



# Dental Plan Description



## State of Vermont Employee Dental Assistance Plan

Administered by Northeast Delta Dental

Delta Dental Plan of Vermont, Inc.

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## I. Introduction

This booklet describes your dental benefits program and tells you how to use your plan. Please read it carefully to understand the benefits and provisions of your State of Vermont Employee Dental Assistance plan, administered by Northeast Delta Dental.

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 substantial 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 Participating Dentists available to you.

You are encouraged to take advantage of your State Employee Dental Assistance plan since good oral health is an important part of your overall general health. You are also encouraged to obtain your Dental Care from a Delta Dental Participating Dentist to get the best value from your program.

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

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

You will also receive benefits under your dental benefits plan if you choose to visit a Delta Dental Premier Dentist. Delta Dental Premier Dentists are reimbursed by Delta Dental based on the lesser of the actual submitted charge or Delta Dental's allowance for Premier Dentists in the geographic area in which the services were provided. Premier Dentists agree to accept Delta Dental's payment as payment in full, and further agree not to charge any difference between their fees and the amount paid by Delta Dental back to their Delta Dental patients. Like all Dentists, Premier Dentists are allowed to charge for any applicable Deductibles, Co-Payments, or services not covered under your plan.

You may also choose to visit Dentists who are not Delta Dental network members. Such Dentists are referred to as Non-Participating or Other Dental Providers (ODPs). You will receive benefits based on the lesser of the actual submitted charge or our allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. The Non-Participating Dentist may balance bill up to their submitted charge. When there is not sufficient fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount. You may be requested to bring a claim form for your visit. Claim forms can be downloaded from [www.nedelta.com](http://www.nedelta.com) or you may call 1-800-832-5700.

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

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

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## II. Outline of Benefits

Benefit percentages paid after any applicable deductibles:

Diagnostic & Preventive Benefits (Coverage A)	100%
Basic Benefits (Coverage B)	80%
Major Benefits (Coverage C)	50%
Orthodontic Benefits (Coverage D)	50%

Plan Year Deductible:

\$25	Per Individual
\$75	Per Family

The Deductible applies to Basic, Major, and Orthodontic Benefits.

Maximum Benefits:

\$1,000 per person per benefit plan year. This does not include Orthodontics (Coverage D).  
The Plan Year is the State's fiscal year from July 1 of one year to June 30 of the next year.

Orthodontic Benefits have a separate lifetime maximum of \$1750 for each covered individual.  
Orthodontic charges do not add into the yearly maximum dental benefit.

## III. Eligibility Information

### Who is Eligible for Benefits?

The benefits described in this booklet are provided at no cost to you by the State of Vermont. You and your eligible dependents are covered as soon as you have completed six months of continuous State employment. To be eligible, you must be a permanent full-time employee or a permanent part-time employee regularly working 780 or more hours per year. Temporary and contractual employees are not eligible.

### Who are Eligible Family Members?

Dependents are your spouse as long as you are not legally separated or divorced; your bona fide domestic partner or civil union partner; and each of your children, up to age 26. Children include: step children, foster children, legally adopted children and children of your domestic partner or civil union partner.

Benefits for any of your children who are mentally or physically incapable of earning their own living may be continued beyond the above age limits. To do so, you must submit proof of your child's incapacity directly to the Director of Employee Benefits and Wellness. This must be done within 31 days after the coverage would otherwise end.

Your dependents who are also State employees will be covered as employees rather than as your dependents.

### How to Join the Plan or Add/Delete Dependents:

The State will notify the claims administrator as soon as you become eligible. You will be sent an I.D. card at that time. To add or delete eligible dependents, you must contact the Employee Benefits Division.

### When Coverage Begins:

Coverage for you and your eligible dependents begins the day you complete six months of continuous service. If you are not actively at work on that day, coverage will not begin until you return to work for one full day.

