DENTAL
Plan Description

for Benefits Provided by HealthTrust

HealthTrust

DELTA DENTAL®

Northeast Delta Dental

TABLE OF CONTENTS

INTRODUCTION AND GENERAL INFORMATION 1

I. DEFINITIONS 3

II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE 5

(A) Eligibility 5

(B) Enrollment 6

(C) Termination of Coverage 9

(D) Continuation of Coverage 9

III. HOW TO FILE A CLAIM 12

IV. BENEFITS 14

Coverage A - Diagnostic and Preventive Benefits 14

Coverage B - Basic Benefits 18

Coverage C - Major Benefits 24

Coverage D - Orthodontic Benefits 28

V. GENERAL EXCLUSIONS AND LIMITATIONS 30

VI. COORDINATION OF BENEFITS (DUAL COVERAGE) 33

VII. GENERAL CLAIMS INQUIRY 34

VIII. DISPUTED CLAIMS PROCEDURE 34

IX. DISPUTED CLAIMS REVIEW PROCEDURE 35

X. GENERAL PROVISIONS 35

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 logging in to your account on HealthTrust's Secure Enrollee Portal (SEP) at *www.healthtrustnh.org*. For questions or assistance, contact HealthTrust Enrollee Services (at 800.527.5001 or *enrolleeservices@healthtrustnh.org*) or Northeast Delta Dental's Customer Service (at 800.832.5700 or *customerservice@nedelta.com).*

INTRODUCTION AND GENERAL INFORMATION

Hello from HealthTrust! 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.

Your Dental Plan is provided as a benefit by your employer through HealthTrust, Inc. ("HealthTrust"). Coverage under the Plan is provided by HealthTrust, while Delta Dental Plan of New Hampshire ("Northeast Delta Dental") administers the Benefits and processes claims. Having a dental plan provided through HealthTrust means:

- **You have comprehensive coverage,** including up to 100 percent coverage for preventive care.
- **You have access to an extensive network of Participating Dentists** throughout New Hampshire, New England and the United States.
- **You won't have to submit claim forms.** Participating Dentists complete and submit dental claim forms directly to Northeast Delta Dental.
- **You do not need to pay up front.** Northeast Delta Dental pays Participating Dentists directly; you do not have to pay the covered amount up front and wait for reimbursement.
- **You may be eligible for additional preventive dental Benefits through the Health through Oral Wellness® (HOW®) program.** Your Dentist can perform an oral risk health assessment to see if you qualify for this program.

You can access your Dental Plan information quickly and easily wherever you are through your account on HealthTrust's Secure Enrollee Portal (SEP) at ***www.healthtrustnh.org***. There you can view your Delta Dental identification card (click on ID Cards/Forms), find a Participating Dentist, and access your coverage documents, including your Outline of Benefits.

Remember HealthTrust is here for you. If you have questions about your dental coverage, please send us a message by logging in to your account on HealthTrust's SEP and clicking on the Secure Message Center, or by contacting HealthTrust Enrollee Services at 800.527.5001 or ***enrolleeservices@healthtrustnh.org***.

Before you read this booklet, 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 Dental Care more 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 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 receive the best value from your Plan if you visit a Participating Dentist. You pay no more than the Delta Dental contractual fee for covered services Participating Dentists provide, even if you exceed your annual benefit maximum.

Delta Dental PPO Dentists are part of a more limited network of Participating Dentists who offer lower fees to their Delta Dental PPO patients. Delta Dental PPO Dentists are reimbursed by Delta Dental based on the lesser of the submitted charge or 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 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 Delta Dental based on the lesser of the submitted charge or 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 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 Participating Dentists agree to:

- File your claim forms for you;
- Charge you no more than the amount allowed for payment by Delta Dental; and
- Accept payment directly from 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 submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. When Delta Dental does not have a contractual fee for a specific dental procedure, Northeast Delta Dental will approve the provider's submitted charge. The Non-Participating Dentists 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 to your visit. Claim forms can be downloaded by logging in to your account on HealthTrust's SEP and clicking on the Delta Dental button, or you may call Northeast Delta Dental at 800.832.5700.

Plan Documents and Information

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.

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 your Outline of Benefits by logging in to your account on HealthTrust's SEP at *www.healthtrustnh.org*, or 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.

If you have any questions about your Plan, please check with your employer or contact HealthTrust or Northeast Delta Dental utilizing the contact information below. All correspondence with HealthTrust or Northeast Delta Dental should include your employer's name and number, your identification number, telephone number and/or email address.

HealthTrust:

HealthTrust
25 Triangle Park Drive
PO Box 617
Concord, NH 03302-0617
603.226.2861
800.527.5001
enrolleeservices@healthtrustnh.org

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
customerservice@nedelta.com

I. DEFINITIONS

1. **Anniversary Date** means the first day of your employer'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. **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.
7. **Denied** means that the fee for a procedure or service is not a Benefit under the Plan and is chargeable to the Eligible Person. The approved amount is not payable by the Plan, but is collectable from the Eligible Person.
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 (or electronic equivalent) that must be completed, signed (including by acceptable electronic means), and submitted by you to your employer. An applicant is enrolled for Benefits under the Plan only upon acceptance of the Dental Enrollment Application by HealthTrust. The Application is also used to notify HealthTrust of changes in enrollment information.
10. **Dental Plan Description (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 removable, 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 removable, 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 an Other Dental Provider (ODP). Claims submitted by a Denturist must be accompanied by a copy of a certificate of good oral health that has been issued for the Eligible Person by a Dentist. A copy of the Denturist's license must be filed with Northeast Delta Dental before claims can be processed.
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. **Eligible Dependent(s)** 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.

15. **Eligible Person(s)** 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.

16. **Explanation of Benefits (EOB)** 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 Not Billable to the Eligible Person, and gives the reason(s) for the denial or disallowance. Northeast Delta Dental will produce an EOB detailing what has been processed under your Plan's coverage. To access your EOB, log in to your account on HealthTrust's SEP and click on the Delta Dental button.

17. **HealthTrust** means HealthTrust, Inc., a New Hampshire voluntary corporation.

18. **HealthTrust's Secure Enrollee Portal (HealthTrust's SEP)** means HealthTrust's secure website available to Eligible Persons age 18 and older. To create an account on HealthTrust's SEP, visit ***www.healthtrustnh.org,*** click on the "Secure Login" box, and then click "New User" to enter your information and create your account.

