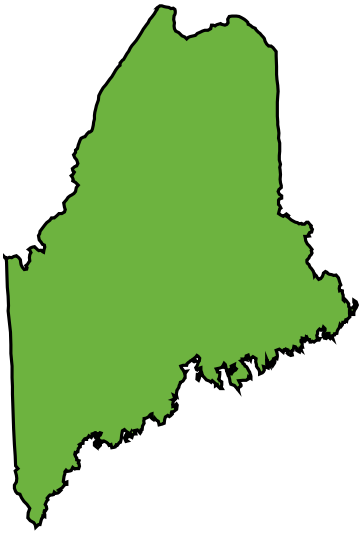
DELTA DENTAL®

Dental Plan Description



MAINE STATE EMPLOYEES HEALTH INSURANCE PROGRAM

Department of Administrative and Financial Services

and

THE STATE EMPLOYEE HEALTH COMMISSION

Notice to Buyer: This policy provides dental benefits only.

Northeast Delta Dental

Delta Dental National Coverage

Discrimination is Against the Law

Northeast Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Northeast Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Northeast Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Neiko Lavery, Associate General Counsel.

If you believe that Northeast Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Neiko Lavery, Associate General Counsel
One Delta Drive
Concord, NH 03301
603-223-1127
TTY: 711
Fax: 603-223-1035
nlavery@nedelta.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Neiko Lavery, Associate General Counsel, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

DELTA DENTAL®

Northeast Delta Dental

Language Assistance Services

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-5700 (ATS : 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-832-5700 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-832-5700 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-832-5700 (TTY: 711).

यान दनु होस:ो्तपाइ ले नेपाल बो नह छ भन तपाइ को िन त भाषा सहायता सवाह नःश क पमा उपल ध छ । फोन गनु होसर् ो्1-800-332-5700 (ट टवाइ: 711) ।

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-238-0075 (رقم هاتف الصم والبكم 117.)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-832-5700 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-832-5700 (телетайп: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-832-5700 (TTY: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-832-5700 (TTY: Telefon za osobe sa oštećenim govorom ili sluhom: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-832-5700 (TTY: 711) 번으로 전화해 주십시오.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-832-5700 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-832-5700 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-832-5700 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-832-5700 (TTY: 711)។

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Note: This Dental Plan Description is intended to be an easy-to-read summary of your plan. It is subject to and superseded by the provisions of the Agreement between Delta Dental and your employer.

Please read this booklet in conjunction with the Outline of Benefits provided inside the cover. The Outline of Benefits lists some specific provisions of your group dental plan.

I. Welcome

The Maine State Employees Health Insurance Program and the State Employee Health Commission, in conjunction with Northeast Delta Dental, have prepared this booklet to promote a better understanding of your dental care benefits. This booklet is intended to be an easy-to-read description of your dental care benefits.

Please review this booklet and retain it for your future reference. If you have questions, please contact one of the offices listed below.

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

This booklet, together with your Outline of Benefits, describes the benefits of your program and tells you how to use your plan. Please read it carefully to understand the benefits and provisions of your Northeast Delta Dental Plan. But, before you turn the page, we'd like you to know something about us...

Northeast Delta Dental is a not-for-profit organization originally 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 the Delta Dental Plans Association (DDPA) which provides Dental Care programs in all states and U.S. territories.

A majority of Dentists in Maine, New Hampshire, and Vermont participate with Northeast Delta Dental through participating dentist agreements. In addition, there is a nationwide network of Delta Dental Participating Dentists available to you.

You are encouraged to take advantage of your Northeast Delta Dental Plan since good oral health is an important part of your overall health. You are also encouraged to participate in Northeast Delta Dental's innovative Health through Oral Wellness® (HOW®) program to be eligible for additional preventive dental benefits based upon a clinical risk assessment by your Dentist. Finally, you are also encouraged to obtain your Dental Care from a State of Maine Employees PPO Network Participating Dentist to get the best value from your program. You pay no more than the Delta Dental contractual fee for covered services our Participating Dentists provide, even if you exceed your annual benefit maximum.

General Information

Eligibility and Enrollment, Payroll Deductions
The Division of Employee Health & Benefits
#114 State House Station
Augusta, ME 04333-0114
207-624-7380 or 800-422-4503 (toll free); TTY users dial Maine relay 711

Claims Questions

Northeast Delta Dental
One Delta Drive
P0 Box 2002
Concord, NH 03302-2002
603-223-1234 or 800-832-5700 (toll free)
TTY/Hearing Impaired – 711

II. Definitions

1. **Agreement:** the contractual relationship between your group and Northeast Delta Dental to provide dental benefits to Eligible Persons, including this document, the contract application, the group contract, and the Outline of Benefits.
2. **Co-Payment:** the amount of the Dental Care cost which you are required to pay.
3. **Contract Holder:** the group named in the contract application.
4. **Contract Year:** the time period specified in the Outline of Benefits.
5. **Coverage:** the Dental Care referred to in the Agreement.
6. **Covered Benefits:** the classifications of Dental Care referred to in the Agreement and any attached appendices which are to be rendered to Eligible Persons and the Dental Benefits Summary (see Section VI, on page 10) in this Dental Plan Description.
7. **Coverage Period:** the Contract Year for Covered Benefits as defined above.
8. **Delta Dental Plans Association (DDPA):** the association which comprises all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.
9. **Delta Dental Participating Dentist:** 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. A Dentist who has signed a participating agreement with a Delta Dental Plan in another state is also a Participating Dentist. 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. Under the State of Maine Employees PPO program, Northeast Delta Dental's reimbursement to Participating Dentists is based on the State of Maine Employees PPO table of allowance.
10. **Denied:** if the fee for a procedure or service is Denied and chargeable to the Eligible Person, the procedure or service is not a benefit of the Eligible Person's plan. The approved amount is not payable by Northeast Delta Dental, but is collectable from the Eligible Person.
11. **Dental Care:** dental services ordinarily provided by licensed Dentists and ODPs for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with accepted standards of dental practice at the time the service is rendered.
12. **Dental Plan Description (DPD):** This Dental Plan Description is part of the Agreement which provides the terms and conditions under which Northeast Delta Dental shall administer your dental benefit plan.
13. **Dentist:** a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
14. **Dependent:**
    (a) The spouse to whom the Subscriber is legally married; and/or
    (b) A Domestic Partner of an Eligible Employee. (A Domestic Partner Affidavit must be completed and all conditions on the Affidavit must be met.)
    (c) A child of the Subscriber or of the spouse or Domestic Partner of the Subscriber, by natural birth or legal adoption or a child in the process of adoption or guardianship and in the custody of the Subscriber or the spouse or Domestic Partner of the Subscriber, a foster child legally placed by order of a court or agency having competent jurisdiction and/or a stepchild, provided such child is under the age of twenty-six (26).

