

# Dental

## *Plan Description*

for Benefits Provided by HealthTrust

**HealthTrust** 

 **DELTA DENTAL®**

Northeast Delta Dental

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**Please see your Outline of Benefits provided to you upon initial enrollment and upon Plan updates for a description of the specific Benefits under the HealthTrust Dental Plan offered by your employer. You can also obtain a copy of the Outline of Benefits by contacting HealthTrust’s Enrollee Services or Northeast Delta Dental’s Customer Service.**

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## INTRODUCTION AND GENERAL INFORMATION

HealthTrust would like to welcome you to the growing number of people receiving dental Benefits through our Dental Care programs. As an additional employee benefit, your employer is providing you with a Dental Care program. Coverage under the program is provided by HealthTrust, Inc. (“HealthTrust”), while Delta Dental Plan of New Hampshire (“Northeast Delta Dental”) administers the program and pays the claims. You are encouraged to participate in Northeast Delta Dental’s innovative Health through Oral Wellness® (HOW®) program to be eligible for additional preventive dental benefits based upon a risk assessment by your Dentist.

This booklet describes the terms and conditions of coverage and Benefits under the HealthTrust Dental Plan offered by your employer (“the Plan”). Please read the booklet carefully so that you will understand how to obtain Benefits under the Plan. But, before you turn the page, we would like you to know some of the reasons we selected Northeast Delta Dental as our Claims Administrator.

- Northeast Delta Dental is a not-for-profit organization established and supported by Dentists to make more Dental Care available to the general public.
- Northeast Delta Dental is affiliated with a national association known as Delta Dental Plans Association and other Delta Dental companies which provide Dental Care programs in all states and U.S. territories.

### **Delta Dental PPO and Delta Dental Premier Dentist National Networks**

A substantial majority of Dentists nationwide participate with Delta Dental through Participating Dentist agreements. The coverage selected for your Plan uses Delta Dental’s PPO and Premier networks of Participating Dentists. This 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 Participating 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 Northeast Delta Dental based on the lesser of the actual submitted charge or Northeast Delta Dental’s allowance for PPO Dentists in the geographic area in which the services were provided. PPO Dentists agree not to charge any difference between their fees and Northeast Delta Dental’s allowance for PPO Dentists. Like all Dentists, PPO Dentists are allowed to charge for any applicable Co-payment, Deductibles, or non-covered services.

You will also receive Benefits under your Plan if you choose to visit a Delta Dental Premier Dentist. Delta Dental Premier Dentists are reimbursed by Northeast Delta Dental based on the lesser of the actual submitted charge or Northeast Delta Dental’s allowance for Premier Dentists in the geographic area in which the services were provided. Delta Dental Premier Dentists agree not to charge any difference between their fees and Northeast Delta Dental’s allowance for Premier Dentists. Like all Dentists, Premier Dentists are allowed to charge for any applicable Co-payment, Deductible, or non-covered services.

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

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

### **Non-Participating Dentists or Other Dental Providers (ODPs)**

You may also choose to visit Dentists who are not Delta Dental Participating Dentists (Non-Participating Dentists) or Other Dental Providers (ODPs). For Non-Participating Dentists and ODPs, payment will be made based on the lesser of the actual submitted charge or Northeast Delta Dental’s allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. When there is not sufficient fee information available for a specific dental procedure, Northeast Delta Dental will determine an appropriate payment amount. The Non-Participating Dentist or ODP may balance bill up to their submitted charge. Payment will be made to you unless the state in which the services are rendered requires that assignment of benefits be honored and Northeast Delta Dental receives written notice of an assignment on the claim form before payment for Benefits is made. Unless assignment of benefits applies, you will be responsible for paying the Dentist both the amount you receive from Northeast Delta Dental and any remaining balance due. You may be requested to bring a claim form for your visit. Claim forms can be downloaded from [www.nedelta.com](http://www.nedelta.com) or you may call Northeast Delta Dental at 800.832.5700.

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**The Outline of Benefits provided to you upon initial enrollment and upon Plan updates sets forth details about the Plan offered by your employer, including the specific categories of dental Benefit coverage for which you are eligible. You can also obtain a copy of the Outline of Benefits by contacting HealthTrust or Northeast Delta Dental at the numbers listed below.**

HealthTrust has sole and exclusive discretion in interpreting the Benefits provided under the Plan and the other terms, conditions, limitations, and exclusions set out in the Plan Document and this Dental Plan Description, and in making factual determinations related to the Plan and its Benefits. HealthTrust may, from time to time, delegate discretionary authority to Northeast Delta Dental or other entities or individuals providing services in regard to the Plan. HealthTrust reserves the right to change, interpret, modify, withdraw, or add Benefits to this Plan without prior notice to or approval by you or your employer. HealthTrust further reserves the right, at its discretion at any time, to terminate this Plan by giving advance notice of at least 30 days to your employer.

The legal documents governing the Plan consist of the Plan Document and this Dental Plan Description (including the Outline of Benefits). Any change or amendment to the Plan shall be made in a written amendment approved by an authorized representative of HealthTrust. No individual or entity has any authority to make any oral changes or amendments to the Plan.

**This Dental Plan Description is intended to be a summary of the Benefits of the Plan. It is subject to, and superseded by the Plan Document. For a complete description of Benefits and the terms and conditions of coverage under the Plan, you may obtain a copy of the Plan Document from your employer or HealthTrust's Enrollee Services.**

If you have any questions about your Plan, please check with your employer or call or write to HealthTrust or Northeast Delta Dental at the locations listed below. All correspondence with HealthTrust or Northeast Delta Dental should include your employer's name and number, your identification number and your telephone number.

**HealthTrust:**

HealthTrust  
25 Triangle Park Drive  
PO Box 617  
Concord, NH 03302-0617  
603.226.2861  
800.527.5001

**Northeast Delta Dental:**

Delta Dental Plan of New Hampshire  
One Delta Drive  
PO Box 2002  
Concord, NH 03302-2002  
603.223.1234  
800.832.5700

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## I. DEFINITIONS

1. **Anniversary Date** means the first day of your Participating Group's Plan Year (either January 1 or July 1).
2. **Benefits** means the categories of covered Dental Care available to Eligible Persons enrolled in the Plan as described in this Dental Plan Description (including the Outline of Benefits).
3. **Claims Administrator** means Delta Dental Plan of New Hampshire, also known as Northeast Delta Dental, to whom claims administration of the Plan has been assigned.
4. **Co-payment** means the amount of the Dental Care cost that you (the Subscriber) or an Eligible Dependent is required to pay as specified in the Outline of Benefits.
5. **Deductible** means the portion of the charge for covered Dental Care that you (the Subscriber) or an Eligible Dependent must pay before the Plan's payment responsibility begins as specified in the Outline of Benefits.
6. **Denied** means that the fee for a procedure or service is not a Benefit under the Plan and is chargeable to the patient. The approved amount is not payable by the Plan, but is collectable from the patient.
7. **Delta Dental** means the dental service corporations and not-for-profit dental care companies, including Northeast Delta Dental, that comprise the members of Delta Dental Plans Association and which provide Dental Care programs in all states and U.S. territories.
8. **Dental Care** means dental services ordinarily provided by Dentists or ODPs for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practice at the time the service is rendered.
9. **Dental Enrollment Application (or Application)** means the form that must be completed, signed, and submitted by you and your employer to HealthTrust. An applicant is enrolled for Benefits under the Plan only upon acceptance of the Dental Enrollment Application by HealthTrust. This form is also used to notify HealthTrust of changes in enrollment information.
10. **Dental Plan Description (or DPD)** means this document, including the Outline of Benefits and all applicable riders, which documents are incorporated herein by this reference. The Dental Plan Description together with the Plan Document form the terms and conditions under which Northeast Delta Dental will administer your dental Plan.
11. **Dentist** means an individual duly licensed to practice dentistry in the state in which the Dental Care is provided.
12. **Denturist** means an individual licensed to practice denturism by the state in which the services are rendered. The practice of denturism includes:
  - (a) The taking of denture impressions and bite registration for the purpose of or with a view to the making, producing, reproducing, construction, finishing, supplying, altering or repairing of a complete maxillary (upper) or complete mandibular (lower) prosthetic denture, or both, to be fitted to an edentulous arch or arches;
  - (b) The fitting of a complete maxillary (upper) or mandibular (lower) prosthetic denture, or both, to an edentulous arch or arches, including the making, producing, reproducing, constructing, finishing, supplying, altering and repairing of dentures; and
  - (c) The procedures incidental to the procedures specified in paragraphs (a) and (b), as defined by the applicable state licensing board.