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#### IV. Definitions

1. **Agreement:** the contract between the State of Vermont and Delta Dental, including this document.
2. **Co-payment:** the amount of the Dental Care cost which you are required to pay.
3. **Contract Holder:** the State of Vermont.
4. **Contract Year for Benefits:** July 1 through June 30.
5. **Coverage:** the Dental Care referred to in the Agreement.
6. **Coverage Period:** the Contract Year for Benefits as defined above.
7. **DDPA (Delta Dental Plans Association):** the association which is made up of all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.
8. **Deductible:** the portion of the charge for covered Dental Care which the Subscriber or Eligible Dependent must pay before Delta Dental's payment responsibility begins.

There is no deductible for Coverage A Diagnostic and Preventive services. For all other services, you must pay a \$25 deductible each plan year before the plan pays benefits. However, there is a maximum of \$75, per family, per plan year. When three or more family members incur covered dental expenses during the same plan year and the combined expenses used toward satisfying their individual deductibles total \$75, no further deductible amounts are required for the plan year. Also, any covered dental expenses incurred during April, May or June that are used to meet a deductible for the plan year ending June 30, will also be used to satisfy the deductible for the next plan year.

9. **Dental Care:** dental services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with accepted standards of dental practice at the time the service is rendered.
10. **Dental Plan Description (DPD):** this document which serves as your certificate of insurance. This Dental Plan Description is part of the Agreement which provides the terms and conditions under which Delta Dental shall administer your dental benefit program.
11. **Dentist:** a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
12. **Dependent:**
  - (a) the spouse to whom the Subscriber is legally married or a partner in a valid domestic partnership or civil union; and/or
  - (b) a child of the Subscriber or of the spouse, domestic partner or civil union partner of the Subscriber, by natural birth or legal adoption or a child in the process of adoption or guardianship, 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 sixty (60) days following birth. Coverage will continue if the child is formally enrolled. Employees must notify their employer within sixty (60) days of the birth of a new child.

13. **Eligible Dependents:** those Dependents who meet the eligibility requirements of the Agreement and are enrolled by Subscribers in the group's benefit program.
14. **Eligible Persons:** the Subscriber and Dependent(s) (as defined herein).
15. **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.
  - For Coverage A, B, and C dental services, the yearly maximum payable for each individual is \$1,000. Orthodontia services are not included in this amount.
  - For Coverage D dental services, (Orthodontia), the lifetime maximum payable for each individual is \$1,750.

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16. **Non-Participating Dentist:** a Dentist who has not signed a participating dentist agreement with Northeast Delta Dental or another Delta Dental company.
  17. **Northeast Delta Dental:** the Delta Dental Plans in Maine, New Hampshire, and Vermont, collectively known as Northeast Delta Dental.
  18. **Participating Dentist:** a Dentist who has signed a participating agreement with Northeast Delta Dental. 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 company in another state is also a Participating Dentist.
  19. **Predetermination:** an administrative procedure by which the Dentist submits the treatment plan to Northeast Delta Dental in advance of performing dental services. 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.
  20. **Processing Policies:** policies approved by Northeast Delta Dental, as may be amended from time to time, to be used in processing treatment plans for Predetermination and claims for payment. 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.
  21. **Subscriber:** any person who:
    - (a) is certified by the State as eligible, and
    - (b) enrolls in the group's dental benefit program.

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## V. How To File a Claim

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

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

Ask your Dentist if he/she participates with Delta Dental, visit Northeast Delta Dental's website at [www.nedelta.com](http://www.nedelta.com) or call Northeast Delta Dental for information.

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 and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Northeast Delta Dental for payment for covered services.

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

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

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

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

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

The Predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office. Questions concerning Predetermination should be directed to Northeast Delta Dental's Customer Service Department at 1-800-832-5700 or 603-223-1234.

## VI. Benefits

**PLEASE NOTE:** Eligible Persons will only be entitled to those benefit coverages which are part of the State of Vermont Employee Dental Assistance Plan.