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

A newborn child is automatically covered for the first thirty-one (31) days following birth. Coverage will continue if the child is formally enrolled within the first sixty (60) days following birth or the child may be enrolled at any open enrollment thereafter, or within the first sixty (60) days following its first birthday. The child will become effective on the first day of the month following the month of enrollment.

15. **Domestic Partner:** the same sex or opposite sex partner of the Subscriber (and their Dependents) who:

    (a) Is a mentally competent adult as is the Subscriber.

    (b) Has been legally domiciled with the Subscriber for at least twelve (12) months.

    (c) Is not legally married to or legally separated from another individual.

    (d) Is the sole partner of the Subscriber and expects to remain so.

    (e) Is jointly responsible with the Subscriber for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

16. **Eligible Dependent(s):** those Dependents who meet the eligibility requirements of the Agreement and are enrolled by Subscribers in the groups benefit program.

17. **Eligible Employee:** All persons who render service on an employer/employee relationship, are certified as being eligible by the Contract Holder, receive compensation from the Contract Holder, and are members of the group specified in the Agreement.

18. **Eligible Person(s):** the Subscriber and Dependent(s) (as defined herein) to the extent eligible in accordance with the eligibility requirements established by the Group (or the employer).

19. **Explanation of Benefits (EOB)**: this notice which explains the benefits that were paid on your behalf, lets you know if any services are Denied or Not Billable to the Eligible Person, and gives you the reason(s) for the denial or why this service is not billable to you.

20. **Maximum:** the dollar amount Northeast Delta Dental will pay per Eligible Person within any Coverage Period (or in a lifetime for orthodontic benefits) for Covered Benefits. All benefits paid, including benefits for Diagnostic and Preventive services, are counted toward an Eligible Person's Coverage Period Maximum. However, orthodontic payments count only toward the orthodontic Maximum.

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

22. **Non-Participating Other Dental Provider**: an Other Dental Provider who has not signed a participating agreement with Northeast Delta Dental or another Delta Dental company.

23. **Northeast Delta Dental:** the Delta Dental Plans in Maine, New Hampshire, and Vermont, collectively known as Northeast Delta Dental.

24. **Not Billable to the Eligible Person**: if the fee for a procedure or service is Not Billable to the Eligible Person, it is not payable by Northeast Delta Dental, nor collectable from the Eligible Person by a Participating Dentist. The Exclusions and Limitations provisions in Section III. and Section VII. 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.

25. **Open Enrollment Period:** the time during which an Eligible Employee may change enrollment of Eligible Dependents.

26. **Participating Other Dental Provider (ODP)**: a person, other than a Dentist, who provides Dental Care and is authorized and licensed to independently provide such services by the state in which the services are rendered. ODPs include independent practice dental hygienists, dental hygiene therapists and denturists.

27. **Outline of Benefits (OOB):** the insert to this booklet that describes some of the particular provisions of your Covered Benefits.

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

29. **Processing Policies:** 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. Processing Policies are approved by the Contract Holder by signing the Group Contract. Most frequently used Processing Policies are contained in the terms, conditions, and limitations described in this DPD.

30. **State of Maine Employees PPO Network Dentist:** is a Dentist who is a Participating Dentist (as defined above) who has signed a supplement agreement agreeing to reimbursement under the State of Maine Employees PPO table of allowance, in addition to the Delta Dental participating Dentist agreement.

31. **Subscriber:** any person who:

    (a) Renders service to the Contract Holder as a paid employee.

    (b) Is certified by the Contract Holder as an Eligible Employee.

    (c) Enrolls in the group's dental benefit program.

Health through Oral Wellness® (HOW®) program: A healthy mouth is part of a healthy life, and Northeast Delta Dental's innovative Health through Oral Wellness (HOW) program works with your dental benefits to help you achieve and maintain better oral wellness. Here's how to participate in the HOW program.

- **REGISTER**

  Go to www.healththroughoralwellness.com and click on "Register Now."

- **KNOW YOUR SCORE**

  After you register, please take the free oral health risk assessment by clicking on "Free Assessment" in the Know Your Score section of the website.

- **SHARE YOUR SCORE WITH YOUR DENTIST**

  The next step is to share your results with your Dentist at your next dental visit. Your Dentist can discuss your results with you and perform a clinical version of the risk assessment. Based on your risk and subject to the provisions of your dental benefits plan, you may be eligible for additional preventive benefits at no cost.

III. State of Maine: Your Dental Care Coverage

Types of Coverage:

You may choose to provide benefits for yourself only or for yourself and all Eligible Dependents. The following variations are available:

Individual: Coverage for the Eligible Employee only.

Two Person: Coverage for the Eligible Employee with one Eligible Dependent.

Family: Coverage for the Eligible Employee with a spouse and one or more Eligible Dependents; or coverage for the Eligible Employee with two or more Eligible Dependents.

Newborn children may be enrolled on the first day of the month up to sixty (60) days following the date of birth. See page 4 for definitions of "Eligible Dependents."

Effective Date

A new Eligible Employee's coverage becomes effective on the first of the month following the completion of one month of employment.

Enrollment

You must complete an application for dental insurance when completing other employment forms. Consult with your Payroll/Personnel office when you are first hired to discuss enrollment. You must enroll yourself and any Eligible Dependents within the first sixty (60) days of your employment. If you do not wish to include your Eligible Dependents, you may only add Eligible Dependents during an Open Enrollment Period, unless one of the conditions described in the Change of Status section apply.

Change of Status

The Eligible Employee shall notify Northeast Delta Dental through the Maine State Employees Health Insurance Office 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, dependents reaching the age limit, death, divorce, and entrance into military service. A list of life events may be obtained from the Maine State Employees Health Insurance Program. (See page 2 for full contact information.)

Marriage. If you marry while you are enrolled as an active employee under the State's Plan and wish to include your new spouse under your coverage, you must add your spouse within sixty (60) days of marriage. Coverage will become effective on the first of the month following receipt of the application.

New Dependents. A newborn child is automatically covered for the first thirty-one (31) days following birth. Coverage will continue if the newborn child is formally enrolled within the first sixty (60) days following the date of birth. If not enrolled during the first sixty (60) days after its birth, the child may be enrolled during any Open Enrollment Period following the first sixty (60) days or within the first sixty (60) days following its first birthday. The child's coverage will become effective on the first day of the month following the month of enrollment. See page 4 for definition of "Eligible Dependents."