For the purpose of paying claims, Denturists will be treated as Other Dental Providers (ODPs). Claims submitted by a Denturist must be accompanied by a copy of a certificate of good oral health that has been issued for the patient by a Dentist. A copy of the Denturist's license must be filed with Northeast Delta Dental before claims can be processed.

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13. **Dependent** means an individual who may be enrolled for Benefits under the Plan as described in Section II of this Dental Plan Description.
  14. **Disallowed** means that the fee for a procedure or service is not payable by the Plan, nor collectable from the patient by a Participating Dentist. The Exclusions and Limitations provisions in Section IV and Section V identify services which are Disallowed. In each instance, a Participating Dentist agrees not to charge a separate fee.
  15. **Eligible Dependents** means those Dependents who meet the eligibility criteria and are properly enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.
  16. **Eligible Persons** means you, the Subscriber, and your Eligible Dependent(s) who are enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.
  17. **Explanation of Benefits** means the notice which explains to an Eligible Person the Benefits that were paid by the Plan, whether any fees for services are Denied or Disallowed, and gives the reason(s) for the denial or disallowance. Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at [www.nedelta.com](http://www.nedelta.com)) detailing what has been processed under your Plan's coverage.
  18. **HealthTrust** means HealthTrust, Inc., a New Hampshire voluntary corporation.
  19. **Maximum** means the maximum dollar amount the Plan will pay in any Plan Year (or lifetime for orthodontic Benefits) for covered Benefits as specified in the Outline of Benefits.
  20. **Non-Participating Dentist** means a Dentist who has not signed a participating agreement with Northeast Delta Dental or another Delta Dental company.
  21. **Northeast Delta Dental** means Delta Dental Plan of New Hampshire, also known as the Claims Administrator.
  22. **Other Dental Provider (ODP)** means an individual, other than a Dentist, who provides dental services and is authorized and licensed to provide such services by the state in which the services are rendered.
  23. **Outline of Benefits** means the document which describes the specific categories of dental Benefit coverage, and certain terms and conditions of coverage, available under the Plan selected by your employer.
  24. **Participating Dentist** means a Dentist who has signed a participating agreement with Northeast Delta Dental or another Delta Dental company. A Participating Dentist agrees to abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental or another Delta Dental company.
  25. **Participating Group (or your employer)** means your employer that is a participating member of HealthTrust and has elected to provide dental coverage under the Plan.
  26. **Plan** means the HealthTrust Dental Plan offered by your employer as described in the Plan Document and this Dental Plan Description.
  27. **Plan Document** means the comprehensive description of the dental Benefit coverage available under the Plan.
  28. **Plan Year** means the twelve (12) month period selected by your employer during which Eligible Persons may receive Benefits under the Plan as specified in the Outline of Benefits.
  29. **Predetermination** means an administrative procedure where the Dentist or ODP submits the treatment plan to Northeast Delta Dental in advance of performing Dental Care. Northeast Delta Dental recommends that you ask your Dentist or ODP to request a Predetermination of proposed services that are considered to be other than brief or routine. A Predetermination provides an estimate of what your Plan will pay for the services which helps avoid confusion and misunderstanding between you and your Dentist or ODP.
  30. **Probationary Period** means the period of time as determined by your employer before you become eligible for Benefits under the Plan.

31. **Processing Policies** means the policies approved by Northeast Delta Dental, as may be amended from time to time, to be used in processing claims for payment and treatment plans for Predetermination of Benefits. Most frequently used Processing Policies are contained in the terms, conditions, limitations and exclusions described in this DPD.
32. **Selected Benefits** means the specific coverage options selected by your employer as specified in the Outline of Benefits.
33. **Selected Percentage** means the percentage amount of charges for Selected Benefits which the Plan will pay as specified in the Outline of Benefits.
34. **Subscriber (or you)** means you, an employee or retiree who satisfies the eligibility criteria established by your employer and HealthTrust, and who is properly enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.

## II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE

### (A) ELIGIBILITY

Your employer may choose to have either Employee Only (no Dependent coverage), or Employee and Dependents coverage. If Dependent coverage is offered and you elect to cover your eligible Dependents, you must enroll all of your eligible Dependents (other than Dependent children age 19 and over) who do not otherwise have dental coverage and keep them enrolled for the term of each Plan Year unless there is a qualified family status change (as described later in this Section II).

You and your Dependents are eligible to enroll in the Plan only if you meet all applicable eligibility requirements, including any Probationary Period established by your employer. For details regarding your employer's eligibility requirements, see the Outline of Benefits or ask your employer.

**NOTE:** By accepting coverage under the Plan, you represent that all statements made in your Dental Enrollment Application, or any other documentation that you provide with respect to your and your Dependent's eligibility and enrollment, are true to the best of your knowledge and belief. You must give your employer or HealthTrust information upon request that HealthTrust deems necessary to verify coverage eligibility. Examples of documentation that HealthTrust may need to decide coverage eligibility are information regarding: Dependent child status, incapacitated child status, marital status, divorce, legal separation, adoption or court orders regarding health care coverage for Eligible Dependent children.

HealthTrust reserves the right to retroactively cancel an Eligible Person's coverage under the Plan if you fail to provide verification upon request or misrepresent the eligibility status of you or any of your Dependents.

#### 1. Eligible Employee

You are eligible to enroll as a Subscriber on the first day of the calendar month following the date determined by your employer and HealthTrust provided that you:

- (a) are certified as being an eligible employee or retiree by your employer; and
- (b) have satisfied any applicable Probationary Period.

#### 2. Eligible Dependents (if Dependent Coverage is Offered by Your Employer)

You may enroll the following individuals as Dependents provided that Dependent coverage is offered by your employer:

- (a) **Your Spouse.** Your spouse is eligible to enroll unless you are legally separated. Throughout this DPD, any reference to your "spouse" means:
  - i. the individual to whom you are lawfully married, as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages; or
  - ii. the individual with whom you have entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

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**Throughout this DPD any reference to “marriage” means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a marriage or civil union.**

Coverage is available for same-sex or opposite-sex domestic partners (including “common law” type relationships and other unmarried couples) **only if** your employer has purchased a Domestic Partner Rider and **only if** all of the criteria for domestic partner status and eligibility are met, as stated in the Domestic Partner Rider.

**(b) Your (or your spouse’s) child who is:**

- i. at least two (2) and under twenty-six (26) years of age whether married or unmarried; or
- ii. an unmarried incapacitated dependent who is 26 years of age or older and physically or mentally incapable of self-support (as certified by a physician), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined above.

The physical or mental incapacity must have occurred before the child reached age 26 and must have occurred while the Dependent was a covered Dependent child. Incapacitated Dependents may remain covered as long as their disability continues and as long as they are financially dependent on you and are incapable of self-support. HealthTrust must receive an Application for the incapacitated Dependent child status and medical certification of the incapacity by a physician within 31 days of the date coverage would otherwise end for the child. HealthTrust must approve a Dependent child’s incapacitated status and may periodically request that the incapacitated status of the child be recertified.