### **Diagnostic & Preventive Benefits (Coverage A)**

<b>Diagnostic:</b>	Limited oral evaluations. Oral evaluations – two (2) times in any period of twelve (12) months. Evaluations can be comprehensive or periodic and may be provided by a specialist or a general Dentist. Radiographic images – a complete series or a panoramic image once in any period of three (3) years; bitewings two (2) times in any period of twelve (12) months; images of individual teeth as necessary.
<b>Preventive:</b>	Prophylaxis (cleaning) – two (2) times in any period of twelve (12) months (child prophylaxis through age twelve (12), adult prophylaxis thereafter). A prophylaxis can be routine or periodontal maintenance under Diagnostic and Preventive Benefits (Coverage A). A full mouth debridement under Basic Benefits (Coverage B) is covered once in a lifetime and when performed is counted towards your prophylaxis benefit. Fluoride treatments – once in any period of twelve (12) months to age nineteen (19). Space Maintainers. Sealants to age fourteen (14).
<b>Palliative Treatment:</b>	Minor emergency treatment for the relief of pain.
<b>NOTE:</b>	<ul style="list-style-type: none"><li>• <b><i>Time limitations are measured from the date the service was last performed.</i></b></li></ul>

### **Coverage A Exclusions and Limitations:**

1. A panoramic image, with or without accompanying bitewings, is considered the same as a complete series and is paid as such.
2. Cone beam imaging is not a covered benefit.
3. Sealant benefit limitation:
  - (a) The sealant benefit is provided only to Eligible Persons to age fourteen (14).
  - (b) The sealant benefit includes the application of sealants to caries-free (no decay) and restoration-free occlusal, buccal, and/or lingual surfaces of bicuspids and permanent molars only.
  - (c) The sealant benefit is provided no more than once every three years per tooth.
4. A limited oral evaluation, when done in conjunction with a procedure (other than radiographic images) on the same visit, is considered a part of, and included in the fee for, the procedure and is not a covered benefit. Patient is responsible for any additional fee.
5. Payment for additional periapical radiographic images within a thirty-day (30-day) period of a complete series or panoramic image, unless there is evidence of trauma, is subject to consultants' review. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
6. The replacement or repair of space maintainers is not a covered benefit, unless performed by a Dentist who did not do the original placement. Patient is financially responsible.
7. Space maintainers are a covered benefit for Eligible Dependents when a space is being maintained for an erupting permanent tooth.
8. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for a periodontal scaling and root planing and a Northeast Delta Dental Participating Dentist agrees not to charge a separate fee for the additional procedure.

### Basic Benefits (Coverage B)

<b>Restorative:</b>	<ul style="list-style-type: none"><li>• Amalgam (silver) restorations (fillings).</li><li>• Resin (white) restorations.</li></ul>
<b>Oral Surgery:</b>	Extractions and covered surgical procedures.
<b>Periodontics:</b>	Treatment of diseased tissue supporting the teeth and periodontal maintenance.  Prophylaxis (cleaning) – two (2) times in any period of twelve (12) months (child prophylaxis through age twelve (12), adult prophylaxis thereafter). A prophylaxis can be routine or periodontal maintenance under Diagnostic and Preventive Benefits (Coverage A).  A full mouth debridement under Basic Benefits (Coverage B) is covered once in a lifetime and when performed is counted towards your prophylaxis benefit.
<b>Endodontics:</b>	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.
<b>Denture Repair:</b>	Repair of a removable complete or partial denture to its original condition.
<b>Clinical Crown Lengthening:</b>	Once per tooth per lifetime.
<b>Anesthesia:</b>	General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with: an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body; biopsy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.
<b>Occlusal Guard:</b>	Occlusal Guard and occlusal adjustments are a covered benefit.
<b>NOTE:</b>	<ul style="list-style-type: none"><li>• <b><i>Time limitations are measured from the date the service was last performed.</i></b></li></ul>

### Coverage B Exclusions and Limitations:

1. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for a periodontal scaling and root planing and a Northeast Delta Dental Participating Dentist agrees not to charge a separate fee for the additional procedure.
2. Bases, copings, sedative fillings, impressions, and local anesthesia, or other services that are part of the complete dental procedure, are considered components of, and included in the fee for, a complete procedure. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
3. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
4. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
5. Periodontal scaling and root planing is a covered benefit per quadrant once in any period of twelve (12) consecutive months. Benefits are paid for a maximum of two (2) quadrants per office visit.
6. Exploratory surgical services are not a covered benefit. Patient is financially responsible.
7. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
8. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years.
9. Clinical crown lengthening is a covered benefit once per tooth per lifetime and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown.