Loss of other Dental Coverage

You may choose not to enroll your spouse and any Eligible Dependents in the State's dental plan because they are covered by a group dental plan through your spouse's employer. If your spouse loses the ability to continue coverage due to a layoff, termination of employment, etc., you may provide benefits for all Dependents who had coverage through the other group plan. The application must be completed within sixty (60) days of the end of your spouse's coverage. Failure to complete the application will result in a delay in coverage until the next Open Enrollment Period.

Seasonal Employees

A seasonal employee may continue under the plan on a direct bill basis by paying the entire premium for the pay periods the employee is not in pay status. If you do not keep your premium payment current, coverage will be cancelled and reapplication can only be made upon your return to work or during an Open Enrollment Period. New seasonal employees must enroll themselves and any Eligible Dependents within sixty (60) days of their original dates of hire.

Leave of Absence

An employee on a leave of absence may continue under the plan on a direct bill basis by paying the entire premium for the pay periods the employee is not in pay status. If you do not keep your premium payment current, coverage will be cancelled and reapplication can only be made upon your return to work or during an Open Enrollment Period.

IV. How To File A Claim

To Use Your Plan Follow These Steps:

1. Please read this Dental Plan Description carefully to familiarize yourself with the benefits and provisions of your dental plan.

2. You are assured of receiving maximum benefits under this dental plan if you visit a State of Maine Employees PPO Network Dentist (refer to your State of Maine Employees PPO Dentist directory at www.nedelta.com). When you visit your dental office, inform them that you are covered under a Northeast Delta Dental program and show your identification card. Your Dentist will perform an evaluation, plan the course of treatment and, when the treatment has been completed, the claim form will be sent to Northeast Delta Dental for payment. Clean written claims must be paid in thirty (30) days; clean electronic claims must be paid within fifteen (15) days.

3. You or someone in the dental office must fill in the information portion of the claim form. Please be sure information is complete and accurate to ensure prompt and correct payment of your claim.

4. Subject to the provisions contained in the Agreement and to such uniform requirements as are deemed appropriate by its Board of Directors, Northeast Delta Dental agrees to make payments for Dental Care in the following manner:

   (a) For Covered Benefits provided by a State of Maine Employees PPO Network Dentist, Northeast Delta Dental will pay to the Participating Dentist the applicable selected Co-payment as specified in the Classes of Benefits (see Section V. on page 9), the lesser of the Participating Dentist's submitted charge; or the amount listed on the State of Maine Employees PPO Network table of allowance. An Explanation of Benefits (EOB) will be sent or accessible to you that will indicate the amount you should pay, if any, to your Dentist. State of Maine Employees PPO Network Dentists agree to accept Delta Dental's payment as payment in full, and further agree not to charge any difference between their charge and the amount paid by Delta Dental. Like all Dentists, State of Maine Employees PPO Network Dentists are allowed to charge for any applicable Co-payments, or non-covered services.

   (b) For Covered Benefits provided by a Delta Dental Participating Dentist who is not a State of Maine Employees PPO Network Dentist, Northeast Delta Dental will pay to such Participating Dentist the applicable selected Co-payment as specified in the Classes of Benefits (see Section V. on page 9), the lesser of the Participating Dentist's submitted charge or; the amount listed on the State of Maine Employees table of allowance. Delta Dental Participating Dentists may balance bill the difference between the State of Maine Employees table of allowance and Delta Dental's maximum allowance for Participating Dentists. Like all Dentists, Delta Dental Participating Dentists are allowed to charge for any applicable Co-payments, or non-covered services.

(c) For Covered Benefits provided by a Non-Participating Dentist or ODP, Northeast Delta Dental will pay directly to the Subscriber the applicable selected Co-payment for the Non-Participating Dentist or ODP, as specified in the Classes of Benefits (see Section V. on page 9), the lesser of the submitted charge or; the amount listed on the State of Maine Employees table of allowance. Some states may require that assignment of benefits (directing that payment be sent to the dentist) be honored. In these instances, payment will be made directly to the Non-Participating Dentist or ODP when written notice of such an assignment is made on the claim. It is your responsibility to make full payment to the Dentist or ODP. Non-Participating Dentists or ODPs may balance bill up to their submitted charge. Like all Dentists, Non-Participating Dentists or ODPs are allowed to charge for any applicable Co-payments, or non-covered services.

Predetermination of Benefits:

Prior to rendering any services subject to Predetermination, your Dentist should send the claim form and diagnostic aids to Northeast Delta Dental. This procedure informs both you and your Dentist of Covered Benefits, Northeast Delta Dental's financial obligation under the term of your Agreement, and your financial obligation. Northeast Delta Dental's and your financial obligation may be subject to change if, after the date of Predetermination, but before the predetermined services were completed, you have additional services performed, lose eligibility, or the Contract Holder changes the benefit design of your program. Payment will be based on eligibility and the benefits which existed when the service was rendered.

If the amount of services set aside for Predetermination causes you to reach your Contract Year Maximum, no payment can be made for any additional treatment until Northeast Delta Dental is instructed to cancel the Predetermination or a new Contract Year begins. Because this Predetermination procedure requires only a minimal amount of time, it normally does not interfere with scheduling your appointments. You and your Dentist should review this Predetermination before proceeding with treatment. Prior authorization is not required for emergency services.

NOTE: If you have any questions about your plan, please contact the Maine State Employees Health Insurance Program or Northeast Delta Dental, PO Box 2002, Concord, NH 03302-2002, 800-832-5700. All correspondence with Northeast Delta Dental should include your group name and number, Subscriber ID number, and your telephone number.

V. Classes of Benefits

Important - Eligible Persons shall be entitled to ONLY those Covered Benefits listed in the Dental Benefits Summary (see Section VI., beginning on page 10).

	State of Maine Employees PPO Network		Delta Dental Participating Network		Non-participating	
Coverage A	100%	State of Maine Employees Table of Allowance	100%	State of Maine Employees Table of Allowance	90%	State of Maine Employees Table of Allowance
Coverage B	90%		80%		70%	
Posterior Composites	80%		70%		60%	
Coverage C	60%		50%		40%	
Calendar Year Maximum	$1,500		$1,250		$900	
Coverage D	60%		50%		40%	
Life Maximum Coverage D	$1,500		$1,200		$900	

Please refer to Section IV, No.4 for a description of how payments are determined or call Customer Service at 800-832-5700.

