from this policy to another plan that includes minimum essential coverage.

Delta Dental may also terminate coverage for an Enrollee under your policy if we become aware that the Enrollee is no longer eligible for coverage under this policy in accordance with DVHA policies and procedures.

In the event of termination by Delta Dental, it will return promptly the unearned portion of any policy premium on a pro-rata basis.

Effective Date of Termination: Except as specially reference in this Section D., coverage and benefits under this policy will terminate for the Enrollees on the date this policy terminates. The effective date of termination will be:

(a) The last day of the month following receipt by the Contract Holder of required notice and the expiration of the applicable grace period in the event policy premiums are not paid when due; or

(b) The last day of the month of your current Plan Year if you change your legal residence to a place other than Vermont; or

(c) Following receipt of thirty (30) days written notice of termination due to fraud or material misrepresentation; or

(d) The last day of the month of the current Plan Year in which this plan terminates or is decertified; or

(e) The effective date of the replacement coverage through another plan including minimum essential coverage.

E. Renewal and Non-Renewal

This policy will automatically renew for a new twelve (12) month Plan Year if the policy premium continues to be paid by the Contract Holder. If you do not want the policy to be renewed, send written notice to VHC at the address shown above before the policy's renewal date. If you send notice not to renew, this policy will terminate on the last day of the current Plan Year. If we or VHC sends you notice of non-renewal at least sixty (60) days before the end of the Plan Year, your policy will end on the last day of the Plan Year.

Prior to renewal, Delta Dental will provide at least sixty (60) days written notice of any premium adjustment. If the Contract Holder sends written notice to VHC at the address shown above, before the policy's renewal date, your policy will terminate as of the last day of the Plan Year.

If either you, Delta Dental or VHC provides the required written notice that your policy will not be renewed, your policy will terminate on the last day of the Plan Year.

If any renewal premium is not paid within the time granted you for payment, a subsequent acceptance of premium by VHC or by any agent duly authorized by VHC to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if VHC or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by VHC or, lacking such approval, upon the 45th day following the date of such conditional receipt unless VHC has previously notified you in writing of its disapproval of such application. The reinstated policy shall only cover claims after the date of reinstatement. In all other respects you, Delta Dental and VHC shall have the same rights thereunder as each had under the policy immediately before the due date of the defaulted premium to any provisions in connection with the reinstatement. Any premium accepted in connection

with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

F. Reporting a Change in Status for a Person Covered Under Your Plan

You must notify Delta Dental (1-866-848-2608), VHC (1-800-654-8977) and your Group (for employees of Group Contract Holders) of any event causing a change in your status or that of an Enrollee covered under your policy. Events that can affect status include, but are not limited to, marriage, birth, adoption, death, divorce, an Enrollee reaching twenty-one (21) years of age, a Dependent child reaching twenty-six (26) years of age, and change of address.

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.

Ask your Dentist if he/she is a Delta Dental PPO Dentist or participates as a Delta Dental Premier Dentist; 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. Clean written claims must be paid within 30 days.

Participating Dentists: Participating Dentists will have claim forms available in their offices. A Participating Dentist will not charge at the time of treatment for covered services, but may request payment for non-covered services, and applicable Deductibles and Coinsurance. Delta Dental will pay the Participating Dentists directly based on their allowed charges. An Explanation of Benefits form will be sent to you that will indicate the amount you should pay, if any, to your Dentist.

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

Prior Authorizations: For several identified procedures, Prior Authorization is required for Pediatric Enrollees.

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

Predetermination of Benefits: 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. A Predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office.

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

Questions concerning Prior Authorization and Predetermination should be directed to Delta Dental's Customer Service Department at 1-866-848-2608 or 603-223-1444.

V. Benefits

In this section of your policy, we give you the details of what services your policy covers and the conditions and limitations on those services. If you have any questions regarding those services, you may call Customer Service at 1-866-848-2608 Monday through Friday from 8:00 a.m. to 5:00 p.m. EST excluding holidays.