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. **Not Billable to the Eligible Person** means that the fee for a procedure or service is not billable to the Eligible Person, it is not payable by the Plan, nor collectable from the Eligible Person by a Participating Dentist. The Exclusions and Limitations provisions in Section IV and Section V identify services which are Not Billable to the Eligible Person. In each instance, a Delta Dental Participating Dentist agrees not to charge a separate fee.

23. **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.

24. **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. The Outline of Benefits is part of this Dental Plan Description.

25. **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.

26. **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.

27. **Plan** means the HealthTrust Dental Plan offered by your employer as described in the Plan Document and this Dental Plan Description.

28. **Plan Document** means the comprehensive description of the dental Benefit coverage available under the Plan.

29. **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.

30. **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.

31. **Probationary Period** means the period of time as determined by your employer before you become eligible for Benefits under the Plan.

32. **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 or review, and processing treatment plans for Predetermination. Most frequently used Processing Policies are contained in the terms, conditions, limitations and exclusions described in this DPD.

33. **Selected Benefits** means the specific coverage options selected by your employer as specified in the Outline of Benefits.

34. **Selected Percentage** means the percentage amount of charges for Selected Benefits which the Plan will pay as specified in the Outline of Benefits.

35. **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

You and your Dependents are eligible to enroll in the Plan only if you meet your employer's and HealthTrust eligibility rules and the terms set forth in this Section II. Please contact your employer for information about your employer's specific eligibility rules.

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).

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 in accordance with applicable rules and procedures of 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 established by your employer.

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. To be eligible to be enrolled as a Dependent, the family member must be listed on the Dental Enrollment Application completed by the Subscriber, meet all Dependent eligibility criteria established by your employer and HealthTrust, and be one of the following

(a) **Your Spouse.** For information on spousal eligibility, please contact your employer. If your employer offers spousal coverage, 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; 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.

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; or

ii. an unmarried incapacitated dependent who is twenty-six (26) years of age or older and incapable of self-support due to a physical or mental handicap (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 twenty-six (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 thirty-one (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 automatically for up to thirty-one (31) days from the child's date of birth at no additional premium, as long your coverage is in effect during that time. 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. A child is not otherwise eligible to be enrolled for coverage until at least age two (2), unless (i) specifically permitted by your employer's eligibility rules, or (ii) permitted by HealthTrust by exception pursuant to a determination of medical necessity by the child's physician.

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 legal guardian by court order including children for whom the Subscriber or the Subscriber's spouse was the legal guardian at the time the child attained 18 years of age and the legal guardianship terminated by operation of NH RSA 463:15(l); 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.

(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 thirty-one (31) days from the date you first satisfy such requirements, including any applicable 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 thirty-one (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 thirty-one (31) days but within sixty (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 sixty (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 as determined by your employer during which you may apply for or change coverage for you and/or your eligible Dependents. Open enrollment is generally a period of 30 to 60 days prior to, your employer's Anniversary Date (either January 1 or July 1) each year, and may also include the month of your employer's Anniversary Date. If the Dental Enrollment Application is received by HealthTrust on or before the last day of the month of your employer's Anniversary Date, coverage will be effective as of either the Anniversary Date or the first of the month following receipt of the Application, as determined by your employer. If, however, the Dental Enrollment Application is not received by HealthTrust by the end of the month of your employer's Anniversary Date, the requested enrollment may not be made until the next open enrollment period, a special enrollment period, or in the event of a "qualified family status change" (as described later in this Section). 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 thirty-one (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, or legal guardianship, you will be permitted to enroll yourself and your Dependents in the Plan within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption or legal guardianship. These special enrollment rights are in addition to your right to add Dependents to existing coverage as described in subsection 3(b) below.

   You and any Dependents who become eligible for enrollment pursuant to special enrollment provisions (a) or (b) above 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 subsection 3 below. 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 (or your Dependent) 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 sixty (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 two (2) or twenty-six (26)) or incapacity;

(c) adoption, placement for adoption or legal guardianship 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 thirty-one (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 thirty-one (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 thirty-one (31) days but is received within sixty (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 sixty (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 thirty-one (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 you or 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.

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 status as an Eligible Dependent.** 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 Continuation of 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.

   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.

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*** or at ***www.healthcare.gov.***

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 receive the best value from your Plan if you visit a Participating Dentist. Ask your Dentist if he/she participates with Delta Dental. For a current list of Participating Dentists in your area, visit ***www.healthtrustnh.org***, click on the "Dental" button, then click on the button that says, "Dental Plan Provider Directories;" or log in to your account on HealthTrust's SEP and click on the Delta Dental button.

3. When you visit your dental office, inform them that you are covered under a Northeast 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. Clean paper claims must be paid in thirty (30) days; clean electronic claims must be processed within fifteen (15) days.

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 is required to submit appropriate clinical documentation for procedures. All clinical procedures are subject to review of clinical notes, radiographs, etc. to determine coverage. 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 submitted charge or 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 Delta Dental's allowance. To access your Explanation of Benefits (EOB), log in to your account on HealthTrust's SEP and click on the Delta Dental button. The EOB 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 on HealthTrust's website. Visit ***www.healthtrustnh.org***, click on the "Forms & Documents" icon, and scroll to "Claims," or log in to your account on HealthTrust's SEP and click on the Delta Dental button.

Northeast Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you may submit a claim for Benefits without the form. The time limit for submitting your claim will be met if you submit a written claim for Benefits within the time limit set forth in paragraph 7 below. Notice given by or on behalf of you to Northeast Delta Dental, or to any authorized agent of Northeast Delta Dental, with information sufficient to identify you and your claim information, shall be deemed notice to Northeast Delta Dental.

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 on the claim form before payment for Benefits is made. In either case, payment for treatment performed by a Non-Participating Dentist or ODP will be limited to the lesser of the submitted charge or Northeast Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which services are provided. When Delta Dental does not have a contractual fee for a specific dental procedure, Northeast Delta Dental will approve the provider's submitted charge. It is your responsibility to ensure that full payment is made to the Dentist or ODP. You can find this information on the Explanation of Benefits by logging in to your account on HealthTrust's SEP and click on the Delta Dental button. The EOB 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 Eligible Person information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

7. 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.

Predetermination of Benefits

HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving 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. This is 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 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 your employer's Selected Benefits and the percentage amount of charges for Selected Benefits which the Plan will pay.**

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 are 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 comprehensive series or panoramic image once in any period of five (5) years; bitewings 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 cleaning through age thirteen (13), adult cleaning thereafter). This can be a routine cleaning 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 cleaning benefit.

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

Space Maintainers through age fifteen (15).

Sealants through age eighteen (18).