VI. Dental Benefits Summary

Diagnostic & Preventive Benefits (Coverage A)

Diagnostic: Evaluation and radiographic images to determine required dental treatment.

Limited oral evaluation.

Oral Evaluation: two (2) times in a period of twelve (12) months. This can be a comprehensive or periodic evaluation provided by a specialist or a general Dentist.

Radiographic Images: Comprehensive series or panoramic image once in any period of five (5) years, bitewing images one (1) time in any period of twelve (12) months, images of individual teeth as necessary.

Brush biopsy – once in a twelve (12) month period.

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

Cleaning (prophylaxis): two (2) times in any period of twelve 12 months (child cleaning through age thirteen (13); adult cleaning thereafter). This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive (Coverage A), or periodontal maintenance under Basic Benefits (Coverage B).

Fluoride treatment- one (1) time in any period of twelve (12) months to age nineteen (19).

Space Maintainers

Sealants.

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, co-insurance and/or co-pays and other standard policy provisions. These additional preventive benefits may include more frequent prophylaxis (cleanings), fluoride treatments, sealants, periodontal maintenance and full mouth debridement, and availability of caries susceptibility tests, oral hygiene instruction, nutritional counseling, and tobacco cessation counseling.***

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

Coverage A 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 benefit. 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. 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 and crosscheck for time limitations. 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.

6. 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.

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

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

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

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

20. 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.

21. Cephalometric images and oral/facial photographic images are not a Covered Benefit.

22. Oral cancer screening, except brush biopsy, is not a Covered Benefit.

23. 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 less inclusive procedure is Not Billable to the Eligible Person.

24. 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.

25. 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).

26. 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 if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.

27. Sealant benefit limitation:

    (a) Sealant benefit is provided only to Eligible Dependents fourteen (14) years of age or younger.

    (b) Sealant benefit includes the application of sealants only to caries-free (no decay) and restoration-free permanent molars.

    (c) Sealant benefit is provided no more than one (1) time in a three (3) year period per tooth.

    (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.

28. Pulp vitality tests are a Covered Benefit only when done in conjunction with a radiographic image, limited oral evaluations; palliative treatment; or a protective restoration. Payment is otherwise Not Billable to the Eligible Person.

29. Genetic test for susceptibility to diseases is not a Covered Benefit.

30. Space maintainers are a Covered Benefit for Eligible Dependents fifteen (15) years of age or younger when a space is being maintained for an erupting permanent tooth.

31. The replacement or repair of space maintainers is not a covered benefit, unless performed by a Dentist who did not do the original placement.

32. 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.

33. 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.

34. Nutritional counseling, tobacco counseling and oral hygiene instruction are not Covered Benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

35. 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.

36. 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.

37. 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.

38. 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.

Basic Benefits (Coverage B)

Restorative:	Amalgam restorations (silver fillings).
	Resin restorations (white fillings).
Oral Surgery:	Extractions and covered surgical procedures.
Periodontics:	Treatment of diseased tissue supporting the teeth and periodontal maintenance.
	Cleaning (prophylaxis) two (2) times in a period of twelve (12) months (child cleaning through age thirteen (13), adult cleaning thereafter). This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive Benefits (Coverage A), or periodontal maintenance under Basic Benefits (Coverage B).
	A full mouth debridement under Diagnostic and Preventive Benefits (Coverage A) is covered once in a lifetime and when performed is counted towards your prophylaxis benefit.
Endodontics:	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.
Denture Repair:	Repair of removable complete or partial denture to its original condition.
Clinical Crown Lengthening: Once per tooth per lifetime.	
Palliative Treatment:	Minor emergency treatment for the relief of pain.
Athletic Mouthguards:	Once in a period of twenty-four (24) months.
Occlusal Guards	
Anesthesia:	General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with an extraction; tooth reimplantation; surgical exposure of tooth; surgical placement of implant body; biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy; and/or frenuloplasty.

NOTE: Time limitations are measured from the date the services were most recently performed.

Coverage B 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. The replacement of amalgam (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office is Not Billable to the Eligible Person.
2. 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.
3. Tooth preparation; bases; copings; protective restorations; impressions; image capture only; and local anesthesia; or other services which are part of the complete dental procedure, are considered components of and included in the fee for a complete procedure, and are Not Billable to the Eligible Person.

4. Protective 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.

5. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Delta Dental Participating Dentist agrees not to charge a separate fee.

6. Interim therapeutic restorations are a covered benefit once in a lifetime on primary dentition only. Interim therapeutic restorations are not a covered benefit when performed within twenty-four (24) months of amalgams or composites and the fees are Not Billable to the Eligible Person.

7. 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.

8. Prefabricated stainless steel crowns are a covered benefit once in a period of two (2) years. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. Recementation or re-bond of a space maintainer is a Covered Benefit once per space maintainer.

17. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Not Billable to the Eligible Person.

18. 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.

19. Exploratory surgical services are not a Covered Benefit. Eligible Person is financially responsible.

20. Clinical crown lengthening is a covered benefit once per tooth per lifetime and only when performed in a healthy periodontal environment, on natural teeth only, 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.

21. 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.

22. 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.

23. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Delta Dental Participating Dentist agrees not to charge a separate fee.

24. Direct or indirect pulp caps are a covered benefit once in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure and the fee for the pulp cap is Not Billable to the Eligible Person.

25. Recementation of a crown, 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. Anterior deciduous root canal therapy is not a Covered Benefit.

31. 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.

32. Root canal therapy is not a benefit in conjunction with overdentures and benefits are Denied. The Eligible Person is responsible for the additional fee.

33. Incomplete endodontic therapy is a Covered Benefit, subject to dental consultant's review.

34. 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.

35. 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.

36. Root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Not Billable to the Eligible Person.

37. An upper or lower frenulectomy or frenuloplasty is a covered benefit once per site per lifetime and 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.

38. 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.

39. The fee for repairs of complete or partial dentures cannot exceed half the fees for a new appliance, and any excess fee billed by the same Dentist/dental office is Not Billable to the Eligible Person on the same date of service.

40. 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.

41. 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.

42. 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.

43. General anesthesia is a Covered Benefit only when administered by a properly licensed Dentist in a dental office in conjunction with covered oral surgical procedures or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is Denied.

44. 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.

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

46. The fee for non-intravenous conscious sedation is Not Billable to the Eligible Person in conjunction with intravenous sedation and/or general anesthesia.

47. 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.

48. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Additional pins in the same tooth are Not Billable to the Eligible Person. Pin retention is Not Billable to the Eligible Person when billed in conjunction with a core buildup.

49. An apexification is a covered benefit once per tooth in a lifetime. Retreatment by the same Dentist/dental office within twenty-four (24) months is Not Billable to the Eligible Person.

50. An apicoectomy is a covered benefit once per tooth in a period of three (3) years. Retreatment by the same Dentist/dental office within twenty-four (24) months is Not Billable to the Eligible Person.

51. 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.

52. Retrograde fillings are a covered benefit once per root per 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.

53. 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.

54. Pulpal debridement is a covered benefit once 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.

55. 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.

56. 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.

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

58. 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 on the same date of service.

59. A consultation is a covered benefit only if performed by a Dentist that is not performing further treatment. 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.

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

61. 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.

62. 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.

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

64. Osseous surgery is a covered benefit per quadrant (maximum of two (2) quadrants per office visit) 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.

65. 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.

66. Occlusal guards are a covered benefit once in a period of five (5) years.

67. An occlusal guard adjustment is a covered benefit once per year following six (6) months from initial placement. If adjustments are made within the first six (6) months of initial placement and/or if performed by the same Dentist/dental office, the fee is Not Billable to the Eligible Person.

68. Repair or reline of an occlusal guard is a covered benefit twice in a lifetime following six (6) months from initial placement.

69. The fee for repair or reline of an occlusal guard cannot exceed one-half of the fee for a new appliance, and any excess fee is Not Billable to the Eligible Person.

70. The fabrication of an athletic mouthguard is a covered benefit once in a twenty-four (24) month period for Eligible Persons age eighteen (18) and younger. The fee for the fabrication of an athletic mouthguard for Eligible Persons nineteen (19) and older is Denied. The Eligible Person is responsible for the fee.

71. 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.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist.

Major Benefits (Coverage C)	
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 posts and cores; and crown and onlay repairs.
Implant Services:	Surgical placement of an endosteal implant body including healing cap.
Implant Supported Prostheses:	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

NOTE: Time limitations are measured from the date the services were most recently performed.

Coverage C 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. 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).
2. 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.
3. Prosthodontics (Coverage C) benefit limitations:
   (a) 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.
   (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of seven (7) years.
   (c) One (1) removable or fixed partial denture per quadrant in a period of seven (7) years unless the loss of additional teeth requires the construction of a new appliance.
   (d) Crowns, onlays, core buildups and post and cores are a Covered Benefit once per tooth in any 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 service was last performed.
4. Inlays are not a covered benefit. An allowance will be paid equal to an amalgam (silver) restoration. If an inlay is performed, the Eligible Person is responsible for any additional fee.
5. 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, 3/4 crowns or onlays and indirectly fabricated or prefabricated post and cores.

6. 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.

7. A core buildup or indirectly fabricated and prefabricated post and core in conjunction with an implant/implant abutment supported crown or fixed partial denture crown is a Covered Benefit once in a seven (7) year period per tooth for Eligible Persons age sixteen (16) and older.

8. Scaling and debridement in the presence of inflammation or mucositis of a single implant 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.

9. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant 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, and osseous surgery or debridement of peri-implant defect.

10. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is Not Billable to the Eligible Person when performed in conjunction with a cleaning, periodontal maintenance or scaling of moderate or severe gingival inflammation.

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

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

13. 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.

14. 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.

15. 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.

16. Removable or fixed, complete or partial dentures are not Covered Benefits for Eligible Persons under the age of sixteen (16).

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

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

23. When implant services are covered, 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.

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

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. 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 or implant repair.

32. Bone replacement graft for ridge preservation is not a Covered Benefit.

33. 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.

34. Recementation of a fixed partial denture is a Covered Benefit once in a lifetime. 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.

35. 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.

36. 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.

37. 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.

38. 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.

39. 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.

40. 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 covered but is subject to a dental consultant's review.

41. Placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is not a covered benefit and the fee is Denied. If placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is performed in conjunction with an extraction and/or post-operative procedure, it is considered part of that procedure and Not Billable to the Eligible Person.

42. 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.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist.

Orthodontic Benefits (Coverage D)

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

Placement of device to facilitate eruption of an impacted tooth.

Exposure of an un-erupted tooth.

NOTE: Time limitations are measured from the date the services were most recently performed.

Coverage D 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:

   (a) For treatment commenced while an Eligible Person is eligible for Orthodontic benefits, Northeast Delta Dental will initiate payment of its liability once bands or orthodontic devices are placed. Northeast Delta Dental will complete payment of its liability (up to the orthodontic Maximum specified in the Outline of Benefits) in accordance with paragraph 3 below.

   (b) For Eligible Persons who become eligible after orthodontic treatment has commenced, Northeast Delta Dental will pro-rate its liability based on the number of remaining months of active treatment compared to the total number of months of active treatment.

   (c) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the 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. Northeast Delta Dental's payment for orthodontic benefits shall be limited to the lifetime Maximum per Eligible Person specified in the Outline of Benefits. Northeast Delta Dental will make one (1) payment at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of twenty-four (24) months for its total liability provided that the Eligible Person maintains coverage throughout the payment period.

4. Placement of an appliance must take place for Northeast Delta Dental 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, Northeast Delta Dental has no liability beyond its share of the allowable fee, or table of allowance, for procedure D0150-comprehensive oral evaluation.

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. 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.

8. 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.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist.

VII. General Exclusions and Limitations

1. **The dental benefits provided by Northeast Delta Dental shall not include the following:**

   (a) Services for injuries or conditions compensable under Worker's Compensation or employers liability laws.

   (b) Services that are determined by Northeast Delta Dental 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 the Subscriber or Eligible Dependent became eligible under the Agreement.

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

   (e) Prescription drugs, premedications, and/or relative analgesia, or the application of anti-microbial agents.

   (f) Charges for (i) hospitalization; (ii) general anesthesia or intravenous sedation for restorative dentistry (except as noted in the Dental Benefits Summary); (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) Office visit after hours.

   (i) Charges for completion of forms are not a benefit nor shall a charge be made to a Subscriber or Eligible Dependent by Participating Dentist's.

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

   (k) Dental Care or supplies which are not within the classification of benefits defined in the Agreement.

   (l) Appliances, procedures or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, restoring or maintaining occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv) custom sleep apnea appliance fabrication, placement, adjustment, repair or reline; or (iv) esthetic purposes. This exclusion is not intended to exclude services provided for congenital defects and/or developmental malformations.