Diagnostic & Preventive Benefits

Diagnostic:	Evaluations and radiographic images (x-rays) to determine required dental treatment.
	Limited oral evaluations.
	Oral evaluations – one time in any period of six (6) consecutive months. Evaluations can be comprehensive or periodic and may be provided by a specialist or a general Dentist.
	Radiographic images – complete series or panoramic image once in any period of three (3) years; bitewing images once in any period of twelve (12) consecutive months; images of individual teeth as necessary.
Preventive:	Specific procedures employed to prevent the occurrence of dental disease.
	Prophylaxis (cleaning) – one time in any period of six (6) consecutive months (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). A prophylaxis can be routine under Diagnostic and Preventive Benefits or periodontal maintenance under Basic Benefits.

A full mouth debridement under Diagnostic and Preventive Benefits is covered once in a two (2) year period and, when performed, is counted towards your prophylaxis benefit.

Fluoride treatments – one time in any period of six (6) consecutive months for Pediatric Enrollees.

Sealants are a covered benefit for Pediatric Enrollees.

Space maintainers are a covered benefit for Pediatric Enrollees.

NOTE: ***Time limitations are measured from the date the service was last performed.***

All covered services for Pediatric Enrollees containing a frequency limitation are available for more frequent treatment only with Prior Authorization.

Diagnostic & Preventive Benefits - Exclusions and Limitations:

1. A limited oral evaluation is a covered benefit, and when performed, is counted towards your oral evaluation benefits. The third limited oral evaluation claim received in 180 days is subject to the dental consultant's review.
2. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings and/or occlusal), is considered a complete series for time limitations and any fee in excess of the fee allowed for a complete series is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.
3. Payment for additional periapical radiographs within a thirty (30) day period of a complete series or panoramic film, unless there is evidence of trauma, is subject to dental consultant's review. A Delta Dental Participating Dentist agrees not to charge a separate fee.
4. When benefits are requested for a panoramic radiographic image in conjunction with a complete series by the same Dentist/dental office, fees for the panoramic radiographic image are Disallowed as a component of the complete series on the same date of service. A Delta Dental Participating Dentist agrees not to charge a separate fee.
5. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure and separate fees are Disallowed on the same date of service.
6. If the fee for bitewing and occlusal radiographic images is equal to or exceeds the fee for a full mouth series, it would be considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service. A Delta Dental Participating Dentist agrees not to charge a separate fee.
7. Cephalometric images, oral/facial photographic images and diagnostic models are covered once every two (2) years when performed for potential Medically Necessary Orthodontic cases for Pediatric Enrollees.
8. Cleanings (Prophylaxis – a Diagnostic/Preventive benefit) are effectively included in both full mouth debridement (a Diagnostic/Preventive benefit) and periodontal maintenance (a Basic Restorative benefit). As a result, each of these procedures is counted toward your prophylaxis benefit of once in a six (6) month period.
9. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, scaling or root planing is considered to be part of and included in those

procedures and the fee is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

10. The replacement of space maintainers is a covered benefit once in a period of two (2) consecutive years for Pediatric Enrollees.

11. Benefits for the removal of a fixed space maintainer by the same Dentist/dental office who placed the appliance are Disallowed anytime following the placement of the space maintainer. A Delta Dental Participating Dentist agrees not to charge a separate fee.

12. The repair of space maintainers is not a covered benefit. The patient is financially responsible.

13. Sealant benefits limitation:

    (a) The sealant benefit is only covered for Pediatric Enrollees.

    (b) The sealant benefit is for the application of sealants to permanent first and second molars.

    (c) The sealant benefit includes the application of sealants to deciduous second molars and bicuspids.

    (d) The sealant benefit is provided no more than once in any five (5) consecutive years per tooth.

    (e) Sealants are Disallowed within two (2) years of initial placement by the same Dentist/dental office. A Delta Dental Participating Dentist agrees not to charge a separate fee. Benefits for sealants are Denied if performed within two (2) years by a different Dentist. The patient will be responsible for the additional fee.

14. Preventive resin restorations are a covered benefit one (1) time per tooth in any period of five (5) consecutive years on permanent molars for Pediatric Enrollees only. Fees are Disallowed if replaced by the same Dentist/dental office within twenty-four (24). A Delta Dental Participating Dentist agrees not to charge a separate fee. Benefits are Denied if replaced by a different Dentist within twenty-four (24) months and the patient will be responsible for the additional fee.