NOTE: ***As a participant in Northeast Delta Dental's Health through Oral Wellness® (HOW®) program, you may be eligible for additional preventive Benefits subject to the annual Maximum, Deductible, and/or Co-payments and other 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 "**Not Billable to the Eligible Person**," it is not payable by the Plan, nor collectable from the Eligible Person 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 Eligible Person as the procedure or service is not a Benefit under the Plan.

1. Oral evaluations of any kind are Not Billable to the Eligible Person 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. Detailed and extensive oral evaluations are a covered Benefit once per Dentist/dental office and is counted toward your oral evaluation Benefits. Comprehensive, detailed and extensive oral evaluations performed on children under the age of three (3) will be payable as an oral evaluation. The difference in fees is not Billable to the Eligible Person.

4. Oral evaluations for Eligible Persons under age three (3), when performed on the same date of service by the same Dentist/dental office as a comprehensive evaluation, are Not Billable to the Eligible Person.

5. A panoramic radiographic image is a covered Benefit once in a five (5) year period for Eligible Persons.

6. Benefits are limited to either a panoramic radiographic image or an intraoral complete series radiographic images once in a period of five (5) years.

7. Payment for additional periapical, bitewing and/or occlusal radiographic images within a thirty (30) day period of a comprehensive series, unless there is evidence of trauma is Not Billable to the Eligible Person.

8. 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 Not Billable to the Eligible Person on the same date of service.

9. Bitewing images for children under the age of ten (10) are limited to two (2) bitewing images in a twelve (12) month period. Three (3) or more images will be covered as two (2) bitewing images and any difference in fees is Not Billable to the Eligible Person.

10. If the fee for bitewings, periapicals, intraoral occlusal and extraoral radiographic images is equal to or exceeds the fee for a comprehensive series, it is considered a comprehensive series for payment purposes and time limitations. Any fee in excess of the fee for the comprehensive series is Not Billable to the Eligible Person on the same date of service.

11. Intraoral tomosynthesis - comprehensive series, image capture only, received on the same day as an intraoral tomosynthesis comprehensive series by the same Dentist/dental office is Not Billable to the Eligible Person.

12. Intraoral tomosynthesis - periapical images, image capture only, received on the same day as an intraoral tomosynthesis periapical series by the same Dentist/dental office is Not Billable to the Eligible Person.

13. Intraoral periapicals are Not Billable to the Eligible Person if performed with surgical and non-surgical procedures, and all indirect restorations (crowns, onlays, bridges, inlays or implants).

14. Intraoral tomosynthesis - bitewing images, image capture only, received on the same day as an intraoral tomosynthesis bitewing radiographic image by the same Dentist/dental office is Not Billable to the Eligible Person.

15. Fees for additional bitewings (including vertical bitewings) done by the same Dentist/dental office within six (6) months of a comprehensive series is Not Billable to the Eligible Person. If performed by a different Dentist/dental office, the fee is Denied.

16. If an extra oral posterior dental radiographic image is performed within five (5) years of a prior extra oral posterior dental radiographic image by the same Dentist/dental office, the fee is Not Billable to the Eligible Person.

17. Fees for additional radiographic images taken by the same Dentist/dental office within sixty (60) days of vertical bitewings are Not Billable to the Eligible Person.

18. The fee for a comprehensive periodontal evaluation is Not Billable to the Eligible Person when performed by the same Dentist/dental office on the same date of service as a full mouth debridement.

19. Cone beam imaging and interpretation are covered Benefits once in a period of twelve (12) months. Cone beam image capture only, received on the same day as a cone beam image capture and interpretation, by the same Dentist/dental office is Not Billable to the Eligible Person.

20. Cephalometric images and oral/facial photographic images are not a covered Benefit.

21. Oral cancer screening, except brush biopsy, is not a covered Benefit.

22. 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 Not Billable to the Eligible Person.

23. Laboratory tests for caries susceptibility are not a covered Benefit and are Not Billable to the Eligible Person when billed with an oral evaluation for children under the age of three (3).

24. Caries risk assessment is a covered Benefit once in a period of twelve (12) months for Eligible Persons age three (3) and older. Benefits for caries risk assessment are Not Billable to the Eligible Person (i) if billed for children under the age of three (3), (ii) if billed within twelve (12) months by the same Dentist/dental office, or (iii) if performed with other risk assessments by the same Dentist/dental office.

25. A cleaning 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 Not Billable to the Eligible Person.

26. The fee for cleanings, scaling in the presence of generalized, moderate or severe inflammation, full mouth debridement and/or periodontal maintenance is Not Billable to the Eligible Person if the services are provided by the same Dentist/dental office within thirty (30) days after the most recent scaling and root planing or other periodontal therapy. The fee for cleanings, scaling in the presence of generalized, moderate or severe inflammation, full mouth debridement and/or periodontal maintenance is Denied if the services are provided by a different Dentist/dental office within thirty (30) days of periodontal therapy.

27. Space maintainers are a covered Benefit once in a lifetime for Eligible Dependents through age fifteen (15) when a space is being maintained for an erupting permanent tooth.

28. The replacement or repair of space maintainers is not a covered Benefit unless performed by a Dentist who did not perform the original placement.

29. Removal of a space maintainer is included as part of the total treatment. Charges for removal of a space maintainer are Not Billable to the Eligible Person if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.

30. Distal shoe space maintainers are a covered Benefit for Eligible Persons age eight (8) and younger. Fees for distal shoe space maintainers performed on Eligible Persons nine (9) and older are Denied.

31. 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 only to caries-free (no decay) and restoration-free permanent molars.

    (c) Sealants are a covered Benefit no more than once per tooth in any period of three (3) years.

    (d) Sealants are Not Billable to the Eligible Person within two (2) years of initial placement on the same tooth by the same Dentist/dental office. A sealant is Not Billable to the Eligible Person if performed by the same Dentist/dental office on the same date of service as a restoration which includes the occlusal surface.

32. Pulp vitality tests are a covered Benefit only when done in conjunction with a radiographic image, a limited oral evaluation, a palliative treatment, or placement of interim direct restoration. Payment is otherwise Not Billable to the Eligible Person.

33. Pre-diagnostic services, such as a screening or an assessment of an Eligible Person, are covered Benefits once in a period of twelve (12) months. Payment for a screening or assessment are Not Billable to the Eligible Person if billed on the same date of service or billed with an oral evaluation.

34. Pre-visit screening of an Eligible Person is not a covered benefit. The fee for a pre-visit screening is Not Billable to the Eligible Person.

35. 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.