In addition, a newborn child will be covered for the initial 31-day period following birth at no additional premium. Coverage may resume on the first day of the month following the child’s second birthday if the child is properly enrolled at that time.

**Definition of a Child**

As used above, the term “child” means:

- i. a natural child or a stepchild;
- ii. a legally adopted child, or a child who has been placed for adoption with you or your spouse. (For this purpose, “placed for adoption” means that the child has been placed in the custody of you or your spouse pursuant to an adoption proceeding under the provisions of NH Revised Statutes Annotated 170-B before the adoption becomes final);
- iii. a child for whom you or your spouse has been appointed the permanent legal guardian by court order; or
- iv. a child otherwise required to be enrolled under the Plan by federal or state law or by court order.

A foster child or grandchild is not eligible for coverage as a Dependent unless the child meets the definition of “child” above.



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**(B) ENROLLMENT**

If you have satisfied the eligibility requirements described in the preceding section, you may enroll yourself and all eligible Dependents by submitting a Dental Enrollment Application to your employer within 31 days from the date you first satisfy your Probationary Period. An applicant is considered enrolled only upon acceptance of the Dental Enrollment Application by HealthTrust. Provided that HealthTrust receives your Dental Enrollment Application within 31 days of the date you first satisfy any applicable Probationary Period, coverage will be effective as of the first day of the calendar month following your eligibility date. If the Dental Enrollment Application is received by HealthTrust after 31 days but within 60 days from the date you first satisfy any applicable Probationary Period, your coverage will become effective the first of the month following receipt of the application.

If you do not enroll yourself or your Dependents within 60 days after you first become eligible under the Plan, you may not enroll at a later date, except during an open enrollment period, a special enrollment period or in the event of a “qualified family status change” (as described later in this section).

**NOTE: You and all your enrolled Dependents must remain enrolled throughout the Plan Year and may be removed only during an open enrollment period, except in the event of a qualified family status change.**

1. **Open Enrollment Period.** There will be an annual open enrollment period during the 60 days prior to, and during the month which includes, your employer’s Anniversary Date each year. If the Dental Enrollment Application is received by HealthTrust on or before the last day of the annual open enrollment period, coverage will become effective on the Anniversary Date. If, however, the Dental Enrollment Application is not received by HealthTrust by the end of the annual open enrollment period, the requested enrollment may not be made until the next open enrollment period. Special open enrollment periods may be allowed at the sole discretion of HealthTrust.
2. **Special Enrollment Period.** A special enrollment period will be offered to you and/or your eligible Dependents in the following circumstances:

**(a) Involuntary Loss of Other Insurance Coverage**

If you decline enrollment for yourself and/or your eligible Dependents when initially eligible or during an annual open enrollment because of coverage under another group dental plan or dental insurance, you will be permitted to enroll yourself and/or your Dependents in the Plan within 31 days after an involuntary loss of such other insurance coverage. For this purpose, an “involuntary loss” of other insurance coverage means (i) if the other coverage is COBRA continuation coverage, such COBRA coverage has been exhausted, or (ii) if the other coverage is not COBRA continuation coverage, the coverage has been terminated as a result of loss of eligibility (other than loss due to failure to pay premiums on a timely basis or termination of coverage for cause), or employer contributions towards the other coverage have been terminated.

**(b) New Dependents**

If you previously declined enrollment upon initial eligibility or during an annual open enrollment period and you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you will be permitted to enroll yourself and your Dependents in the Plan within 31 days after the marriage, birth, adoption, or placement for adoption. These special enrollment rights are in addition to your right to add Dependents to existing coverage as described in 3 (b) below.

You and any Dependents who become eligible for enrollment pursuant to these Special Enrollment provisions may enroll in the Plan by submitting a completed Dental Enrollment Application in accordance with the above timeframes and the terms and conditions for enrollment set forth in the following section. Coverage of such individual(s) will become effective in accordance with that section and the applicable event allowing for special enrollment.

(c) **Loss of Coverage, or Becoming Eligible for Premium Assistance, under Medicaid or a State’s Children’s Health Insurance Program.**

If you and/or your Dependent(s) are eligible but not enrolled under the Plan, you may enroll during the Plan Year in either of the following situations:

- i. You or your Dependent loses coverage under a Medicaid plan (under title XIX of the Social Security Act) or under a State Children’s Health Insurance Plan (under title XXI of the Social Security Act) due to loss of eligibility for such coverage; or
- ii. You or your Dependent becomes eligible for state funded group health plan premium assistance with respect to this Plan through a state Medicaid or Children’s Health Insurance Program.

You must request enrollment under the Plan by submitting a completed Dental Enrollment Application within 60 days of the date the other coverage is lost or the date you or your Dependent is determined to be eligible for premium assistance (whichever is applicable). Coverage for you and/or your Dependent(s) will become effective as of the first of the month following the date coverage is lost or the date of your Dependent’s eligibility for premium assistance.

**3. Changes in Enrollment upon Qualified Family Status Changes**

You may enroll or remove Dependents and/or change coverage type during a Plan Year provided that such change is due to and consistent with a qualified family status change. A “qualified family status change” includes:

- (a) your marriage, divorce, or legal separation;
- (b) a change in a child’s eligibility under Section II (A) 2 (b) due to age (turning age 2 or 26) or incapacity;
- (c) adoption, placement for adoption or a change in legal custody of a child who is at least two (2) years of age;
- (d) death of your spouse or a Dependent child;
- (e) a change in employment status of you or your spouse that affects dental benefits coverage (e.g., termination or commencement of employment, a change from part-time to full-time status or vice versa, an unpaid leave of absence, a strike or lockout);
- (f) a significant change in your dental plan cost or coverage, or that of your spouse’s, relating to you or your spouse’s employment status or coverage;
- (g) your spouse’s employer holds open enrollment at a time other than your employer and, as a result of its benefit offerings, you would like to make a change and your employer recognizes this as a qualified change in status; or
- (h) your or your Dependent’s involuntary loss of, or becoming newly eligible for, other dental insurance coverage.

HealthTrust is not responsible for automatically changing your coverage type or adding or removing Dependents upon a qualified family status change event. You must request any desired change in coverage type and must promptly notify your employer and HealthTrust of any Dependent(s) to be added to or removed from coverage under the Plan.

You may enroll or remove Dependents and/or change your coverage type by submitting a Dental Enrollment Application to your employer within 31 days of the qualified family status change. The Application must include any requested change in coverage type. If a Dental Enrollment Application requesting to enroll Dependent(s) and/or to change coverage type is received by HealthTrust within 31 days of a qualified family status change, the requested change(s) will take effect on the first of the month following the date of the event. If the Dental Enrollment Application is not received by HealthTrust within the 31 days but is

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received within 60 days from the date of the qualified family status change event, the requested change will become effective the first of the month following receipt of the Dental Enrollment Application. If a request is not made within 60 days, coverage of Eligible Dependents and coverage type may not be changed until the next open enrollment or special enrollment period.

**4. Retroactivity Limit on Addition or Removal of Enrolled Dependents**

Except as otherwise provided for in this DPD and the Plan Document, addition or removal of enrolled Dependents or changes of coverage type may not be made more than 31 days retroactively.