   (m) Payments of benefits incurred by the Subscriber and/or Dependent(s) on the date on which the Subscriber becomes ineligible for benefits.

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

   (o) 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.

   (p) Temporary services or incomplete treatment.

   (q) A consultation is not a Covered Benefit 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 patient management and the fees are Not Billable to the Eligible Person. Dental case management for motivational interviewing and patient education are not a covered benefit. If services are provided on the same day by the same Dentist/dental office as nutritional or tobacco counseling or oral hygiene instruction, fees for dental case management for motivational interviewing and patient education are Not Billable to the Eligible Person.

(s) Case presentation and treatment planning are not Covered Benefits. The Eligible Person will be responsible for any additional fee.

(t) Those services and benefits excluded by Northeast Delta Dental's Processing Policies.

(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. **The dental benefits provided by Northeast Delta Dental shall 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. Such other treatment performed by an ODP shall be a benefit, so long as the treatment is within the ODP's scope of practice and in accordance with generally accepted dental practice standards.

(b) Optional Dental Care: In all cases in which the Subscriber or Eligible Dependent agree, after consultation with their Dentist, to more expensive Dental Care than is customarily provided, Northeast Delta Dental will pay based on the applicable Co-insurance Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. The Subscriber or Eligible Dependent shall be responsible for the remainder of the Dentist's fee.

(c) Predetermination does not guarantee payment. Payment is based upon eligibility, benefits selected by the group, and allowable charges at the time the Dental Care is rendered. Additionally, in the case of orthodontic treatment, payment is based upon continued eligibility during the treatment period or up to twenty-four (24) months. If Coordination of Benefits is involved, the amount of payment may change dramatically depending on the payment made by the primary carrier.

(d) Services completed or in progress at the Subscriber's or Eligible Dependent's date of death will be paid in full to the limit of Northeast Delta Dental's liability.

(e) When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, Northeast Delta Dental will review the claim to determine the payment, if any, due each Dentist.

(f) Maximum Payment:

(i) The Maximum amount payable in any Benefit Period, or any portion thereof, shall be limited to the amount specified in Section V., Classes of Benefits. In no instance will the total amount paid for all Dentists exceed the maximum allowance for the In Network Dentist.

(ii) Delta Dental's payment for Coverage D (Orthodontics) will be limited to one lifetime Maximum per Eligible person as specified under Section V., Classes of Benefits.

(g) Specialized techniques including, but not limited to, precision attachments, overdentures and procedures associated therewith and personalizations or characterization are excluded. 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 a Covered Benefit as part of the total orthodontic case fee. 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 onlay or a crown is at the option of the Eligible Person and the Eligible Person will be responsible for any additional cost.

(j) A completed claim (or satisfactory written proof acceptable to Northeast Delta Dental) must be furnished to Northeast Delta Dental at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on claims with dates of service in excess of the twenty-four (24) month limitation except for a demonstrated reason preventing submission within the twenty-four (24) month period.

(k) The Date of Incurred Liability refers to the date a covered service is subject to the applicable Co-payment percentage, Maximum benefit, and limitations. The total cost of the service is applied to the Coverage Period during which the service is completed, irrespective of the Coverage Period in which the service is started.

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

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

(ii) Fixed Partial Dentures (abutment crowns and pontics) - The total cost for fixed partial dentures shall be incurred on the date that the said appliance is cemented.

(iii) Removable Complete and Partial Dentures - The total cost for removable complete and partial dentures shall be incurred on the date that the said appliance is delivered to the Eligible Person.

(iv) Endodontics - The total cost for endodontic treatment shall be incurred when the canal is filled to completion.

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

(vi) Implant Prosthetics - The total cost for the prosthetic portion of an implant shall be incurred on the date that the said appliance is cemented or delivered to the Eligible Person.

(l) The date(s) of incurred liability for orthodontic treatment refer to the date(s) that Northeast Delta Dental will make payment(s) for the orthodontic treatment. The initial 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. The subsequent cost for the orthodontic treatment shall be incurred at the time each monthly payment is made (up to a maximum of twenty-four (24) months), provided that the Eligible Person maintains coverage throughout the payment period.

(m) No action may be brought to recover a claim under this policy prior to the expiration of sixty (60) days after the claim has been filed or the claim review and appeal process, described in Articles IX., X. and XI. herein have been completed. In no event shall any action be brought on a claim more than two (2) years after the completed claim has been filed.

VIII. Coordination of Benefits

The Coordination of Benefits provision is designed to provide maximum coverage, but not to exceed 100% of the total fee for a given service. In the event that any Eligible Person is entitled to benefits under any other health care program, the following Coordination of Benefits provision shall determine the sequence and extent of payment. Other health care programs may include any other sponsored plan or group insurance plan.

When an Eligible Person is covered under another health care program, the following rules shall be followed to establish the order of determining liability.

1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.
2. For oral surgery procedures also covered under medical insurance, coverage under this dental benefits plan will be secondary to such medical coverage.
3. The plan covering an Eligible Person solely as an employee shall determine its benefits before the plan which covers the Eligible Person solely as a Dependent.
4. The plan covering the Eligible Person solely as a Dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the Eligible Person solely as a Dependent of the parent whose birthdate occurs later in a calendar year ("Birthday Rule"). A parent's year of birth is not relevant. If both parents have the same birthdate (month and day) the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. If the other health care program does not use the Birthday Rule, then that plan's provisions will determine the order of liability.
5. If the paragraphs 1 through 4 above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time shall be determined first.
6. The order of payment for the claims of a Dependent child of divorced or legally separated parents will be as follows:

   (a) The plan of the parent with custody.

   (b) The plan of the spouse of the parent with custody (step-parent).

   (c) The plan of the parent without custody.

   (d) If the parents have joint legal custody, paragraph 4 above will apply.

   However, when the parents are separated or divorced and there is a court decree which establishes financial responsibility with respect to the child, the benefits of the plan which cover the child as a Dependent of the parent with financial responsibility pursuant to the decree shall be determined before the benefits of any other plan which covers the child as a Dependent.

7. When Northeast Delta Dental is the first to determine its benefits under the foregoing, benefits hereunder shall be paid without regard to Coverage under any other plan. When Northeast Delta Dental is not the first to determine its benefits and there are remaining expenses of the type allowable, Northeast Delta Dental will pay only the amount by which its benefits exceed the amount of benefits payable under the other plan up to the amount Northeast Delta Dental would have paid without regard to the payment by the other plan or the amount of such remaining expenses, whichever is less. In other words, the combined payment of both plans will not exceed the total cost of the service.