36. Genetic test for susceptibility to diseases is not a covered Benefit.

37. Application of caries arresting medicament is a covered Benefit twice per tooth in a twelve (12) month period. If the application of caries arresting medicament is placed by the same Dentist/dental office on the same day as a restoration, it is not a covered Benefit and is Not Billable to the Eligible Person.

38. Fees for restorations on the same tooth by the same Dentist/dental office performed within sixty (60) days of the application of caries arresting medicament are Denied. The Eligible Person is responsible for the fee.

39. HbA1c and blood glucose testing are not covered Benefits and fees are Denied. If blood glucose level testing is performed on the same day as an HbA1c test, fees for the blood glucose testing are Not Billable to the Eligible Person.

40. Assessment of salivary flow is a covered Benefit once in a three (3) year period. Additional assessments are Not Billable to the Eligible Person within twelve (12) months of initial assessment. Assessments performed between twelve (12) months and three (3) years are Denied and the Eligible Person is responsible for the fee.

41. 3D intraoral surface scans, whether direct or indirect, and testing for a cracked tooth are included as part of the definitive procedure and the fees are Not Billable to the Eligible Person.

You and your Eligible Dependents will only be entitled to those Benefit coverage categories selected by your employer. See your Outline of Benefits for your employer's Selected Benefits and the percentage amount of charges for Selected Benefits which the Plan will pay.

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 are measured from the date the services were most recently performed.

Restorative: Amalgam (silver) and/or resin (white) 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 cleaning through age thirteen (13), adult cleaning thereafter). A cleaning 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 cleaning Benefit.

Treatment of gum disease.

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; biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

General anesthesia or intravenous sedation will also be covered when administered in conjunction with procedures performed in the dental office for the following covered Eligible Persons:

(a) A child under the age of thirteen (13) 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 "**Not Billable to the Eligible Person**," it is not payable by the Plan, nor collectable from the Eligible Person 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 Eligible Person 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 (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office are Not Billable to the Eligible Person.
2. Fees for placement of interim direct restorations are Not Billable to the Eligible Person 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. Removal of an indirect restoration on a natural tooth or on an implant retained abutment is included in the fee for definitive treatment and the fees are Not Billable to the Eligible Person.
5. 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.
6. 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 Not Billable to the Eligible Person.
7. Tooth preparation, bases, copings, placement of interim direct restorations, impressions, image capture only, 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.
8. The placement of interim direct restoration is a covered benefit [once] in a [lifetime]. The fee for the placement of interim direct restorations are Not Billable to the Eligible Person when performed in conjunction with definitive dental treatment on the same date of service, by the same Dentist/dental office.
9. Recementation of a crown, inlay, onlay, veneer or partial coverage restoration is a covered Benefit once per tooth per lifetime. Payment is Not Billable to the Eligible Person if performed within six (6) months of the initial placement by the same Dentist/dental office.
10. Recementation of a cast or prefabricated post and core is a covered Benefit once per tooth per lifetime. Payment is Not Billable to the Eligible Person 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.
11. 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 Not Billable to the Eligible Person. The fee for pin retention is Not Billable to the Eligible Person when billed in conjunction with a core buildup.
12. A partial extraction for immediate implant placement is a covered benefit once per tooth in a lifetime.
13. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered Benefit. Payment is Not Billable to the Eligible Person if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.
14. An upper or lower frenulectomy or frenuloplasty is a covered Benefit once per site per lifetime, and the fee is Not Billable to the Eligible Person when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office.
15. Alveoloplasty is included in the fee for extractions. Separate fees for these procedures are Not Billable to the Eligible Person if performed by the same Dentist/dental office in the same area on the same date.

16. Removal of coronal remnants of a primary tooth is considered part of any other (more comprehensive) surgical procedure in the same surgical area, on the same date by the same Dentist/dental office, and the fees are Not Billable to the Eligible Person.

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

18. Exploratory surgical services are not a covered Benefit and fees are Denied. The Eligible Person is financially responsible.

19. Recementation or re-bond of a space maintainer is a covered Benefit once per space maintainer.

20. 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 Not Billable to the Eligible Person.

21. The fee for cleanings, scaling in the presence of generalized, moderate or severe inflammation, full mouth debridement and/or periodontal maintenance is Not Billable to the Eligible Person if the services are provided by the same Dentist/dental office within thirty (30) days after the most recent scaling and root planing or other periodontal therapy. The fee for cleanings, scaling in the presence of generalized, moderate or severe inflammation, full mouth debridement and/or periodontal maintenance is Denied if the services are provided by a different Dentist/dental office within [thirty (30)] [days] of periodontal therapy.

22. A cleaning 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 Not Billable to the Eligible Person.

23. Periodontal scaling and root planing is a covered Benefit per quadrant (maximum of two (2) quadrants per office visit) once in a period of twenty-four (24) months.

24. Fees for periodontal scaling and root planing per quadrant are Not Billable to the Eligible Person within twenty-four (24) months when performed by the same Dentist/dental office. If treatment is done by a different Dentist/dental office within twenty-four (24) months, Benefits are Denied.

25. The fee for periodontal scaling and root planing is Not Billable to the Eligible Person if performed within ninety (90) days of periodontal surgery by the same Dentist/dental office, or if more than two (2) quadrants are treated in one office visit.

26. Fees are Not Billable to the Eligible Person if more than two quadrants of periodontal scaling and root planing are performed by the same Dentist/dental office on the same date of service.

27. If periodontal surgery is performed less than four (4) weeks after periodontal scaling and root planing by the same Dentist/dental office, the fee for the surgical procedure is Not Billable to the Eligible Person.

28. Fees are Not Billable to the Eligible Person for periodontal scaling and root planning done on the same day by the same Dentist/dental office as a gingival flap procedure, surgical repair of root resorption or surgical exposure of root surface.

29. Gingivectomy, gingival flap procedure, or mesial/distal wedge is a covered Benefit once in a period of three (3) years on natural teeth. The fee for surgical re-entry by the same Dentist/dental office within three (3) years is Not Billable to the Eligible Person.

30. Bone replacement graft, biologic material, guided tissue regeneration, and tissue grafts are a covered benefit once in a period of three (3) years and limited to two teeth per quadrant per day. Fees for more than two teeth per quadrant in a day are Denied. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Not Billable to the Eligible Person.

31. Fees for guided tissue regeneration, resorbable or non-resorbable barrier per site or per implant, edentulous area, resorbable or non-resorbable barrier per site, are Denied when done in conjunction with mucogingival/soft tissue grafts in the same surgical area.

32. Guided tissue regeneration, resorbable barrier, per site in conjunction with periradicular surgery is not a covered benefit.