**(C) TERMINATION OF COVERAGE**

This section describes circumstances under which your coverage under the Plan will terminate. Whether or not you or your employer contacts HealthTrust to effect any of the terminations in this section, HealthTrust will administer the termination if HealthTrust has knowledge of the termination event. In no event are Benefits available for Dental Care rendered or delivered after the date coverage under the Plan terminates:

**Subject to any right to continue coverage as described below in Section II (D), your (or your Eligible Dependents') coverage will automatically terminate on the earliest of the following dates:**

1. The date HealthTrust ceases to offer the Plan to Participating Groups;
2. The date as of which your employer (or your subunit of your employer) terminates its participation in the Plan;
3. The end of the month during which you or your Eligible Dependent(s) no longer meet the eligibility requirements for coverage under the Plan, or such other date as of which your employer notifies HealthTrust to terminate your coverage;
4. The date specified by HealthTrust that your coverage will end because your employer failed to pay any required contribution for coverage under the Plan;
5. The date of your or your Eligible Dependents' enrollment if HealthTrust or the Claims Administrator determines that you have omitted or made a misrepresentation of fact on the Dental Enrollment Application (or other required documentation) or used fraud in obtaining or maintaining coverage under the Plan;
6. The date specified by HealthTrust that your employer failed to meet the Plan's or HealthTrust's requirements for participation or continued participation in the Plan or in HealthTrust; or
7. The date established by HealthTrust for other causes as permitted by law. Cause may include failure to disclose other dental plan coverage, fraud committed by an Eligible Person in connection with any claim filed under the Plan, if an unauthorized individual is allowed to use any Eligible Person's identification card, or if an Eligible Person otherwise cooperates in the unauthorized use of such Eligible Person's identification card.

**(D) CONTINUATION OF COVERAGE**

1. **Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA)** – COBRA is a federal law which requires the Participating Group to offer Eligible Persons (“qualified beneficiaries”) the opportunity to continue group coverage under the Plan for a temporary period, at the Eligible Person's expense, when coverage would otherwise end because of certain “qualifying events.” COBRA continuation rights under the Plan are available only through the Participating Group. HealthTrust assists the Participating Group with certain COBRA notice and other administrative requirements. Subscribers and covered spouses will receive a separate document, which describes the continuation rights in further detail, upon initial enrollment in the Plan.

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2. **Qualifying Events** – Eligible Persons will become qualified beneficiaries if their coverage under the Plan would otherwise end due to one of the following qualifying events:

- Subscriber's hours of employment are reduced; or
- The Subscriber's employment ends for any reason other than gross misconduct.

Additionally, Eligible Dependents will become qualified beneficiaries if their coverage would otherwise end due to one of the following qualifying events:

- The Subscriber dies;
- The Subscriber divorces or legally separates;
- The Subscriber becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- In the case of an Eligible Dependent, he or she no longer meets the eligibility requirements for coverage under the Plan.

3. **Notices and Election Rights** – COBRA coverage is available under the Plan to qualified beneficiaries only after the Participating Group and HealthTrust have been notified that a qualifying event has occurred. **The Subscriber or an Eligible Dependent who is a qualified beneficiary must notify the Participating Group within 60 days of the date coverage under the Plan would otherwise end due to divorce, legal separation or a child losing Dependent status.** If the Participating Group and HealthTrust are not notified of these qualifying events within the 60-day notice period, any Eligible Person who loses coverage will not be offered the right to elect continuation coverage.

Once the Participating Group is notified of a qualifying event, the Participating Group must then notify HealthTrust. The Participating Group also must notify HealthTrust of other qualifying events including the Subscriber's death, termination of employment, reduction in hours of employment, or Medicare entitlement.

After HealthTrust receives notice that a qualifying event has occurred, HealthTrust will provide notice to eligible qualified beneficiaries of their right to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the later of the following dates to make their election:

- 60 days after the date their coverage would otherwise end due to the qualifying event; or
- 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

4. **Nature and Duration of COBRA Coverage** – If a qualified beneficiary elects COBRA, the qualified beneficiary generally will receive the same coverage and enrollment rights as are provided to similarly situated active employees of the Participating Group and their family members.

COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage will depend on the nature of the qualifying event as follows:

- **18 months** if the qualifying event is the Subscriber's termination of employment or reduction in hours of employment (the 18-month period may be extended to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA coverage); or
- **36 months** if the qualifying event is the Subscriber's death, divorce or legal separation, Medicare entitlement, or a child losing Dependent status.

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**Additional non-COBRA continuation period for former or surviving spouses** – In addition to the maximum COBRA coverage period, the following continuation periods are available under the Plan:

- If the qualifying event is divorce or legal separation and the former spouse is a qualified beneficiary age 55 or older at the time of the relevant court decree, the maximum continuation period will extend until the former spouse becomes eligible for coverage under another group dental plan or Medicare; or
- If the qualifying event is the Subscriber's death and the Subscriber's surviving spouse is a qualified beneficiary age 55 or older at the time of the death, the maximum continuation period will extend until the surviving spouse becomes eligible for coverage under another group dental plan or Medicare.

**NOTE: The Plan does not provide additional continuation coverage rights to former spouses under NHRSA 415:18, VII-b.**

COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under the COBRA law. Eligibility for COBRA coverage under the Plan will end if your employer terminates participation in the Plan for its active employees.

5. **Cost of Continuation Coverage** – You and other qualified beneficiaries will be obligated to pay the full cost for COBRA or other continuation coverage unless your employer has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium cost and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event.
6. **Continuation of Coverage Due to Military Service (USERRA)** – In the event you are no longer actively at work because you are called to military service in the Armed Forces of the United States, you may elect to continue coverage for you and any Eligible Dependents under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). “Military service” means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and any Eligible Dependents under the Plan. You may be obligated to pay the full premium cost (and any applicable administrative fee) for continuation coverage under the Plan. This may include the amount your employer normally pays on your behalf. If your military service is for a period of less than 31 days, you may not be required to pay more than the active employee contribution, if any, for the continuation coverage. If continuation is elected under this provision, the maximum period of continuation coverage under the Plan shall be the lesser of:

- 24 months; or
- Your period of military service (measured from the date the military service begins and ending on the day after the date on which you fail to apply for re-employment or return to employment with your employer).

Whether or not you elect continuation coverage, if you return to employment with your employer, you and your Eligible Dependents' coverage under the Plan will be reinstated. No Probationary Period or exclusions may be imposed on you or your Eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of military service.

**For more information regarding COBRA and other continuation coverage rights and obligations, please contact your Group Benefits Administrator or HealthTrust, or refer to the COBRA information document provided to you upon initial enrollment. If you would like a current version of the COBRA initial notice, please contact HealthTrust.**

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7. **Availability of Individual Coverage** – When your group coverage under the Plan ends for any reason, including at the end of any continuation of coverage period, you may have access to an individual plan with Northeast Delta Dental. Individual policies will be subject to terms, conditions, and limitations set forth in the individual policy. Applications will be subject to Northeast Delta Dental’s normal underwriting requirements. Application forms and information are available at [www.deltadentalcoversme.com](http://www.deltadentalcoversme.com) or at [www.healthcare.gov](http://www.healthcare.gov).