   Northeast Delta Dental may use reasonable efforts to determine the existence of other benefit programs but shall be under no obligation to do so. The Eligible Person is required to furnish Northeast Delta Dental with information relative to any other health care program in order to determine liability. For the purposes of determining the applicability and implementing the terms of this provision in the Agreement, Northeast Delta Dental may release or obtain from any third party, without consent or notice, any information which it deems to be necessary to determine its liability. Northeast Delta Dental shall be free from any liability that might arise in relation to such action.

8. Multiple Coverage: When benefits are coordinated with another Northeast Delta Dental plan, or any other plan providing dental benefits, time limitations and frequency of service limitations will not change. Coverages for services for which a specified number are provided per a specified time period shall not be added together to provide more than the number of services specified per time period under this plan. For example, if each plan covers one prophylaxis (cleaning) in a six month period, the combined Coverages will still only cover one prophylaxis in any six month period. If such a service is covered under this plan, but has been paid for, whether in full or part, by another plan, such service will still be counted toward the maximum number of such services allowed per period under this plan.

9. Right of Recovery: Northeast Delta Dental has the right to recover from the payee excess benefit payments.

10. Subrogation: In the event of any payments for Dental Care under this Agreement, Northeast Delta Dental shall be subrogated to all the Subscriber's or Eligible Dependent's right of recovery thereof against any third person or organization who may be liable for such payment. The Subscriber or Eligible Dependents 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.

IX. General Claims Inquiry

After a claim is submitted by your Dentist and processed by Northeast Delta Dental, you will be sent or have access to an EOB. This notice will explain the benefits that were paid on your behalf, let you know if any services are Denied or Not Billable to the Eligible Person, and give you the reason(s) for the denial or why this service is not billable to you.

If you have any questions regarding your benefits, you may call Northeast Delta Dental for an explanation at 603-223-1234. The toll-free number is 800-832-5700. You will be connected directly to our Customer Service Department.

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

X. Disputed Claims Procedure

If you have reason to believe your benefit determination was not in accordance with the terms of this policy, you have the option of using Northeast Delta Dental's Disputed Claims Procedure. This may be requested within six (6) months of the issuing of Northeast Delta Dental's original Explanation of Benefits. We recommend 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 refer to the claim(s) in question, state your name and address, and the reasons you think the denial should be evaluated. You may provide 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.

2. The specific reference to the provision of this Agreement 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 XI. 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, you may also contact your group for assistance.

XI. Disputed Claims Review Procedure

After you have followed the Disputed Claims Procedure in Section VII., 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 before the final appeal date set forth in 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. We recommend 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 from 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 Agreement 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.

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

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

You must ask for this Independent External Review no later than one year after receiving the notice of internal review denial.

Call the Department of Professional & Financial Regulation at 800-300-5000 to ask for this review.

Department of Professional & Financial Regulation
Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034
800-300-5000 (toll free in Maine) or 207-624-8475
Fax: 207-624-8599
http://www.state.me.us/pfr/insurance/index.shtml

XII. Termination

Benefit entitlement may be automatically terminated:

1. As determined by your employer.
2. On the last day of the month for which your employer has failed to make a required payment and appropriate notice has been issued.

Under certain circumstances, state or federal law may require that benefits be continued for terminated or reduced hour employees, surviving spouses and Dependents of covered employees, divorced or legally separated spouses and children of current employees, and children of employees entitled to Medicare benefits. A thirty-one (31) day grace period exists under the Group Contract and coverage under this policy will continue in force during the grace period.

XIII. Continuation of Benefits

State and Federal Law Rights to Continue Coverage

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

In addition to continuation of coverage, you may have access to individual dental benefits plans that are more cost-effective for your needs. Please review your options at www.healthcare.gov and www.deltadentalcoversme.com.

A. Continuation Coverage Rights Under COBRA:

Introduction

You are receiving this information because you recently gained coverage under a group dental plan (the Plan). This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group dental coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this policy or contact the Plan Administrator.

You may have other options available to you when you lose group dental coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group dental plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his/her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his/her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

Qualified beneficiaries will be offered COBRA continuation only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group dental plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Plan Administrator

The employer is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to the individual who is acting on behalf of the Plan Administrator.

For More Information

If you, your spouse or Dependent children have any questions about this notice or COBRA, please contact the Plan Administrator. Also, please contact the Plan Administrator if you wish to receive the most recent copy of the Plan's Dental Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

XIII. General Conditions

Change of Status:

The Subscriber shall notify his/her employer of any event causing a change in life status of an Eligible Person. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, and adoption. A list of the events may be obtained from the Maine State Employees Health Insurance Program. (See page 2 for full contact information.)

Transfer of Benefits Prohibited:

Benefits of Eligible Persons are personal and cannot be transferred.

Physical Examinations:

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

Right of Recovery:

Upon your prior written approval, Delta Dental will succeed to the right of any person covered under your policy to recover on a just and equitable basis for expenses paid under your policy from any third person or organization that may be liable. Such prior written approval will authorize Delta Dental to do whatever is necessary to secure such rights.

Doctor-Patient Relationship:

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

Loss of Eligibility During Treatment:

If an Eligible Dependent loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment. Someone enrolled under your policy may lose eligibility if such person ceases to be an Eligible Person in accordance with the provision of Section II. 19 of this DPD.

Notice of Legal Action:

You may not bring a legal action against Delta Dental under this policy until sixty (60) days after notice of claim. No such action shall be brought after the expiration of two (2) years after the time written notice of claim is required to be furnished.

Maintaining Your Privacy:

Northeast Delta Dental has always respected and carefully preserved the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

By receiving coverage pursuant to this dental plan, each Eligible Person, including a parent or guardian in the case of a minor Dependent, agrees that, except as restricted by applicable state and federal laws, Northeast Delta Dental may have access to all dental and health records, and medical data from Dentists, ODPs, and other health care providers for reasons of essential insurance functions; claims administration; claims adjustment and the management, detection, investigation, or reporting of actual or potential fraud; misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; or quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers' compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit.