33. Osseous surgery is a covered Benefit per quadrant once in a period of three (3) years. Fees are Not Billable to the Eligible Person for surgical re-entry by the same Dentist/dental office within a three (3) year period, and/or if more than two quadrants are treated in one office visit, the fee will be Denied.

34. Anterior deciduous root canal therapy is not a covered Benefit.

35. 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 Not Billable to the Eligible Person.

36. Root canal therapy is not a covered Benefit in conjunction with overdentures, and Benefits are Denied. The Eligible Person is responsible for the additional fee.

37. Endodontic treatments and retreatments are Not Billable to the Eligible Person if performed by the same Dentist/dental office within twenty-four (24) months of an initial endodontic treatment or within twenty-four (24) months of a previous endodontic retreatment.

38. Incomplete endodontic procedure due to inoperable or fractured tooth may be covered at 50% of the fee for a completed endodontic therapy, subject to a consultant's review of radiographic images and clinical notes.

39. The fee for root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Not Billable to the Eligible Person.

40. 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 Not Billable to the Eligible Person.

41. A partial pulpotomy is a covered Benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Not Billable to the Eligible Person if performed within thirty (30) days on the same tooth by the same Dentist/dental office as root canal therapy.

42. Pulpal therapy is a covered Benefit once in a three (3) year period on primary first and second molars only. If pulpal therapy is performed on primary anterior or permanent teeth, the procedure will be covered as a palliative treatment.

43. Therapeutic pulpotomy is a covered Benefit once in a three (3) year period per tooth on primary teeth only. If the service is provided on permanent teeth, the procedure will be covered as a palliative treatment.

44. Fees for therapeutic pulpotomy or palliative treatment are Not Billable to the Eligible Person when performed on the same date of service as root canal procedure or root canal therapy.

45. 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 Not Billable to the Eligible Person.

46. An apexification is a covered Benefit once per tooth in a lifetime. The fee for retreatment by the same Dentist/dental office within twenty-four (24) months is Not Billable to the Eligible Person.

47. 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 Not Billable to the Eligible Person.

48. An internal root repair of perforation defects 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 of perforation defects is Not Billable to the Eligible Person if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.

49. Surgical repair of root resorption or surgical exposure of root surface without apicoectomy or repair of root resorption without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling, surgical repair of root resorption, surgical exposure of root surface without apicoectomy or repair of root resorption, root amputation, internal root repair of perforation defects and/or periodontal surgical services are Not Billable to the Eligible Person.

50. Pulpal debridement is a covered Benefit once per tooth in a lifetime. The fee for pulpal debridement is Not Billable to the Eligible Person when performed in conjunction with endodontic therapy on the same tooth by the same Dentist/dental office or within thirty (30) days of root canal therapy or an apexification.

51. Removal of residual tooth roots is Not Billable to the Eligible Person when performed on the same date of service as an extraction by the same Dentist/dental office.

52. The fee for repairs of complete or partial dentures cannot exceed half the fees for a new appliance. Any excess fee billed by the same Dentist/dental office is Not Billable to the Eligible Person.

53. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office, are Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office within six (6) months of initial placement.

54. Denture adjustments, relines or tissue conditioning performed within three (3) months of a complete immediate denture are Not Billable to the Eligible Person.

55. 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 Not Billable to the Eligible Person 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 Not Billable to the Eligible Person.

56. 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 Not Billable to the Eligible Person if performed on the same date of service by the same Dentist/dental office as the crown placement.

57. Clinical crown lengthening when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for the complete procedure and is Not Billable to the Eligible Person.

58. 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.

59. The fee for palliative treatment is Not Billable to the Eligible Person when submitted with all procedures except radiographic images and diagnostic codes, and is performed by the same Dentist/dental office on the same date.

60. 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 Not Billable to the Eligible Person.

61. General anesthesia or IV sedation 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. More than one hour of general anesthesia or IV sedation is Not Billable to the Eligible Person.

62. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure and fees are Not Billable to the Eligible Person.

63. The fee for nitrous oxide is Not Billable to the Eligible Person in conjunction with Intravenous sedation and/or general anesthesia.

64. The fee for in-office administration of minimal sedation, single enteral and moderate sedation, non-intravenous parenteral sedation is Not Billable to the Eligible Person in conjunction with intravenous sedation and/or general anesthesia.

65. A consultation is a covered Benefit only if performed by a Dentist that is not performing further treatment. The fee for a consultation is Not Billable to the Eligible Person if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.

66. Fees for restorations on the same tooth by the same Dentist/dental office performed within sixty (60) days of the application of caries arresting medicament application are Denied. The Eligible Person is responsible for the fee.

67. 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 Not Billable to the Eligible Person 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.

68. Gingival irrigation is not a covered Benefit and fees are Denied. Fees for gingival irrigation are Not Billable to the Eligible Person when performed in conjunction with any periodontal service.

69. Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied and hyperplastic tissue) is not a covered benefit.

70. Nerve dissection is part of the removal of a completely bony impacted tooth and the fees are Not Billable to the Eligible Person when done on the same date of service.

71. Fees for photobiomodulation therapy are Not Billable to the Eligible Person when performed as part of another procedure. If performed as a standalone procedure, the fees are Denied.

NOTE: HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving 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.

You and your Eligible Dependents will only be entitled to those Benefit coverage categories selected by your employer. See your Outline of Benefits for your employer's Selected Benefits and the percentage amount of charges for Selected Benefits which the Plan will pay.

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 are measured from the date the services were most recently performed.

Restorative Crowns and Onlays:	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and reline of such prosthetic appliances; core buildups; cast and prefabricated post and cores; repairs to crowns, fixed partial dentures and onlays.
Implant Services:	Surgical placement of an endosteal implant body, including healing cap.
Implant Supported Prosthetics:	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 "**Not Billable to the Eligible Person**," it is not payable by the Plan, nor collectable from the Eligible Person 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 Eligible Person 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) partial, complete or immediate maxillary (upper) and one (1) partial, complete or immediate mandibular (lower) denture in a period of seven (7) years.
   - (c) One (1) 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 allowance will be paid equal to an amalgam (silver) or resin (white) restoration. If an inlay is performed, the Eligible Person is responsible for any additional fee.

4. A core buildup 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 buildups are Not Billable to the Eligible Person when buildups are performed in conjunction with inlays, three-quarter (¾) crowns or onlays and indirectly fabricated or prefabricated post and cores.