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### III. HOW TO FILE A CLAIM

#### To Use Your Plan Follow These Steps:

1. Please read this Dental Plan Description carefully to familiarize yourself with the Benefits and provisions of your dental Plan.
2. You will generally receive the best value from your Plan if you visit a Participating Dentist. Ask your Dentist if he or she participates with Delta Dental; visit Northeast Delta Dental's website at [www.nedelta.com](http://www.nedelta.com); or call Northeast Delta Dental for information.
3. When you visit your dental office, inform them that you are covered under a Delta Dental program and provide your identification card or other means of verifying coverage. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Northeast Delta Dental for payment of covered services.
4. **Claims Process for Participating Dentists:** Participating Dentists have claim forms available in their offices, which they will submit directly to Northeast Delta Dental. A Participating Dentist will not charge you at the time of treatment for covered services, but may request payment for non-covered services, Deductibles or Co-payments. Northeast Delta Dental will pay the Participating Dentists directly, based on the lesser of the actual submitted charge or Northeast Delta Dental's allowance for Participating Dentists in the geographic area in which the services were provided. Participating Dentists agree not to charge any difference between their fees and Northeast Delta Dental's allowance. An Explanation of Benefits will be available through Northeast Delta Dental's Benefit Lookup site at [www.nedelta.com](http://www.nedelta.com). The Explanation of Benefits will indicate the amount the Eligible Person should pay, if any, to the Dentist.
5. **Claims Process for Non-Participating Dentists or Other Dental Providers (ODPs):** Your Plan provides coverage regardless of the Eligible Person's choice of Participating Dentist, Non-Participating Dentist or ODP. If you visit a Non-Participating Dentist, or ODP, you may be required to submit your own claim form and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting [www.nedelta.com](http://www.nedelta.com). Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits (directing that payment be sent to the Dentist or ODP) be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a Non-Participating Dentist or ODP will be limited to the lesser of the provider's actual submitted charge or Northeast Delta Dental's allowance for Non-Participating Dentists in the geographic area in which services are provided. It is your responsibility to ensure that full payment is made to the Dentist or ODP. An Explanation of Benefits will be available through Northeast Delta Dental's Benefit Lookup site at [www.nedelta.com](http://www.nedelta.com). The Explanation of Benefits will indicate the amount the Eligible Person should pay, if any, to the Dentist.
6. You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

#### Predetermination of Benefits

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

The Predetermination reflects your estimated Benefits based on the procedures and costs submitted by your dental office. Questions concerning Predetermination should be directed to Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

**Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of Benefits payable based on your current Plan Benefits. A new Plan Year, additional paid Benefits and/or a change in Benefits under the Plan may alter the Plan's final payment, because payment is based on information at the time treatment is provided and Benefits are payable, which may be different than information available at the time the Predetermination estimate was given. Any changes in a Dentist's participating status or Northeast Delta Dental's allowance may also affect the Plan's final payment.**

#### IV. BENEFITS

This Section IV describes the various coverage categories of dental benefits that may be selected under a HealthTrust Dental Plan. **You and your Eligible Dependents will only be entitled to those Benefit coverage categories selected by your employer. See your Outline of Benefits for the coverage categories selected.**

Benefits will be provided to you and your Eligible Dependents in accordance with the terms and conditions of the Plan, this DPD and the rules, regulations and Processing Policies (including applicable American Dental Association (ADA) dental terminology and CDT codes) of the Claims Administrator, as amended from time to time.

##### Coverage A - Diagnostic and Preventive Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

**Diagnostic:** Oral evaluations – twice in a calendar year. This can be a comprehensive, limited (problem focused) or periodic evaluation provided by a specialist or a general Dentist.

Radiographic images – a complete series or panoramic image once in any period of five (5) years; bitewing images once in a calendar year; and images of individual teeth as necessary.

Brush biopsy once in a calendar year, no age limit.

**Preventive:** Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age thirteen (13), adult prophylaxis thereafter) This can be a routine prophylaxis under Diagnostic and Preventive Benefits (Coverage A) or periodontal maintenance under Basic Benefits (Coverage B).

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

Fluoride treatment twice in a calendar year through age eighteen (18).

Space Maintainers through age fifteen (15).

Sealants through age eighteen (18).

**NOTE:** *Participants in Northeast Delta Dental's Health through Oral Wellness® (HOW®) program may be eligible for additional preventive benefits based on a clinical oral health risk assessment performed by your Dentist. Subject to the provisions of the Plan and this DPD, these additional preventive benefits may include: i) more frequent fluoride treatments, sealants, and full mouth debridement; and ii) availability of caries susceptibility tests, oral hygiene instruction, nutritional counseling, or tobacco cessation counseling.*

**Coverage A Exclusions and Limitations.** The following specific exclusions and limitations apply to Coverage A. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is “**Disallowed**,” it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is “**Denied**,” it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.
1. Oral evaluations of any kind are Disallowed if performed within ninety (90) days after periodontal surgery by the same Dentist/dental office.



2. Comprehensive oral evaluation and comprehensive periodontal evaluation are a covered Benefit once in a lifetime (unless there is history of no care for three (3) years) and is counted toward your oral evaluation Benefits. Subsequent comprehensive oral evaluations are covered as a periodic oral evaluation and are subject to frequency limitations.
3. The fee for oral evaluations for patients under age three (3), when performed on the same date of service by the same Dentist/dental office as a comprehensive evaluation, is Disallowed.
4. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings, and/or occlusal) is considered a complete series for time limitations and any fee in excess of the fee for a complete series is Disallowed.
5. 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 a consulting Dentist's review. A Participating Dentist agrees not to charge a separate fee.
6. 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.
7. 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.
8. If the fee for bitewings, periapicals, intraoral occlusal and extraoral radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.
9. Cone beam imaging and interpretation are not covered Benefits. Cone beam imaging, when performed by the same Dentist/dental office as an image interpretation, is combined as a cone beam capture and interpretation. Any fees in excess of the combined code are Disallowed.
10. Cephalometric images, oral/facial photographic images and diagnostic casts are not a covered Benefit.
11. Oral cancer screening, except brush biopsy, is not a covered Benefit.
12. Oral Pathology laboratory services are a covered Benefit when accompanied by a pathology report. If more than one of these procedures is billed for the same tooth site on the same day, by the same Dentist/ dental office, payment is allowed for the most inclusive procedure and the fee for the less inclusive procedure is Disallowed.
13. Laboratory tests for caries susceptibility are not a covered Benefit and the fees are Disallowed when billed with an oral evaluation for children under the age of three (3).
14. Caries risk assessment is a covered Benefit once in a period of three (3) years for children between the ages of three (3) and nineteen (19). Benefits for caries risk assessment are Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.
15. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Disallowed.
16. Space maintainers are a covered Benefit once in a lifetime per tooth for Eligible Dependents through age fifteen (15) when a space is being maintained for an erupting permanent tooth.
17. The replacement or repair of space maintainers is not a covered Benefit unless performed by a Dentist who did not perform the original placement.
18. Removal of a space maintainer is included as part of the total treatment. A fee for removal of a space maintainer is Disallowed if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.

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19. Sealant Benefit limitation:
    - (a) Sealants are a covered Benefit only to Eligible Persons through age eighteen (18).
    - (b) Sealant Benefit includes the application of sealants to caries-free (no decay) and restoration-free permanent molars only.
    - (c) Sealants are a covered Benefit no more than once per tooth in any period of three (3) years.
  20. Pre-diagnostic services, such as screening and assessment of a patient, are not covered Benefits. Payment for a screening and assessment is Disallowed if billed with an oral evaluation.
  21. Nutritional counseling, tobacco counseling, and oral hygiene instruction are not covered Benefits except for Eligible Persons participating in Northeast Delta Dental's Health through Oral Wellness® (HOW®) program.
  22. Genetic test for susceptibility to diseases is not a covered Benefit.

### Coverage B - Basic Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

**Restorative:** Amalgam (silver) and/or resin (white) restorations (fillings).  
If Coverage C – Major Benefits is not offered, and unless otherwise specified in the Outline of Benefits, payment for restorative crowns and onlays will be at the Selected Percentage specified in the Outline of Benefits for a four (4) surface amalgam restoration.

**Oral Surgery:** Extractions and covered surgical procedures.

**Periodontics:** Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). A prophylaxis can be routine under Diagnostic and Preventive Benefits (Coverage A) or periodontal maintenance under Basic Benefits (Coverage B).

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

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

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

**Clinical Crown Lengthening:** Once in a lifetime per tooth.

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

**Anesthesia:** General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with: an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body (only when Coverage C - Major Benefits is specified in the Outline of Benefits); biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients:

- (a) A child under the age of six (6) who is determined by a Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or
- (b) An individual who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician, which place the individual at serious risk.