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10. Clinical crown lengthening is not a covered benefit when performed on the same day as a crown preparation, restoration or osseous surgery. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
  11. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a consulting Dentist's review. Payment will be based on the most comprehensive procedure.
  12. An indirect pulp cap, when rendered at the same time as the final restoration, is considered a base and is not a benefit when billed as a separate procedure in conjunction with the final restoration. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
  13. Recementation of a crown, inlay, onlay, and/or partial coverage restoration is a benefit once in any period of twelve (12) consecutive months.
  14. Recementation of a cast or prefabricated post and core is a benefit once in any period of twelve (12) consecutive months.
  15. Anterior deciduous root canal therapy is not a covered benefit.
  16. A partial pulpotomy is a covered benefit on permanent teeth only.
  17. A root canal or apexification procedure that is performed within thirty (30) days of a partial pulpotomy, and is performed by the same Dentist, will have the payment for the procedure reduced by the payment for the partial pulpotomy. A Northeast Delta Dental Participating Provider agrees not to charge a separate fee.
  18. A post removal is not a covered benefit.
  19. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, distal wedge, or soft tissue graft procedure is a benefit once in any period of three (3) consecutive years.
  20. Recementation of a fixed partial denture is a covered benefit once in any period of twelve (12) consecutive months.

**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 relines of such prosthetic appliances; core buildups; cast and prefabricated posts and cores; and fixed partial denture and crown repairs.

**Implant Services:**

Surgical placement of an endosteal implant body including healing cap.

**Implant Supported Prosthesis:**

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 service was last performed.*

### Coverage C Exclusions and Limitations:

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 benefits for Eligible Dependents under the age of twelve (12).
2. Tissue conditioning is a covered benefit.
3. Coverage C time limitations:
  - (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of five (5) consecutive years.
  - (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of five (5) consecutive years.
  - (c) A removable or fixed partial denture in any period of five (5) consecutive years unless the loss of additional teeth requires the construction of a new appliance.
  - (d) Crowns, onlays, inlays, core buildups, and post and cores are a benefit once per tooth in any period of five (5) consecutive years.
  - (e) The period of five (5) consecutive years referred to in (a), (b), (c), and (d) above is to be measured from the date the service was last performed.
5. A core buildup or post and core performed on the same day as an inlay or onlay is not a covered benefit. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.
6. An implant body including healing cap is a benefit once in a lifetime per site.
7. Implant services are not a benefit for patients under the age of sixteen (16).
8. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. Patient will be responsible for any additional fee.
9. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are a covered benefit. Patient will be responsible for any additional fee.
10. Inlays are not a covered benefit. An allowance will be paid equal to a resin restoration. If an inlay is performed, the patient is responsible for any additional fee.
11. The relining of a denture is a covered benefit once in any period of three (3) consecutive years.
12. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is not a covered benefit. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a consulting Dentist.

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13. Special complex attachments for removable partial dentures are not a covered benefit.
  14. The replacement of a fixed partial denture or removable complete or partial denture when the current denture meets or can be made to meet commonly held dental standards of functional acceptability 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.**

### 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.

**NOTE:**

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

#### Coverage D Exclusions and Limitations:

1. Orthodontic benefit limitations:
  - (a) For treatment commenced while a patient is eligible for orthodontic benefits, Northeast Delta Dental will initiate payment of its liability up to the orthodontic Maximum specified once bands or orthodontic devices are placed.
  - (b) For patients 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 patient for services to position and align teeth.
2. Clear orthodontic appliances are included in orthodontic benefits provided that upon the consulting Dentist's review of pretreatment radiographs it is indicated that the patient has full adult dentition.  
Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. Patient is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.
3. Northeast Delta Dental's payment for orthodontic benefits shall be limited to the lifetime Maximum per patient.
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 for a comprehensive oral evaluation.
5. The replacement or repair of an orthodontic appliance is not a covered benefit if done by the same orthodontist who placed the appliance. If performed by an orthodontist who did not originally place the appliance, payment will be made for one repair per lifetime.