15. The fee for preventive resin restoration is Disallowed if performed on the same date of service as a conventional restoration by same Dentist/dental office. A Delta Dental Participating Dentist agrees not to charge a separate fee.

Basic Restorative Benefits

Restorative: Amalgam (silver) restorations (fillings).
Resin (white) restorations (fillings).
Prefabricated Stainless Steel Crowns for Pediatric Enrollees only.

Periodontal Maintenance: Prophylaxis (cleaning) – one time in any period of six (6) consecutive months (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive, or periodontal maintenance under Basic Restorative.

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

Periodontics: Periodontal scaling and root planing is a covered benefit one time in any period of twelve (12) consecutive months.

Endodontics: Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.

Clinical Crown Lengthening: Once in a lifetime per tooth.

Oral Surgery: Extractions and covered surgical procedures. Excision of lesions and removal of cysts and tumors are covered benefits for Pediatric Enrollees only.

Denture Repair: Repair of removable complete or partial denture to its original condition.

Palliative Treatment: Minor emergency treatment for the relief of pain.

Anesthesia (Adult Enrollees only): General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with: an extraction; a tooth reimplantation; surgical exposure of a tooth; surgical placement of an implant body; a biopsy; a transseptal fiberotomy; an alveoloplasty; a vestibuloplasty; an incision and drainage of an abscess; a frenulectomy and/or a frenuloplasty.

Anesthesia (Pediatric Enrollees only): General anesthesia, intravenous sedation, non-intravenous conscious sedation and nitrous oxide are covered benefits when done in conjunction with other covered services.

Note: ***Time limitations are measured from the date the service was last performed.***

All covered services for Pediatric Enrollees containing a frequency limitation are available for more frequent treatment only with Prior Authorization.

Basic Restorative Benefits - Exclusions and Limitations:

1. Resin or amalgam restorations are covered once per tooth every twenty-four (24) months, irrespective of the number or combination of procedures performed. The replacement of amalgam (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee
2. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Delta Dental Participating Dentist agrees not to charge a separate fee.
3. Prefabricated stainless steel crowns are a covered benefit once in any period of two (2) years for Pediatric Enrollees. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.
4. Cleanings (Prophylaxis – a Diagnostic/Preventive benefit) are effectively included in both full mouth debridement (a Diagnostic/Preventive benefit) and periodontal maintenance (a Basic Restorative benefit). As a result, each of these procedures is counted toward your prophylaxis benefit of once in a six (6) month period.
5. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, scaling or root planing is considered to be part of and included in those procedures and the fee is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

6. Fees for periodontal maintenance, when billed within three (3) months of periodontal therapy by the same Dentist/dental office, are Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

7. Periodontal scaling and root planing is a covered benefit per quadrant once in any period of twelve (12) consecutive months. Benefits are paid for a maximum of two (2) quadrants per office visit. Fees are Disallowed for twelve (12) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. A Delta Dental Participating Dentist agrees not to charge a separate fee. If treatment is done by a different Dentist within twelve (12) months, benefits are Denied. The patient is responsible for the fee.

8. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. When a surgical procedure is billed within three (3) years of the initial surgical procedure by the same Dentist/dental office, the fee for the surgery is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

9. 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. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee. A gingivectomy for the removal of hyperplastic tissue (D7970) is not a covered benefit unless diseased tissue is present.

10. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years. Retreatment of root canal therapy or retreatment of apical surgery by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

11. Direct or indirect pulp caps provided on the same date of service as the final restoration by the same Dentist/dental office are considered part of a single complete restorative procedure and fees are Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

12. A partial pulpotomy is a covered benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within thirty (30) days on the same tooth by the same Dentist/dental office as root canal therapy. A Delta Dental Participating Dentist agrees not to charge a separate fee.

13. Root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

14. The fee for a frenulectomy or frenuloplasty is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office. A Delta Dental Participating Dentist agrees not to charge a separate fee.

15 Alveoplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office, in the same surgical area on the same date. A Delta Dental Participating Dentist agrees not to charge a separate fee.