**Coverage B Exclusions and Limitations.** The following specific exclusions and limitations apply to Coverage B. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is “**Disallowed**,” it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is “**Denied**,” it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.
1. Restorations are a covered Benefit only once per surface in a period of twenty-four (24) months, irrespective of the number or combination of procedures performed. Fees for the replacement of amalgam

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- (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office are Disallowed.
2. Fees for protective restorations are Disallowed if performed on the same date of service as a definitive restoration or palliative treatment by the same Dentist/dental office.
  3. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Participating Dentist agrees not to charge a separate fee.
  4. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Participating Dentist agrees not to charge a separate fee.
  5. Prefabricated stainless steel crowns are a covered Benefit once in a period of twenty-four (24) months. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Disallowed.
  6. Tooth preparation, bases, copings, impressions, local anesthesia, or other services that are part of a complete dental procedure are considered components of, and included in the fee for, the complete procedure. A Participating Dentist agrees not to charge a separate fee.
  7. Recementation of a crown, inlay, onlay or partial coverage restoration is a covered Benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office.
  8. Recementation of a cast or prefabricated post and core is a covered Benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.
  9. Pin retention is a covered Benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Fees for additional pins in the same tooth are Disallowed. The fee for pin retention is Disallowed when billed in conjunction with a core build-up.
  10. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered Benefit. Payment is Disallowed if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.
  11. A frenulectomy or frenuloplasty is a covered Benefit once per site per lifetime, and the fee is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/ dental office.
  12. Alveoloplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office in the same surgical area on the same date.
  13. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Participating Dentist agrees not to charge a separate fee.
  14. Exploratory surgical services are not a covered Benefit. The patient is financially responsible.
  15. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. The fee for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.
  16. Fees for periodontal maintenance, when billed within three (3) months of periodontal therapy by the same Dentist/dental office, are Disallowed.
  17. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Disallowed.
  18. Periodontal scaling and root planing is a covered Benefit per quadrant once in any period of twenty-four (24) months. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. The fee for periodontal scaling and root planing is Disallowed if performed within four (4) weeks of periodontal surgery by the same Dentist/dental office.

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19. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, distal wedge, or soft tissue graft procedure is a covered Benefit once in a period of three (3) years. The fee for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.
  20. Anterior deciduous root canal therapy is not a covered Benefit.
  21. Root canal therapy is a covered Benefit once in a period of three (3) years. Retreatment of root canal therapy by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed.
  22. Root canal therapy is not a covered Benefit in conjunction with overdentures, and Benefits are Denied.
  23. The fee for root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Disallowed.
  24. Direct or indirect pulp caps are a covered Benefit once in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure and the fee for the pulp cap is Disallowed.
  25. 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.
  26. Pulpal therapy or therapeutic pulpotomy is a covered Benefit once in a three (3) year period per tooth on primary teeth only. If provided on permanent teeth, the Benefit is Denied.
  27. Retrograde fillings are a covered Benefit once per root in a period of three (3) years. Retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Disallowed.
  28. An apexification or an apicoectomy is a covered Benefit once per tooth in a period of three (3) years. The fee for retreatment by the same Dentist/dental office within twenty-four (24) months is Disallowed.
  29. An internal root repair is a covered Benefit once in a lifetime on permanent teeth only. If performed on a primary tooth the Benefit is denied. The fee for an internal root repair is Disallowed if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.
  30. The fee for periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling and/or root amputation is Disallowed.
  31. Pulpal debridement is a covered Benefit once in a three (3) year period. The fee for pulpal debridement is Disallowed if performed within thirty (30) days of a root canal treatment by the same Dentist/dental office. The fee for surgical removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same Dentist/dental office.
  32. The fee for repair of a complete denture cannot exceed half the fee for a new appliance, and any excess fee billed by the same Dentist/dental office is Disallowed on the same date of service.
  33. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office, are Disallowed.
  34. Adjustment or repair of a denture is a covered Benefit twice in a twelve (12) month period for Eligible Persons age sixteen (16) and older. Fees for an adjustment or repair of a denture is Disallowed if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Disallowed on the same date of service.
  35. Clinical crown lengthening is a covered Benefit once per tooth per lifetime and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown or prosthetic device. The fee for clinical crown lengthening is Disallowed if performed on the same date of service by the same Dentist/dental office as the crown placement.

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36. 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. A Participating Dentist agrees not to charge a separate fee.
  37. 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.
  38. 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.
  39. 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.
  40. General anesthesia is a covered Benefit only when administered by a properly licensed Dentist in a dental office in conjunction with covered oral surgical procedures or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is Denied.
  41. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure and fees are Disallowed.
  42. A consultation is a covered Benefit only if performed by a Dentist that is not performing further treatment. The fee for a consultation is Disallowed if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.
  43. Interim caries arresting medicament application is not a covered Benefit.
  44. Cleaning and inspection of a removable complete or partial denture is not a covered Benefit. The fee for cleaning and inspection of a removable complete or partial denture is Disallowed when done by the same Dentist/dental office on the same date of service as a reline or rebase of the denture. Otherwise, the fee for cleaning and inspection of a removable complete or partial denture is Denied.

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

### Coverage C - Major Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

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

**Coverage C Exclusions and Limitations.** The following specific exclusions and limitations apply to Coverage C. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is “**Disallowed**,” it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is “**Denied**,” it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.
1. Coverage C - Major Benefits time limitations:
    - (a) Crowns, onlays, core buildups, and post and cores are a Benefit once per tooth in a period of seven (7) years.
    - (b) One (1) complete or immediate maxillary (upper) and one (1) complete or immediate mandibular (lower) denture in a period of seven (7) years.
    - (c) A removable or fixed partial denture in a period of seven (7) years unless the loss of additional teeth requires the construction of a new appliance.
    - (d) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in a period of seven (7) years.
    - (e) The period of seven (7) years referred to in (a), (b), (c) and (d) above is to be measured from the date the services were most recently performed.
    - (f) Implant body and implant abutment are covered Benefits once in a lifetime per site.
  2. Onlays or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal (where the metal is high noble metal, titanium, noble metal or predominantly base metal) are not covered Benefits for Eligible Dependents under the age of twelve (12).
  3. Inlays are not a covered Benefit. An alternate benefit will be paid equal to an amalgam (silver) restoration. If an inlay is performed, the patient is responsible for any additional fee.
  4. A core build-up is a covered Benefit once in a seven (7) year period per tooth for Eligible Persons age twelve (12) and older. The fees for core build-ups are Disallowed when build-ups are performed in conjunction with inlays, three-quarter ( $\frac{3}{4}$ ) crowns or onlays.
  5. Removable or fixed partial dentures are not covered Benefits for patients under the age of twelve (12).
  6. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are covered Benefits. The Eligible Person will be responsible for any additional fee.

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7. Recementation of a fixed partial denture is a covered Benefit once in a period of twelve (12) months.
  8. The relining of a denture is a covered Benefit once in a period of three (3) years.
  9. 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 a covered Benefit but is subject to review by a dental consultant.
  10. Implant services are not a covered Benefit for patients under the age of sixteen (16).
  11. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. The Eligible Person will be responsible for any additional fee.
  12. Tissue conditioning is a covered Benefit two (2) times in a period of three (3) years. The fee for tissue conditioning is Disallowed if performed on the same date of service as a denture rebase or reline by the same Dentist/dental office.

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



### Coverage D - Orthodontic Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

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

Placement of device to facilitate eruption of an impacted tooth.