For a copy of Northeast Delta Dental's Notice of Privacy Practices which describes in detail our respective privacy practices, please visit our website www.nedelta.com. If you wish to have a copy mailed to you or have any questions about the privacy of your health information, please contact:

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

Entire Agreement; Amendment:

This DPD, together with the group contract application, Group Contract and the OOB constitute the entire contract of insurance. As referenced in this DPD, the provisions of this DPD are subject to the jurisdiction and requirements of the Maine Bureau of Insurance (the "Maine Bureau"). Additionally, we reserve the right to implement changes in American Dental Association (ADA) dental terminology and CDT codes and Delta Dental internal processing policies which do not materially affect the provisions of this DPD. Any material modification in this DPD shall be valid only if approved by the Maine Bureau and an executive officer of Northeast Delta Dental and evidenced by a written, signed amendment hereof or endorsement hereto. Any such amendment or endorsement will be provided to you at least sixty (60) days in advance of its effective date. No broker or agent has authority to change this document or waive any of its provisions.

Governing Law: This policy is governed by and shall be construed according to the laws of the state of Maine and its regulations. This dental plan is under the jurisdiction of the Superintendent of the Maine Bureau.

XIV. Questions & Answers

1. **May I Choose Any Dentist or Denturist/ODP?**

   Yes. You are free to choose any Dentist or Denturist/ODP. It is not necessary for you to notify either the Health Insurance Office or Northeast Delta Dental of your choice of a Dentist, Denturist/ODP. If you or a family member choose a State of Maine Employees PPO Network Dentist, you will receive the maximum benefits from your dental plan.

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

   If the Dentist is participating, Northeast Delta Dental will make payment directly to the Participating Dentist. If the Dentist is not a Participating Dentist, or if you obtain services from a Denturist or ODP, then payment for Covered Benefits will be made directly to you. Payment may be made directly to a Non-Participating Dentist, Denturist or ODP if you sign an assignment of your benefits to the Non- Participating Dentist.

3. **What Difference Does It Make if I go to a PPO Network Dentist, Delta Dental Participating Dentist or a Non- Participating Dentist?**

   Apart from any applicable Co-payments or non-covered services, State of Maine Employees PPO Network Dentists will be reimbursed based on a percentage of the lesser of the Dentist's submitted charge or the State of Maine Employees PPO allowance.

   State of Maine Employees PPO Network Dentists cannot charge the Eligible Person the difference, if any, between the submitted charge and the amount paid by Delta Dental. State of Maine Employees PPO Network Dentists will receive payment directly from Northeast Delta Dental.

   A Participating Dentist who elects not to join the State of Maine Employees PPO Network will be reimbursed based on the applicable percentage of the submitted charges not to exceed the Delta Dental's allowed amount. However, the Eligible Person will be responsible for the difference, if any, between Delta Dental's allowed amount and the Dentist's submitted charge. Payment will be made directly to the Dentist.

   If a Dentist does not participate with the State of Maine Employees PPO Network or with Delta Dental, reimbursement will be based on the applicable percentage of the lesser of the submitted charge or Delta, not to exceed the Delta Dental's allowance with a reduced Contract Year Maximum. Payment will be made to the Subscriber and the Eligible Person is responsible for the balance of the Dentist's, Denturist's or ODP's submitted charge(s). There is no protection from balance billing when utilizing a Non- Participating Dentist, therefore, payment at the time treatment is rendered may be required from the Eligible Person.

4. **How Much of the Dental Bill Do I Pay?**

   See the Dental Benefits Summary (Section VI., beginning on page 10) for coverage. You will note that the Co-payments and Maximums are determined by the status of the Dentist you are using. You may also request a Predetermination of Benefits.

5. **Can a Dentist Who Participates With Delta Dental But Not in the State of Maine Employees PPO Bill Up Front for Any Portion of his/her Dental Charges?**

   State of Maine Employees PPO Network Dentists, Participating and Non-Participating Dentists can require that you pay your portion of the dental charge (any portion of the approved charge that is not covered by Northeast Delta Dental.) Non-Participating Dentist's and Dentist's outside the geographic area of Northeast Delta Dental (ME, NH, VT) are free to bill up front for the entire charge.

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

   The Covered Benefits are described in this Dental Plan Description. They are governed by the Exclusions, Limitations, and Northeast Delta Dental's Processing Policies. PLEASE READ THEM CAREFULLY.

7. **What if my Spouse is Covered by Another Dental Plan?**

   Dual Coverage may entitle the Subscriber to as much as (but not more than) 100% of the Dentist's charges for Covered Benefits and subject to the provisions of this policy. It is important to notify your Dentist of any dual coverage so that the proper claim filing procedures may be followed.

XV. Provisions Required By Law

Before approving a claim, Northeast Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to, or examination of, or treatment provided to, an Eligible Person as may be required to administer the claim, or that an Eligible Person be examined by a dental consultant retained by Northeast Delta Dental, in or near his community or residence. Northeast Delta Dental shall in every case hold such information and records confidential.

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

Written notice of sickness or of injury must be given to Delta Dental within thirty (30) days after the date when such sickness or injury occurred or as soon thereafter as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

No action at law or in equity shall be brought to recover on the policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the policy, nor shall an action be brought at all unless brought within two years from expiration of the time within which proof of loss is required by the Contract.

Cognitive Impairment or Functional Incapacity – Notice of Rights:

Under Maine law, a person having a mental or nervous disorder with a demonstrable organic origin causing significant cognitive impairment or functional incapacity, including, but not limited, to Pick's Disease; Parkinson's Disease; Huntington's Chorea or Alzheimer's Disease; and related dementias (a "Cognitive Impairment or Functional Incapacity") has certain rights with respect to his/her coverage under this dental benefits plan. Those include the right:

(a) To designate a third party to receive notice of cancellation of this dental benefits plan.

(b) To change the designated third party upon written request sent or given to Delta Dental.

(c) To reinstatement of this dental benefits plan if the coverage was cancelled due to non-payment of premium or other default.

Within ten (10) days of a request by an insured, Northeast Delta Dental will mail or cause to be personally delivered a Third Party Notice Request Form. In the event that coverage under this policy is to be terminated, Delta Dental shall provide, in addition to any other notice to the insured required by law, a notice of the pending cancellation to any third party properly designated by a covered person having a Cognitive Impairment or Functional Incapacity. Such notice shall contain all information required by law and shall be at least twenty-one (21) days prior to the expiration of the applicable payment grace period.

If a request for reinstatement of coverage is denied, notice of denial shall be provided to the subscriber, to any third party properly designated, and to the person making the request, if different. The notice of denial shall include notification of a thirty (30) day period following the receipt of the notice during which a hearing before the Superintendent may be requested.

XVI. Statement of ERISA Rights

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

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

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

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

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

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

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

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

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

XVII. Exceptional Service Is Our Guarantee

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

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

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

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

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

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

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

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603-223-1234
800-832-5700
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