16. Clinical crown lengthening is a covered benefit once per tooth in a lifetime and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown.

17. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure and is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

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

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

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

21. Fee for repair of a complete denture cannot exceed half the fees for a new appliance, and any excess fee billed by the same Dentist/dental office is Disallowed on the same date of service. A Delta Dental Participating Dentist agrees not to charge a separate fee.

22. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office are Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

23. The fee for palliative treatment is Disallowed when submitted with all procedures except radiographic images and diagnostic codes and is performed by the same Dentist/dental office on the same date. A Delta Dental Participating Dentist agrees not to charge a separate fee.

24. Palliative treatment is a covered benefit. The third palliative treatment claim received in 180 days is subject to dental consultant's review.

25. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office and a separate fee is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

26. 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 Delta Dental Participating Dentist agrees not to charge a separate fee.

Please note: ***Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, 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.***

Major Restorative Benefits

Restorative Crowns and Onlays:	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations. Stainless Steel Crowns for Adult Enrollees only. Onlays are a covered benefit for Adult Enrollees only.
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures (Pediatric Enrollees require a Prior Authorization), including rebase and reline of such prosthetic appliances; core buildups; cast and prefabricated posts and cores; and fixed partial denture and crown repairs.
Implant Services:	Surgical placement of an endosteal implant body including healing cap. Implant services are a covered benefit for Adult Enrollees only.
Implant Supported Prostheses:	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device for Adult Enrollees only.
Medically Necessary Orthodontia:	Medically Necessary Orthodontic treatment and procedures (subject to Prior Authorization) required for the correction of malposed (crooked) teeth for Pediatric Enrollees only. Placement of device to facilitate eruption of an impacted tooth for Pediatric Enrollees only.

Note: ***Time limitations are measured from the date the service was last performed.***

All covered services for Pediatric Enrollees containing a frequency limitation are available for more frequent treatment only with Prior Authorization.

Major Restorative Benefits - Exclusions and Limitations:

1. Onlays (Adult Enrollees only) or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not benefits for Enrollees under the age of twelve (12) without a Prior Authorization.
2. Time limitations:
   - (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of seven (7) consecutive years.
   - (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of seven (7) consecutive years.
   - (c) One (1) immediate maxillary (upper) and one (1) immediate mandibular (lower) denture in a lifetime.
   - (d) A removable or fixed partial denture in any period of seven (7) consecutive years unless the loss of additional teeth requires the construction of a new appliance.

(e) Onlays (Adult Enrollees only), crowns, core buildups, and post and cores are a benefit once per tooth in any period of seven (7) consecutive years.

(f) The period of seven (7) consecutive years referred to in (a), (b), (c), (d) and (e) above is to be measured from the date the service was last performed.

3. Prefabricated stainless steel crowns are a covered benefit once in any period of five (5) years for Adult Enrollees. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Disallowed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

4. Tissue conditioning is a covered benefit once every two (2) years per denture for Pediatric Enrollees.

5. Inlays are not a covered benefit for any Enrollee.

6. Onlays are not a covered benefit for Pediatric Enrollees.

7. A core buildup or post and core performed on the same day as an inlay or onlay is not a covered benefit. A Delta Dental Participating Dentist agrees not to charge a separate fee.

8. The fees for core buildups are Disallowed when buildups are performed in conjunction with inlays, 3/4 crowns or onlays. A Delta Dental Participating Dentist agrees not to charge a separate fee.

9. An indirectly fabricated post and core in addition to a crown is payable only on an endodontically treated tooth. Fees for post and cores are Disallowed when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth. A Delta Dental Participating Dentist agrees not to charge a separate fee.

10. Removable fixed partial dentures are a covered benefit for Pediatric Enrollees, only with a Prior Authorization.

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

12. Recementation of a fixed partial denture is a covered benefit once in any period of five (5) years for Adult Enrollees only. Fees for recementation of fixed partial dentures are Disallowed if done within six (6) months of the initial placement by the same Dentist/dental office. A Delta Dental Participating Dentist agrees not to charge a separate fee.