**Coverage D Exclusions and Limitations.** The following specific exclusions and limitations apply to Coverage D. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is “**Disallowed**,” it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is “**Denied**,” it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.
1. Orthodontic Benefit limitations:
    - (a) Orthodontic Benefits are provided until the end of the month of the Eligible Dependent’s nineteenth (19) birthday. You, your spouse, and your Eligible Dependents age nineteen (19) and over will not be eligible for orthodontic Benefits unless adult coverage is specified in the Outline of Benefits.
    - (b) For treatment commenced while a patient is eligible for orthodontic Benefits, the Claims Administrator will initiate payment of its liability up to the orthodontic Maximum specified in the Outline of Benefits once bands or orthodontic devices are placed.
    - (c) For patients who become eligible after orthodontic treatment has commenced, the Claims Administrator will pro-rate the Plan’s liability based on the number of remaining months of active treatment compared to the total number of months of active treatment.
    - (d) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.
  2. Clear orthodontic appliances are included in orthodontic Benefits, provided that upon the consulting Dentist’s review of pretreatment radiographs, it is indicated that the patient has full adult dentition.  
Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. The patient is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.
  3. The Plan’s payment for orthodontic Benefits shall be limited to the lifetime Maximum per patient specified in the Outline of Benefits. The Claims Administrator will make one (1) payment at the start of treatment for the Plan’s total liability.
  4. For Participating Groups with orthodontic Benefits, placement of an appliance must take place for the Claims Administrator to make payment on diagnostic records. Diagnostic casts, photographs and other diagnostic records are included in the total case fee. If banding does not take place, the Plan has no liability beyond its share of the allowable fee for a comprehensive oral evaluation.
  5. The replacement or repair of an orthodontic appliance is not a covered Benefit if done by the same orthodontist who placed the appliance. If performed by an orthodontist who did not originally place the appliance, payment will be made for one repair per lifetime.

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6. Removable orthodontic retainer adjustment is not a covered Benefit. The fee for a removable orthodontic retainer adjustment is Disallowed if performed by the same Dentist/dental office who provided the orthodontic treatment. If provided by a different Dentist/dental office, the fee is Denied.

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

## V. GENERAL EXCLUSIONS AND LIMITATIONS

1. Unless otherwise specified in this DPD (including the OOB), the dental Benefits provided by the Plan will not include the following:
  - (a) Services for injuries or conditions compensable under workers' compensation or employer's liability laws.
  - (b) Services that are determined by the Claims Administrator to be rendered for cosmetic reasons, such as bleaching or whitening of teeth, placement of veneers, correction of congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)
  - (c) Services, including but not limited to endodontics and prosthodontics (including restorative crowns and onlays), completed prior to the date you or your Eligible Dependent became enrolled in the Plan.
  - (d) Unless otherwise required by law, 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 individual supervised by the Dentist.
  - (e) Prescription drugs, premedications, the application of anti-microbial agents and/or relative analgesia.
  - (f) Charges for: (i) hospitalization; (ii) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section IV, Coverage B - Basic Benefits); (iii) preventive control programs; (iv) periodontal splinting; (v) myofunctional therapy; (vi) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (vii) equilibration; and (viii) gnathological reporting.
  - (g) Charges for failure to keep a scheduled visit with the Dentist.
  - (h) Charges for completion of forms. Such charges will not be made to you or your Eligible Dependent by Participating Dentists.
  - (i) Dental Care which is not necessary and customary, as determined by generally accepted standards of dental practice.
  - (j) Dental Care or supplies which are not within the categories of Benefits defined in this DPD and selected by your employer as specified in the Outline of Benefits.
  - (k) Appliances, procedures, or restorations for: (i) implant services (unless your employer offers Coverage C - Major Benefits); (ii) increasing vertical dimension; (iii) analyzing, altering, restoring, or maintaining occlusion; (iv) replacing tooth structure lost by attrition or abrasion; (v) correcting congenital or developmental malformations; or (vi) esthetic purposes.
  - (l) Payments of Benefits incurred by you and/or your Eligible Dependent after the date you become ineligible for Benefits under the Plan.
  - (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.

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- (o) All services, including evaluations and radiographs, performed for orthodontic purposes where the employer does not offer Coverage D - Orthodontic Benefits. If services are rendered they should be done so with the agreement of the patient to assume additional cost.
  - (p) Temporary or incomplete services.
  - (q) A consultation unless performed by a provider who is not performing further services.
  - (r) Case presentation and treatment planning. The patient will be responsible for any additional fee.
  - (s) Athletic mouthguards and occlusal guards (nightguards).
  - (t) Pulp vitality tests.
2. Unless otherwise specified in the Outline of Benefits, the dental Benefits provided by the Plan will be limited as follows:
- (a) Unless otherwise required by law, Dental Care rendered by anyone other than a Dentist or ODP shall not be a covered Benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a Benefit, so long as the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted standards of dental practice. All claims for payment for Dental Care received must be submitted under the name and license number of the Dentist rendering treatment or supervising treatment.
  - (b) Optional Dental Care: In all cases in which you or your Eligible Dependent agree, after consultation with your Dentist, to more expensive Dental Care than is customarily provided, the Plan will pay the Selected Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. You or your Eligible Dependent shall be responsible for the remainder of the Dentist's fee.
  - (c) Predetermination does not guarantee payment. Payment is based upon eligibility, Benefits selected by your employer, allowable charges at the time the Dental Care is rendered and the Dentist's participating status with Delta Dental. If Coordination of Benefits is involved, the amount of payment is subject to change dramatically depending on the payment made by the primary carrier.
  - (d) Services completed or in progress at your or your Eligible Dependent's date of death will be paid in full to the limit of the Plan's liability.
  - (e) When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, the Claims Administrator will review the claim to determine the payment, if any, due each Dentist.
  - (f) Maximum Payment:
    - (i) The Maximum amount payable in any Plan Year, or portion thereof, will be limited to the amount specified in the Outline of Benefits.
    - (ii) The Plan's payment will be reduced by any Deductible as specified in the Outline of Benefits.
  - (g) Specialized techniques including, but not limited to, precision attachments, implant services (unless your employer offers Coverage C - Major Benefits), overdentures (and associated procedures), personalizations or characterization, are limited. The patient will be responsible for part of or the entire fee for these services.
  - (h) Diagnostic casts (study models) and/or photographs are not a covered Benefit under the Plan unless done for orthodontic purposes and your employer offers Coverage D - Orthodontic Benefits. The charge for such services should be included in the total case fee. The fees for subsequent diagnostic casts and/or photographs are Disallowed.

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- (i) Benefits are paid for amalgam (silver) or resin (white) restorations for the treatment of caries. If a tooth can be restored with amalgam or resin, use of gold, an inlay, an onlay, or a crown is at the option of the patient and the patient will be responsible for any additional fee.
  - (j) A claim (or satisfactory written proof acceptable to the Claims Administrator) must be furnished to the Claims Administrator at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on a claim with dates of service in excess of the twenty-four (24) month limitation.
  - (k) The date of incurred liability refers to the date a service is subject to the applicable Deductible, Co-payment, Maximum Benefit, and limitations. 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.

The Plan's date of incurred liability for multiple visit procedures is as follows:

- (i) Restorative Crowns and Onlays – Total cost for crowns and onlays will 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 will be incurred on the date that the said appliance is cemented.
- (iii) Removable Complete and Partial Dentures – Total cost for removable complete and partial dentures will be incurred on the date that the said appliance is delivered to the patient.
- (iv) Endodontics – Total cost for endodontic treatment will be incurred when the canal is filled to completion.
- (v) Implant Body – Total cost for the implant body, including healing cap, will be incurred on the date of surgical placement.
- (vi) Implant Prosthetics – Total cost for the prosthetic portion of an implant will be incurred on the date the said appliance is cemented or delivered to the patient.
- (vii) Orthodontics – Total cost for orthodontic treatment will be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the patient's mouth.