**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.

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## 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 employer's liability laws.
  - (b) Services performed solely for cosmetic reasons; including cosmetic work to your bicuspids and molars (back teeth).
  - (c) Services including, but not limited to, endodontics and prosthodontics (including restorative crowns and onlays) started prior to the date the Subscriber or Eligible Dependent became eligible under the Agreement.
  - (d) Services not provided by a Dentist, or under the supervision of a Dentist, or that are not within the scope of the license of the Dentist or of the license of the person supervised by the Dentist.
  - (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 Section III., Coverage B Benefits); (iii) preventive control programs; (iv) periodontal splinting; (v) bite registrations (vi) myofunctional therapy; (vii) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (viii) equilibration; and (ix) gnathological reporting.
  - (g) Charges for failure to keep a scheduled visit with the Dentist.
  - (h) Charges for completion of forms. Such charges shall not be made to a Subscriber or Eligible Dependent by Participating Dentists.
  - (i) Dental Care which is not necessary and customary, as determined by generally accepted dental practice standards.
  - (j) Dental Care or supplies which are not within the classification of benefits defined in the Agreement.
  - (k) 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) correcting congenital or developmental malformations; or (v) esthetic purposes.
  - (l) Appliances or restorations, other than complete dentures, whose main purpose is to change or correct your bite or stabilize teeth that have become loose because of gum disease.
  - (m) Payments of benefits incurred by the Subscriber and/or Eligible Dependent(s) after the date on which the Subscriber becomes ineligible for benefits except as described under "Extension of Benefits" on Page 21.
  - (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) Case presentation and treatment planning. Patient will be responsible for any additional fee.
  - (r) Athletic mouthguards.
  - (s) To the extent that payment under this plan is prohibited by any law to which the subscriber or dependents are subject at the time expense is incurred.
  - (t) Replacement of a lost or stolen appliance.
  - (u) Instruction for plaque control or oral hygiene.
  - (v) For occupational accidents.
  - (w) Services which do not have uniform professional endorsement.

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- (x) For confinement or treatment received in a U.S. government owned or operated hospital.
  - (y) For charges the subscriber or dependents are not legally required to pay.
  - (z) To the extent that the expenses are in any way reimbursable through “no fault” vehicle insurance.
2. The dental benefits provided by Northeast Delta Dental shall be limited as follows:
- (a) Dental Care rendered by other than a Dentist shall not be a covered benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted dental practice standards. All claims for payment for Dental Care received must be submitted under the name and license number of the Dentist rendering treatment or supervising treatment.
  - (b) Optional Dental Care: In all cases in which the Subscriber or Eligible Dependent selects more expensive Dental Care than is customarily provided, Northeast Delta Dental will pay the selected Co-payment for the Dental Care which is customarily provided to restore the tooth to contour and function. The Subscriber or Eligible Dependent shall be responsible for the remainder of the Dentist’s fee.
  - (c) Predetermination does not guarantee payment. Payment is based upon eligibility, benefits selected by the group, and allowable charges at the time the Dental Care is rendered. If Coordination of Benefits is involved, the amount of payment 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 Coverage Period, or any portion thereof, shall be limited to the amount specified in this document.
    - (ii) Northeast Delta Dental’s payment shall be reduced by any Deductible.
  - (g) Specialized techniques including, but not limited to, precision attachments; overdentures and procedures associated therewith; and personalizations or characterization are excluded. Patient will be responsible for part of or the entire fee for these services.
  - (h) Diagnostic casts (study models) and/or photographs are not a covered benefit by Northeast Delta Dental unless done for orthodontic purposes. The charge for such services should be included in the total case fee.
  - (i) Benefits are paid for amalgam (silver) or resin (white) restorations for the treatment of caries. If a tooth can be restored with amalgam or resin, use of gold, an inlay, onlay or a crown is paid as a one-surface amalgam and the patient will be responsible for any additional cost.
  - (j) A claim (or satisfactory written proof acceptable to Northeast Delta Dental) must be furnished to Northeast Delta Dental at its principal office within one year from the date the service was performed. No payment will be made on claims with dates of service in excess of the one year limitation.