13. The relining of a denture is a covered benefit once in any period of three (3) consecutive years. The fee for reline of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the Dentist/dental office is Disallowed on the same date of service. A Delta Dental Participating Dentist agrees not to charge a separate fee.

14. The rebase of a denture is a covered benefit once in two (2) years with Prior Authorization for Pediatric Enrollees, and once in seven (7) years for Adult Enrollees. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Disallowed on the same date of service. A Delta Dental Participating Dentist agrees not to charge a separate fee.

15. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is not a covered benefit. Sectioning of a fixed partial denture to preserve a portion

of the denture for continued use may be covered but is subject to review by a dental consultant.

16. Surgical placement of an implant body, including healing cap is a covered benefit for Adult Enrollees only.

17. An implant body including healing cap is a benefit once in a lifetime per site for Adult Enrollees only.

18. Implant services are a covered benefit for Adult Enrollees only.

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

20. Implant services and implant supported prosthetics are not covered benefits for Pediatric Enrollees.

21. Orthodontic benefit limitations (for Pediatric Enrollees only):

    (a) For Medically Necessary Orthodontic treatment commenced while a Pediatric Enrollee is eligible for orthodontic benefits under this policy, Delta Dental will initiate payment of its liability once bands or orthodontic devices are placed. Delta Dental requires dental consultant review to deterimine if Orthodontic treatment is medically necessary.

    (b) For Medically Necessary Orthodontic treatment commenced prior to becoming eligible under this policy, 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 requires dental consultant review to determine if orthodontic treatment was medically necessary at the start of treatment.

    (c) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.

    (d) Delta Dental will make one (1) payment of twenty-five percent (25%) of the allowed charge at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of thirty-six (36) months for its total liability. "Start of treatment" means the date of initial banding or a segment thereof, or a device is placed in the patient's mouth.

    (e) Diagnostic casts, photographs and other diagnostic records are covered once every two (2) years for potential orthodontic cases.

    (f) The replacement of an orthodontic appliance is a covered benefit once per arch in a lifetime.

    (g) The repair of an orthodontic appliance is not a covered benefit. The patient is financially responsible.

    (h) Periodic monthly payments will continue based upon the continuing eligibility of the Pediatric Enrollee.

Please note: ***Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, 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. Waiting Periods and General Exclusions and Limitations

1. Waiting Periods Generally:

   A Waiting period of six (6) months applies to Adult Enrollees only and only in connection with Major Restorative Benefits. There are no waiting periods for Adult Enrollees in connection with Diagnostic and Preventive Benefits and Basic Restorative Benefits. There are no waiting periods in connection with any benefit under this plan for Pediatric Enrollees.

2. Application of Waiting Periods Due to Change in Coverage:

   If you had dental coverage in force with Delta Dental or another carrier for at least six (6) months and within thirty (30) days prior to the Effective Date of your coverage under this dental benefits plan, waiting periods for the same Major benefits will be deemed satisfied under this plan for each Adult Enrollee who was also covered under your prior coverage.

3. 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, such as bleaching or whitening of teeth (unless discolored by previous endodontic therapy), placement of veneers, correction of congenital malformations, or cosmetic surgery. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.

   (c) Services for Adult Enrollees including, but not limited to, endodontics and prosthodontics (including restorative crowns), started prior to the date the Adult Enrollee became eligible under the policy.

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

   (e) Prescription drugs or the application of anti-microbial agents.

   (f) Charges for: (i) hospitalization; (ii) preventive control programs; (iii) myofunctional therapy; (iv) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (v) equilibration; and (vi) gnathological reporting.

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

   (h) Charges for completion of forms. Such charges shall not be made to an Enrollee or eligible dependent by Participating Dentists.

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

   (j) Dental Care or supplies which are not within the benefits for the option selected.

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

(l) Payments of benefits incurred by you and/or the Enrollee after the date on which the Enrollee becomes ineligible for benefits.

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

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

(o) Temporary services or incomplete treatment.

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

(q) Case presentation and treatment planning. You or the Enrollee will be responsible for any additional fee.

(r) Pulp vitality tests.