## **VI. COORDINATION OF BENEFITS (DUAL COVERAGE)**

In the event that any Eligible Person is entitled to benefits for Dental Care under any health care benefit program other than this Plan, the following Coordination of Benefits provisions will determine the sequence and the extent of payment of Benefits under this Plan. Such other benefit programs may include any other group or individual plan providing benefits for Dental Care in which the Eligible Person is enrolled.

When an Eligible Person is covered under another health care benefit program, the following rules will establish the order of determining liability:

1. When only one plan has a Coordination of Benefits provision, the plan without such provision will determine its benefits first.
2. The plan covering the Eligible Person solely as an employee will determine its benefits before the plan that covers the Eligible Person solely as a Dependent.
3. The plan covering the Eligible Person solely as a Dependent of the parent whose birthday occurs earlier in a calendar year will determine its benefits before the plan covering the Eligible Person solely as a Dependent of the parent whose birthday occurs later in a calendar year ("Birthday Rule"). A parent's year of birth is not relevant. If both parents have the same birthday (month and day), the benefits of the plan which covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time. If the other plan does not use the "Birthday Rule," then that plan's provisions will determine the order of liability.

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4. Notwithstanding paragraph (3) above, the order of payment for the claims of a Dependent child whose parents are divorced or legally separated, or are not living together whether or not they have ever been married, will be as follows:
    - (a) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;
    - (b) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of paragraph (3) above shall determine the order of benefits;
    - (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of paragraph (3) above shall determine the order of benefits; or
    - (d) If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - (i) the plan covering the custodial parent;
      - (ii) the plan covering the custodial parent's spouse;
      - (iii) the plan covering the non-custodial parent; and then
      - (iv) the plan covering the non-custodial parent's spouse.

5. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraphs (3) and (4) as if those individuals were parents of the child.
6. If paragraphs (1) through (5) above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time will be determined first.
7. When this Plan is the first to determine its Benefits under paragraphs (1) through (6) above, Benefits hereunder will be paid without regard to coverage under any other plan. When this Plan is not the first to determine its Benefits and there are remaining expenses of the type allowable hereunder, the Claims Administrator will pay up to the amount the Plan 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 Dental Care.

The Claims Administrator may use such reasonable efforts as it deems suitable to determine the existence of other benefit programs but will be under no obligation to do so.

The payment of Benefits under this Plan will be affected by the benefits that would be payable under any and all other plans only to the extent that the Claims Administrator is furnished with information relative to such other plans by the Eligible Person, the Participating Group, a representative of any other health care benefit program, or any other person.

8. For the purposes of determining the applicability and implementing the terms of this Section VI or any provisions of similar purpose of any other plan, the Claims Administrator may, without the consent of or notice to any person, release to or obtain from any health care benefit program or such other person with a legitimate interest in such information, any information with respect to any person which it deems to be necessary for such purposes. In so acting, the Claims Administrator will comply with all federal and state law requirements governing disclosures. Any person claiming Benefits under this Plan will furnish to the Claims Administrator such information as may be necessary to implement this provision.
9. **Multiple Coverage.** In coordinating benefits with any other health care benefit program, time limitations and frequency of service limitations will not change. Coverage for services, when a specified number are provided per a specified time period, will 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 two cleanings in a

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calendar year, the combined plans will still only cover two cleanings in any calendar year. If a cleaning is covered under this Plan, but has been paid for, whether in full or part, by another plan, the cleaning will count toward the maximum number of cleanings allowed under this Plan.

## **VII. GENERAL CLAIMS INQUIRY**

After a claim is submitted to and processed by the Claims Administrator (as described in Section III, HOW TO FILE A CLAIM), you will be sent or have access to an Explanation of Benefits. This notice explains to an Eligible Person the Benefits that were paid by the Plan, whether any fees for services were Denied or Disallowed, and gives the reason(s) for the denial or disallowance. An Explanation of Benefits will be available through Northeast Delta Dental's Benefit Lookup site at [www.nedelta.com](http://www.nedelta.com).

If you have any questions regarding your Benefits, you may call Northeast Delta Dental's Customer Service for an explanation at 603.223.1234 or 800.832.5700.

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

## **VIII. DISPUTED CLAIMS PROCEDURE**

If after you have followed the General Claims Inquiry procedure you disagree with the Benefit determination, you may use the Claims Administrator's Disputed Claims Procedure. You may request a review of your claim within six (6) months of the issuing of the Claims Administrator's original Explanation of Benefits. It is recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002, but you may also submit your request by standard mail.

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

The Vice President, Professional Relations, or his or her 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 Plan provision(s) upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the Vice President, Professional Relations' response. If you do not receive notice within the thirty (30) day period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

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

## **IX. DISPUTED CLAIMS REVIEW PROCEDURE**

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

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

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In addition or as an alternative to the written request procedure, you may request a hearing before the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by legal counsel or other duly authorized representatives, to request the presence of a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. You or your representative may review the Plan Document 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.

## **X. GENERAL PROVISIONS**

### **Notice of Change of Status**

You must notify HealthTrust, through your employer, of any event causing a change in the status of an Eligible Person. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, a change in a child's age or dependent status, involuntary loss of other dental coverage, etc. For further details refer to ENROLLMENT in Section II of this Dental Plan Description.

### **Assignment**

Benefits of Eligible Persons are personal and cannot be transferred or assigned.

### **Right of Recovery**

In the event Benefits are paid under the Plan, the Plan and the Claims Administrator will be subrogated to all of the Eligible Person's rights of recovery against any third party that may be liable. The Eligible Person will execute and deliver such documents and do whatever else is necessary to secure such rights.

### **Doctor-Patient Relationship**

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

### **Loss of Eligibility During Treatment**

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

### **Maintaining Your Privacy**

HealthTrust and Northeast Delta Dental respect and carefully preserve 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 either HealthTrust's or Northeast Delta Dental's Notice of Privacy Practices, that describe in detail their respective privacy practices, please visit HealthTrust's website ([www.healthtrustnh.org](http://www.healthtrustnh.org)) or Northeast Delta Dental's website ([www.nedelta.com](http://www.nedelta.com)). Alternatively, for a copy of the Notice of Privacy Practices, or if you have any questions about the privacy of your health information, please contact:

Privacy Officer  
HealthTrust  
25 Triangle Park Drive  
PO Box 617  
Concord, NH 03302-0617  
800.527.5001

Privacy Officer  
Northeast Delta Dental  
One Delta Drive  
PO Box 2002  
Concord, NH 03302-2002  
800.537.1715

### **Non-ERISA Governmental Plan**

The Plan is a governmental plan established and maintained by your employer and HealthTrust, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974, as amended (ERISA).

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**Waiver of Rights; Severability**

On occasion, HealthTrust may, at its option, choose not to enforce all the terms and conditions of the Plan; however, HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of HealthTrust or Northeast Delta Dental has the right to change or waive any of the provisions of the Plan without the approval of an authorized representative of HealthTrust. Any condition, limitation, exclusion or other provision of this document which is found to be illegal or unenforceable for any reason will not affect the remaining provisions of this DPD.

**Applicable Law**

The Plan, the Plan Document and this Dental Plan Description shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

**Amendment and Termination of Plan**

HealthTrust may, at its sole discretion at any time, amend or modify the Plan through a written amendment approved by a duly authorized representative of HealthTrust. Upon the approval of any such amendment, it will become effective in accordance with its terms as to you and all other Eligible Persons. No individual or entity has any authority to make any oral changes or oral amendments to the Plan. HealthTrust reserves the right to terminate the Plan at any time by giving advance notice of at least thirty (30) days to your employer.



**HealthTrust** 

 **DELTA DENTAL**<sup>®</sup>

Northeast Delta Dental

**HealthTrust**

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**Northeast Delta Dental**

One Delta Dental • P.O. Box 2002 • Concord, NH 03302-2002  
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[www.nedelta.com](http://www.nedelta.com)