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

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

- (i) Restorative Crowns and Onlays — Total cost for crowns and onlays shall be incurred on the date that the tooth is prepared.
- (ii) Fixed Partial Dentures (abutment crowns and pontics) — The total cost for fixed partial dentures shall be incurred on the date that the teeth are prepared to receive said appliance.
- (iii) Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the final impressions are taken for said appliance.
- (iv) Endodontics — Total cost for endodontic treatment shall be incurred when the pulp chamber of the tooth is opened.
- (v) Implant Body — Total cost for the implant body, including healing cap, shall be incurred on the date of surgical placement.
- (vi) Implant Prosthetics — Total cost for the prosthetic portion of an implant shall be incurred on the date the final impression is taken for said appliance.
- (vii) Orthodontics — Total cost for orthodontic treatment shall be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the patient's mouth.

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## VIII. Coordination of Benefits (Dual Coverage)

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

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

1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.
2. The plan covering an Eligible Person solely as an employee shall determine its benefits before the plan which covers the Eligible Person solely as a Dependent.
3. The plan covering the Eligible Person solely as a Dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the Eligible Person solely as a Dependent of the parent whose birthdate occurs later in a calendar year ("Birthday Rule"). A parent's year of birth is not relevant. If both parents have the same birthdate (month and day) the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. If the other health care program does not use the Birthday Rule, then that plan's provisions will determine the order of liability.
4. If paragraphs 2 and 3 above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time shall be determined first.
5. The order of payment for the claims of a Dependent child of divorced or legally separated parents will be as follows:
  - (a) the plan of the parent with custody;
  - (b) the plan of the spouse or civil union partner of the parent with custody (step-parent);
  - (c) the plan of the parent without custody;
  - (d) if the parents have joint legal custody, paragraph 3 above will apply.

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

6. When 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.
  - (a) Northeast Delta Dental may use reasonable efforts to determine the existence of other benefit programs but shall be under no obligation to do so.
  - (b) The Eligible Person is required to furnish Northeast Delta Dental with information relative to any other health care program in order to determine liability.
7. For the purposes of determining the applicability and implementing the terms of this provision in the Agreement, 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.

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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, 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.

#### **XIV. General Claims Inquiry**

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

If you have any questions regarding your benefits, you may call Northeast Delta Dental for an explanation at 603-223-1234. The toll-free number is 1-800-832-5700. 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**

After you have followed the General Claims Inquiry procedure and have reason to believe your benefit determination was not in accordance with the Agreement between Northeast Delta Dental and your group, 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. It is recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002 but you may also submit your request by standard mail.

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

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

1. the specific reason(s) for denial, including reference to the evidence, documentation and/or clinical review criteria used in the decision, and
2. specific reference to the provision(s) upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the Vice President, Professional Relations' response. You have the right to request to meet, either in person or by telephone, with one or more of the reviewers before a final decision on your claim review is made.

If you do not receive notice within the thirty day (30-day) period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

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

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## **XI. Termination**

Coverage for you and/or your eligible dependents through Northeast Delta Dental will end:

1. At midnight at the end of the bi-weekly pay period during which you end employment.
2. For Dependent Children: on the day that they reach their 26th birthday.
3. When you or your dependents are no longer eligible as explained on P. 4; or
4. When the State of Vermont no longer contracts with Northeast Delta Dental.

The State of Vermont Employee Dental Assistance Plan may continue to provide coverage through another dental provider.

Under certain circumstances, state or federal law may require that benefits be continued for terminated or reduced-hour employees, surviving spouses, or surviving partners of civil unions and Dependents of covered employees, divorced or legally separated spouses and children of current employees, and children of employees entitled to Medicare benefits.

### **Leaves of Absence:**

If you stop work because of reduction in force (RIF) or leave of absence without pay, coverage for you and your eligible dependents will continue automatically for four pay periods (approximately two months), after the pay period during which you stopped work. At the end of that time, you may sign up under COBRA and continue your coverage by paying 102% of the premium. Contact the Employee Benefits Division for further details.

When you return to work you will be covered on the day you return, if you return within two years.

### **Extension of Benefits:**

You will be covered for certain dental services for up to three months after your coverage ends if the service began before your coverage ended. A service is considered to begin:

- On the date the final impression is made for an appliance or modification of one. However, this does not apply to Coverage D (Orthodontia) dental services;
- On the date the teeth are actually prepared for a crown, bridge or gold restoration;
- On the date the pulp chamber is opened for root canal therapy.