4. The dental benefits provided by Delta Dental shall be limited as follows unless otherwise required by Vermont law:

(a) Dental Care rendered by anyone 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 you or the Enrollee selects more expensive Dental Care than is customarily provided, Delta Dental will pay the selected applicable Coinsurance Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. You and the Enrollee shall be responsible for the remainder of the Dentist's fee.

(c) Predetermination and Prior Authorization do not guarantee payment. Payment is based upon eligibility, benefits selected, and allowable charges at the time the Dental Care is actually rendered. If Coordination of Benefits is involved, the amount of payment is subject to change depending upon the payment by the primary carrier.

(d) Services completed or in progress at the Enrollee'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) Specialized techniques including, but not limited to, precision attachments, overdentures and procedures associated therewith, and personalizations or characterization are excluded. You and the Enrollee will be responsible for part of or the entire fee for these services.

(g) Interpreter services are a covered benefit when performed in conjunction with other covered services for Pediatric Enrollees only.

(h) Delta Dental programs provide amalgam (silver) and resin (white) restorations for treatment of caries. If the teeth can be restored with such materials, any gold restorations, or crowns are also considered optional. You and the Enrollee will be responsible for any additional fee.

(i) A completed 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 claims with dates of service in excess of the twenty-four (24) month limitation. Benefits payable under this policy for any claim will be paid promptly upon receipt of written notice of claim.

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

(k) The Date of Incurred Liability refers to the date a service is subject to the applicable Deductible, Coinsurance Percentage, and limitations. Except as otherwise noted, the total cost of the service is applied to the Plan Year during which the service is completed, irrespective of the Plan Year in which the service is started.

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

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

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

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

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

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

VII. 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 Enrollee 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 Enrollee 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 Enrollee solely as the Subscriber shall determine its benefits before the plan which covers the Enrollee solely as a Dependent.

3. The plan covering the Enrollee solely as a Dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the Enrollee solely as a Dependent child 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 Enrollee for the longer period of time shall be determined first.

5. The order of payment for the claims of an enrolled 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/civil union partner/domestic partner of the parent with custody (step-parent);

   (c) the plan of the parent without custody;

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

   However, when the parents are separated or divorced and there is a court decree which establishes financial responsibility with respect to the enrolled Dependent 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.

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

   (b) The Enrollee 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 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: 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.

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

VIII. General Claims Inquiry

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

If you have any questions regarding your benefits, you may call Delta Dental for an explanation at 603-223-1444. The toll-free number is 1-866-848-2608. You will be connected directly to our Customer Service Department.

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

IX. 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 terms of this policy, 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 Explanation of Benefits. It is recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002, but you may also submit your request by standard mail.

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

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

1. the specific reason(s) for denial, and

2. the specific reference to the provision of this agreement 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:

You may also contact:

Vermont Department of Financial Regulation
Insurance Division, Consumer Services
1-800-964-1784 (toll free in Vermont)

Department of Vermont Health Access
1-802-879-5900

The Office of Health Care Ombudsman
1-800-917-7787 (toll free in Vermont)

X. Disputed Claims Review Procedure

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

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

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

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

You must ask for this Independent External Review no later than one hundred twenty (120) days after receiving the notice of internal review denial.

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

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

The Department of Health Care Ombudsman can provide information and help with appeals.
The Office of Health Care Ombudsman
P.O. Box 1367
264 North Winooski Avenue
Burlington, Vermont 05402
Voice: Toll-free: (800) 917-7787 or (802) 863-2316
TTY: Toll-free: (888) 884-1955 or (802) 863-2473

XI. General Contract Provisions

Assignment:

Benefits of Enrollees are personal and cannot be transferred.

Right of Recovery:

Delta Dental will succeed to the Enrollee's right of recovery against any third person or organization that may be liable.

Physical Examinations:

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

Doctor-Patient Relationship:

The Enrollee has the freedom to choose any Dentist or ODP. Dentists and ODPs rendering service under the Agreement are independent contractors and will maintain the traditional doctor-

patient relationship. The Dentist or ODP will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility during Treatment:

If an Eligible Dependent loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment. Someone enrolled under your policy may lose eligibility if such person ceases to be an eligible person in accordance with the provision of Section II. 14. of this policy, and the policies of DVHA.