5. An indirectly fabricated or prefabricated post and core is payable only on an endodontically treated tooth and is a covered Benefit once in a seven (7) year period for Eligible Persons age twelve (12) and older. Fees for post and cores are Not Billable to the Eligible Person when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth. Each additional post in the same tooth is considered part of the post and core procedure. A separate fee is Not Billable to the Eligible Person.

6. A core buildup or indirectly fabricated and prefabricated post and cores in conjunction with a fixed partial denture crown are a covered Benefit once in a seven (7) year period per tooth for Eligible Persons age sixteen (16) and older.

7. Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths, includes cleaning of the implant surfaces, without flap entry and closure is a covered Benefit once in a twenty-four (24) month period. Fees for retreatment are Not Billable to the Eligible Person if performed within twelve (12) months of restoration or within twenty-four (24) months of initial therapy by the same Dentist/dental office. If performed by a different Dentist/dental office, the fee is Denied.

8. The fee for scaling and debridement of a single implant in the presence of or mucositis, including inflammation, bleeding upon probing and increased pocket depths, includes cleaning of the implant surfaces, without flap entry and closure is Not Billable to the Eligible Person when performed in the same quadrant by the same Dentist/dental office as periodontal scaling and root planing, or gingival flap procedure including root planing, osseous surgery, scaling and debridement of a single implant in the presence of peri-implantitis inflammation or debridement of a peri-implant defect.

9. The fee for scaling and debridement of a single impant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths, includes cleaning of the implant surfaces, without flap entry and closure is Not Billable to the Eligible Person when performed in conjunction with a cleaning, periodontal maintenance or scaling of moderate or severe gingival inflammation.

10. Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure is a covered benefit once in a period of twenty-four (24) months.

11. Fees for scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure are Not Billable to the Eligible Person when performed in the same quadrant by the same Dentist/dental office as periodontal scaling and root planing, gingival flap procedure, including root planing, osseous surgery or debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure.

12. Fees for retreatment of scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure of by the same Dentist/dental office within twenty-four (24) months of initial therapy are Not Billable to the Eligible Person. If retreated by a different Dentist/dental office within twenty-four (24) months, the fees are Denied.

13. Fees for scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure are Not Billable to the Eligible Person when performed within twelve (12) months of crown restorations, interim implant crown, abutment supported crown, implant/abutment supported interim fixed denture, edentulous arch, mandibular or maxillary and abutment supported retainer crown for fixed partial dentures.

14. Fees for scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure are Not Billable to the Eligible Person when performed in conjunction with a cleaning, scaling in the presence of generalized, moderate or severe gingival inflammation or periodontal maintenance cleanings.

15. Post removal is considered part of the endodontic treatment and/or retreatment, and is Not Billable to the Eligible Person.

16. A provisional crown or provisional implant crown is considered part of a crown procedure when performed by the same Dentist/dental office as a permanent crown, and a separate fee is Not Billable to the Eligible Person.

17. Prefabricated porcelain/ceramic crowns for permanent teeth and prefabricated resin crowns for anterior primary teeth are a covered benefit once in a period of twenty-four (24) months. The fee for replacement by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office within twenty-four (24) months.

18. Prefabricated porcelain/ceramic crowns for primary teeth are a covered benefit once in a lifetime. The fee for replacement by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office.

19. Removable or fixed, complete or partial dentures are not covered Benefits for Eligible Persons under the age of twelve (12).

20. Fees for crown, inlay, onlay or veneer repairs performed on the same date of service as a new crown, inlay, onlay or veneer are Not Billable to the Eligible Person.

21. Fees for crown, inlay, onlay or veneer repairs are Not Billable to the Eligible Person if performed within twenty-four (24) months of the original restoration by the same Dentist/dental office.

22. Benefits for crown, inlay, onlay or veneer repairs are Denied if performed within twenty-four (24) months of the original restoration by a different Dentist/dental office. The Eligible Person is responsible for the fees.

23. An implant body, including healing cap, is a covered Benefit once in a lifetime per site. The fees for an implant are Not Billable to the Eligible Person if the implant is part of a fixed partial denture on natural teeth.

24. Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments, per arch, are a covered benefit once in a period of thirty-six (36) months. Benefits are Denied if done more frequently.

25. Fees for implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments, per arch, are Not Billable to the Eligible Person if done within twelve (12) months of an implant/abutment supported removable denture for edentulous arch, maxillary and mandibular.

26. Bone replacement graft for ridge preservation is not a covered Benefit.

27. 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.

28. Recementation of a fixed partial denture is a covered Benefit once in a period of twelve (12) months. Fees for recementation of fixed partial dentures are Not Billable to the Eligible Person if done within six (6) months of the initial placement by the same Dentist/dental office.

29. An interim complete denture is not a covered Benefit. Fees are Not Billable to the Eligible Person if billed in conjunction with a permanent appliance.

30. An interim partial denture is a covered Benefit for Eligible Dependents through age sixteen (16) on anterior, permanent teeth only. The fee for an interim partial denture is Not Billable to the Eligible Person if billed in conjunction with a permanent appliance on the same day by the same Dentist/dental office.

31. The relining of a denture is a covered Benefit twice in a period of twelve (12) months for Eligible Persons age sixteen (16) and older. The fee for reline 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 Not Billable to the Eligible Person on the same date of service.

32. The rebase of a denture is a covered Benefit once in a period of seven (7) years for Eligible Persons age sixteen (16) and older. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Not Billable to the Eligible Person on the same date of service.

33. The reline or rebase of a denture is Not Billable to the Eligible Person if performed within six (6) months of initial placement by the same Dentist/dental office.

34. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is Not Billable to the Eligible Person. 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.

35. Implant services are not a covered Benefit for Eligible Persons under the age of sixteen (16).

36. Fees for more than one surgical placement of mini-implant placed at the same site on the same day are Not Billable to the Eligible Person.

37. 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.

38. Guided tissue regeneration - resorbable barrier or non-resorbable barrier, per implant, is not a covered benefit.

39. Removal of an implant body is a covered benefit once in a lifetime per tooth site. The fee for removal of an implant is Not Billable to the Eligible Person when done by the same Dentist/dental office within three (3) months of surgical placement of an implant or a mini-implant.

40. The fee for removal of an implant body not requiring bone removal or flap elevation when performed within six (6) months of surgical placement of an implant or a mini-implant on the same tooth by the same Dentist/dental office is Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office.

41. Fees for repair of implant or abutment-supported prosthesis performed within six (6) months of the initial placement of the prosthesis by the same Dentist/dental office are Not Billable to the Eligible Person.

42. Replacement of restorative material used to close an access opening of a screw-retained implant supported prostheses, per implant, is a covered benefit once in a period of twenty-four (24) months.