Maintaining Your Privacy:

Delta Dental has always respected and carefully preserved the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained. For a copy of Delta Dental's Notice of Privacy Practices which describes in detail our respective privacy practices, or if you have any questions about the privacy of your health information, please contact:

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
1-800- 537-1715

Entire Agreement:

This Certificate of Insurance, together with the VHC Application, and additionally the Group Contract in the case of a Group Contract Holder, constitute the entire contract of insurance. No change in this Certificate of Insurance shall be valid unless approved by an executive officer of Northeast Delta Dental and evidenced by a written, signed endorsement hereto. No broker or agent has authority to change this Certificate of Insurance or waive any of its provisions.

Governing Law:

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

Notice of Legal Action:

You may not bring a legal action against Delta Dental under this policy until sixty (60) days after notice of claim. No such action shall be brought after the expiration of three (3) years after the time written notice of claim is required to be furnished.

Nonwaiver of Rights: Severability:

Failure of Delta Dental to exercise any right or remedy under this policy in any instance will not affect its right to exercise that right or remedy in any future instance. Any condition, limitation or other provision of this policy which is found to be illegal or unenforceable for any reason will not affect the remaining provisions of this policy.

Voidability:

After three (3) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for such policy shall be used to void the policy or to deny a claim (as defined in the policy) commencing after the expiration of such three (3) year period.

XII. Assignment of Benefits

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

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

XIII. Vermont Mandatory Civil Unions Endorsement

Purpose:

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

Definitions, Terms, Conditions, and Provisions:

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

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

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

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

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

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

Caution: Federal Law Rights May or May Not Be Available

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee

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

XIV. Continuation of Benefits (For Employees of Group Contract Holders Only)

State and Federal Law Rights to Continue Coverage

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

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

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

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

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

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

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

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

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 the entire premium for your continuation coverage. This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than those the COBRA statute requires, and this Notice should be construed accordingly.

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

Qualifying Events: If you are an ***employee*** of the Group and are covered by the Plan and your Group is required to provide COBRA, 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 Group.
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 Group.
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 Certificate of Insurance for details regarding when Plan coverage terminates.) *If you or your spouse or Dependent fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or Dependent fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child's losing Dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with notice of a divorce, legal separation, or a child's losing Dependent status that has caused a loss of coverage, then the Plan Administrator will notify the affected family member of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member's current mailing address—see the "YOU MUST NOTIFY US…" on page 36).

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

Election Procedures

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

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

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

Type of Coverage

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

If the Employer maintains more than one group health plan, you (or your spouse or dependent children) may elect COBRA coverage under any one or more of those plans in which you have

coverage. For example, if you are covered under three separate employer plans, a medical plan, a dental plan, and a vision plan, you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the employer maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

COBRA Premiums You Must Pay

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

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

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

Maximum Coverage Periods

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

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

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

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

- If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

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

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered a qualified beneficiary provided that, where the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The covered employee or other guardian has the right to elect continuation coverage for the child, provided that the child satisfies the otherwise applicable plan eligibility requirements (for example, regarding age). The covered employee or a family member must notify the Plan Administrator within sixty (60) 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 sixty (60)-day grace period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption.) *If the covered employee or family member fails to so notify the Plan Administrator in a timely fashion, then the covered employee will NOT be offered the option to elect COBRA coverage for the child.*

Open Enrollment Rights and HIPAA Special Enrollment Rights

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

Termination of COBRA before the End of Maximum Coverage Period

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

1. The Group no longer provides the group dental plan 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. 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 Dental Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

XV. Statement of ERISA Rights (For Employees of Group Contract Holders Only)

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

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

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

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and

copies of latest annual report (Form 5500 Series) and updated Dental Plan Description. The administrator may make a reasonable charge for the copies.

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

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

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

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

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

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

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

about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Northeast Delta Dental
Delta Dental Plan of Vermont
One Delta Drive
PO Box 2002
Concord, NH 03302-2002

www.nedelta.com

Customer Service
603-223-1444
1-866-848-2608
TTY/Hearing Impaired
1-800-332-5905

Corporate Office
603-223-1000
1-800-537-1715