43. Fees for replacement of restorative material used to close an access opening of a screw-retained implant supported prostheses, per implant, are Not Billable to the Eligible Person when performed by the same Dentist/dental office within six (6) months of placement of the implant prosthesis.

44. Fees for replacement of restorative material used to close an access opening of a screw-retained implant supported prostheses, per implant, are Not Billable to the Eligible Person on the same date of service by the same Dentist/dental office as an implant maintenance procedure when prostheses are removed and reinserted, including cleansing of prostheses and abutments or repair of implant supported prostheses.

45. Accessing and retorquing loose implant screw, per screw, is a covered benefit once in a period of twenty-four (24) months for Eligible Persons age sixteen (16) and older.

46. Fees for accessing and retorquing loose implant screw, per screw, are Not Billable to the Eligible Person when done on the same date of service by the same Dentist/dental office as implant maintenance, implant repair, or replacement of an implant screw.

47. Replacement of an implant screw is a covered benefit [once] per implant in a [twenty-four (24)] [month] period for Eligible Persons age [sixteen (16)] and older. Fees for replacement of an implant screw, if performed within six (6) months of the initial placement of the prosthesis, by the same Dentist/dental office, is Not Billable to the Eligible Person.]

48. [Implant maintenance procedures when a full arch fixed hybrid prosthesis is either not removed or removed and reinserted, including cleansing of prosthesis and abutments is a covered benefit [once] in a period of [three (3)] [years].]

49. [Fee for Implant maintenance procedures when a full arch fixed hybrid prosthesis is either not removed or removed and reinserted, including cleansing of prosthesis and abutments are Not Billable to the Eligible Person if done within twelve (12) months of an implant/abutment supported fixed denture for edentulous arch, maxillary or mandibular.

50. Tissue conditioning is a covered Benefit two (2) times in a period of three (3) years. The fee for tissue conditioning is Not Billable to the Eligible Person if performed on the same date of service as a denture rebase or reline by the same Dentist/dental office.

51. Placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is considered part of the extraction and/or post-operative procedure and is Not Billable to the Eligible Person.

52. Benefits for complete and partial overdentures are Denied. Any benefits are limited to a conventional denture and any additional fees are the responsibility of the Eligible Person.

NOTE: HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving 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.

You and your Eligible Dependents will only be entitled to those Benefit coverage categories selected by your employer. See your Outline of Benefits for your employer's Selected Benefits and the percentage amount of charges for Selected Benefits which the Plan will pay.

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 are 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 unless otherwise specified in the Outline of Benefits.

Placement of device to facilitate eruption of an impacted tooth.

Exposure of an un-erupted 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 "**Not Billable to the Eligible Person**," it is not payable by the Plan, nor collectable from the Eligible Person 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 Eligible Person as the procedure or service is not a Benefit under the Plan.

1. Orthodontic Benefit limitations include:

   (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 an Eligible Person is eligible for orthodontic Benefits, the Claims Administrator will initiate payment of its liability once bands or orthodontic devices are placed. The Claims Administrator will make one (1) payment at the start of treatment for the Plan's total liability. The Plan's payment for orthodontic Benefits will be limited to the lifetime Maximum per Eligible Person specified in the Outline of Benefits.

   (c) For Eligible Persons who become eligible after orthodontic treatment has commenced, the Claims Administrator will pro-rate the Plan's liability for comprehensive orthodontic treatment 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 Eligible Person 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 radiographic images, it is indicated that the Eligible Person has full adult dentition.

   Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. The Eligible Person is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.

   Orthodontic treatment must be provided by a licensed dentist. Self-administered (or any type of 'do-it-yourself') orthodontics is Denied.

   Orthodontic treatment must be diagnosed by a licensed Dentist and the total case fee includes all records through retention (radiographic images, models, impressions, retainer, etc.) necessary to complete the orthodontic treatment. Direct-to-Consumer orthodontic treatment requires a completed attestation by the treating Dentist.

3. 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.

4. Removable orthodontic retainer adjustment is not a covered Benefit. The fee for a removable orthodontic retainer adjustment is Not Billable to the Eligible Person 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.

5. Rebonding or recementing of a fixed retainer is a covered Benefit once in a lifetime per Eligible Person if performed by a different Dentist/dental office than the one who placed the appliance. Rebonding or recementing of a fixed retainer by the same Dentist/dental office who placed the original appliance is Not Billable to the Eligible Person.

6. Fees for repair of a fixed retainer (including reattachment) are considered part of the total orthodontic case fee. Repair of a fixed retainer within twenty-four (24) months of original placement by the same Dentist/dental office is Not Billable to the Eligible Person. If performed within twenty-four (24) months by a different Dentist/dental office than the one who placed the original appliance, payment will be made for one (1) repair in a lifetime.

7. Fees for orthodontic retention (removal of appliance and construction and replacement of retainer) within twenty-four (24) months of original placement by the same Dentist/dental office is Not Billable to the Eligible Person. If performed within twenty-four (24) months by a different Dentist/dental office than the one who placed the original appliance, services are Denied and the Eligible Person is responsible for the fee.

8. Comprehensive orthodontic treatment with orthognathic surgery is a covered benefit. Fees for limited and comprehensive orthodontic treatment submitted on the same date of service as comprehensive orthodontic treatment with orthognathic surgery are Not Billable to the Eligible Person.

9. Periodic orthodontic treatment visit associated with orthognathic surgery is not a covered benefit. Fees for periodic orthodontic treatment visit associated with orthognathic surgery are Not Billable to the Eligible Person when done on the same date of service as comprehensive orthodontic treatment with orthognathic surgery.

NOTE: HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving 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. **Exclusions.** Unless otherwise specified in this DPD (including the Outline of Benefits), 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 or cosmetic surgery. (This exclusion is not intended to exclude services provided for congenital defects and/or developmental malformations.)

(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) splint – intra or extra coronal; (iv) myofunctional therapy; (v) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (vi) equilibration; and (vii) 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) administration of home sleep apnea test or screening for sleep related breathing disorders, custom sleep apnea appliance fabrication, placement, adjustment, repair or reline; or (vi) esthetic purposes. This exclusion is not intended to exclude services provided for congenital defects and/or developmental malformations.

(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.

(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 Eligible Person to assume additional cost.

(p) Temporary or incomplete services.

(q) A consultation unless performed by a Dentist who is not performing further services.

(r) Consultation with medical health care professional and dental case management for addressing appointment compliance barriers and care coordination are part of the overall Eligible Person management and the fees are Not Billable to the Eligible Person. Dental case management for motivational interviewing and Eligible Person education are not a covered Benefit. If services are provided on the same day by the same Dentist/dental office as immunization counseling, counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high risk substance use, nutritional or tobacco counseling or oral hygiene instruction, fees for dental case management for motivational interviewing and Eligible Person education are Not Billable to the Eligible Person.

(s) Case presentation and treatment planning. The Eligible Person will be responsible for any additional fee.

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

(u) The fees for transmitting data via teledentistry are considered inclusive in the overall dental procedure(s) being performed and separate fees are Not Billable to the Eligible Person.

(v) The fees for translation services are considered inclusive in the overall patient management and are Not Billable to the Eligible Person.

(w) The duplication or copying of the Eligible Person's dental records.

(x) In accordance with state laws, a Dentist is required to submit appropriate clinical documentation for procedures. All clinical procedures are subject to review of clinical notes, radiographs, etc. to determine coverage.

(y) Covered periodontal services are only covered when performed on natural teeth for treatment of periodontal disease. Unless otherwise specified by contract, benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites and/or periradicular surgery are Denied and the Eligible Person is responsible for the fee.

2. Limitations. Unless otherwise specified in this DPD (including 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), personalizations or characterization, are limited. The Eligible Person 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 Not Billable to the Eligible Person.

(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 Eligible Person and the Eligible Person 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 Eligible Person.

(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 Eligible Person.

(vii) Orthodontics - incurred liability for orthodontic treatment refers to the date(s) that the Claims Administrator will make payment(s) for the orthodontic treatment. The total cost for the orthodontic treatment shall be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the Eligible Person'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. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:

   (a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married, the following "birthday rule" applies:

      i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.

      ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

   (b) For a Dependent child whose parents are divorced or separated, or are not living together whether or not they have ever been married:

      i. 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. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      ii. 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 subparagraph (a) of this paragraph shall determine the order of benefits;

      iii. 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 subparagraph (a) of this paragraph shall determine the order of benefits; or

      iv. 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:

         - the plan covering the custodial parent;
         - the plan covering the custodial parent's spouse;
         - the plan covering the non-custodial parent; and then
         - the plan covering the non-custodial parent's spouse.

   (c) 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 subparagraphs (a) or (b) of this paragraph as if those individuals were parents of the child.

4. If paragraphs 1 through 3 above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time will be determined first.

5. When this Plan is the first to determine its Benefits under the foregoing, 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 only 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.

6. 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 or obtain from any third party, any information with respect to any person which it deems to be necessary to determine the Plan's liability. 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.

7. 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 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 Not Billable to the Eligible Person, and gives the reason(s) for the denial or why the service is not billable to you. To access your EOB, log in to your account on HealthTrust's SEP and click on the Delta Dental button.

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

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 you have reason to believe your Benefit determination was not in accordance with the terms of the Plan and this DPD, you have the option of using the Claims Administrator's Disputed Claims Procedure. You may request a review of your claim within six (6) months of the date 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 Director, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002. 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 Director, Professional Relations, or his/her designee, will promptly review your claim. He/she may request additional documents as necessary to make such a review. If the claim is denied in any respect, you will be furnished with a written 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 results in an additional payment, it will be made within fifteen (15) working days of the Director, Professional Relations or his/her designee's response. If you have not received a written response (within thirty (30) days as noted above) and/or disagree with the notice received, you may proceed to the Disputed Claims Review Procedure in Section IX. Your claim will remain in a Denied status pending the outcome of the review.

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

IX. DISPUTED CLAIMS REVIEW PROCEDURE

If you have followed the Disputed Claims Procedure in Section VIII and still believe your Benefit determination was not in accordance with the Agreement, you have the option of using Northeast Delta Dental's Disputed Claims Review Procedure. This procedure allows you to request a review by the Review Committee regarding the continued denial of your claim. The Review Committee is composed of Participating Dentists, non-Dentist members of the Board of Directors, and representatives of purchasers.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review within one hundred eighty (180) days from receipt of the Director, Professional Relations or his/her designee's 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 Northeast Delta Dental's address. You may also submit your request by standard mail. It must state the reasons for requesting a review. It should contain the issues, comments, and supporting materials stating why you believe the response of Northeast Delta Dental's Director, Professional Relations or his/her designee was incorrect. Within thirty (30) days after receipt of your request, the Review Committee will provide its written decision, including specific reasons for the decision.

In addition or as an alternative to the written request, 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 a lawyer or other representative, to request 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 no later than thirty (30) days after your request. A decision will be provided within 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 Section II (B), ENROLLMENT of this DPD.

Notices by Claims Administrator

Any notice required or permitted to be given by the Claims Administrator hereunder will be deemed to have been duly given if in writing and personally delivered, or if in writing and sent (i) in the United States mail with postage prepaid or (ii) by email or other electronic medium with proof of transmittal, and addressed to a Subscriber or a Dentist at the last address of record at Northeast Delta Dental. Such notice will be deemed to be given when personally delivered, mailed or emailed.

Right of Recovery

The Plan and the Claims Administrator have the right to recover any excess Benefit payments from the payee.

Subrogation

In the event of any payments for Dental Care under the Plan, the Plan and the Claims Administrator will be subrogated to all of the Eligible Person's rights of recovery thereof against any third person or organization who may be liable for such payment. The Eligible Person shall execute and deliver such instruments and papers and do whatever else is necessary to secure such rights. Such subrogation shall be on a just and equitable basis and not on the basis of a priority lien.

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 the *HealthTrust Notice of Privacy Practices*, visit ***www.healthtrustnh.org***, click on "Forms & Documents," and scroll to "Privacy and Security (HIPAA)." To view the *Northeast Delta Dental Notice of Privacy Practices*, log in to your account on HealthTrust's SEP and click on the Delta Dental button. On the Delta Dental home page, click on "About Us" and scroll to "Privacy Practices." If you have any specific 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).

Nonwaiver 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.

Governing 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.

Assignment of Benefits

Benefits of Eligible Persons are personal and, except as otherwise required by law including as provided in the following two paragraphs, cannot be transferred or assigned.

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

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

Legal Action

No action may be brought to recover a claim under this Plan prior to the expiration of sixty (60) days after the claim has been filed or the claim review and appeal process, described in Sections VII, VIII and IX of this DPD, has been completed. In no event shall any action be brought on a claim more than three (3) years after the completed claim has been filed.

HealthTrust

25 Triangle Park Drive, Concord, NH 03301
www.healthtrustnh.org | 800.527.5001 | enrolleeservices@healthtrustnh.org