All other services begin the date the complete service is actually performed.

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## **XII. Conversion and Continuation of Benefits**

If your or your Eligible Dependent's coverage under the program terminates for any reason, including at the end of any coverage continuation period, you and your Eligible Dependent(s) will have no right to convert to an individual dental plan. The benefits provided under the program are group benefits and are not convertible to individual plans or coverages. However, when your or your Eligible Dependent's group coverage under your employer's Plan terminates, including at the end of any continuation of coverage period, you may apply for an individual plan with Northeast Delta Dental. Individual policies will be subject to the terms, conditions, and limitations set forth in the individual policy and applications will be subject to Northeast Delta Dental's normal underwriting requirements. If you qualify for an individual policy, the coverage provided will be different from your coverage under this Plan. You may apply online at [deltadentalcoversme.com](http://deltadentalcoversme.com) or by calling 888-910-5667.

In addition, there may be other coverage options for you and your family through the Vermont Health Connect ("VHC"). In the VHC, you could be eligible for a tax credit that lowers the monthly premium you would pay for Continuation of Coverage ~~right away~~, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for Continuation of Coverage does not limit your eligibility for coverage for a tax credit through the VHC. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

### **State and Federal Law Rights to Continue Coverage**

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

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

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

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

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

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

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

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

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## **Rights Under the Federal Statute (COBRA)(if applicable):**

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances where coverage under a group health plan would otherwise end. For simplicity, your group dental plan is referred to in this Notice as the “Plan.” You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the premium for your continuation coverage. At the end of the maximum coverage period (described below), there is no individual conversion dental plan available under the Plan. This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than those the COBRA statute requires, and this Notice should be construed accordingly.

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

### **Qualifying Events**

If you are an **employee** of the employer and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two “qualifying events”:

1. Termination of your employment (for reasons other than gross misconduct) or Reduction In Force (RIF).
2. Reduction in the hours of your employment.

If you are the **spouse** of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four “qualifying events”:

1. The death of your spouse.
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the employer.
3. Divorce or legal separation from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your spouse becomes entitled to Medicare benefits.

In the case of a **dependent child** of an employee covered by the Plan, he or she has the right to elect continuation coverage if group dental coverage under the Plan is lost because of any of the following five “qualifying events”:

- (a) The death of the employee parent.
- (b) The termination of the employee parent’s employment (for reasons other than gross misconduct) or reduction in the employee parent’s hours of employment with the employer.
- (c) Parents’ divorce or legal separation.
- (d) The employee parent becomes entitled to Medicare benefits.
- (e) The dependent ceases to be a “dependent child” under the Plan.

### **Your IMPORTANT Notice Obligations**

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child’s losing dependent status under the Plan, then under the COBRA statute, you (the employee) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child’s losing dependent status. You or your spouse or dependent must provide this notice no later than 60 days after the date coverage terminates under the Plan. (See this summary plan description for details regarding when Plan coverage terminates.) *If you or your spouse or dependent fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or dependent fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child’s losing dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

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If the Plan Administrator is timely provided with notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of coverage, then the Plan Administrator will notify the affected family member of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member's current mailing address—see the "You Must Notify Us..." on page 24).

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

**Please note that COBRA does not apply to domestic partners or children of domestic partners because they are not considered legal dependents under the governing rules and regulations of the Internal Revenue Service. However, under Vermont Law 8 V.S.A. §4090a, continuation coverage under state law is available for up to six months by paying 100% of the premium. Please contact the Employee Benefits Division for more information.**

### **Election Procedures**

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

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

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

### **Type of Coverage**

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

If the Employer maintains more than one group health plan, you (or your spouse or dependent children) may elect COBRA coverage under any one or more of those plans in which you have coverage. For example, if you are covered under three separate employer plans, a medical plan, a dental plan, and a vision plan, you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the employer maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

### **COBRA Premiums You Must Pay**

Coverage under COBRA may be continued by paying 102% of the dental premium. See your Personnel Officer for cost and details.

### **Maximum Coverage Periods**

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

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

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

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

### **Children Born to or Placed for Adoption With the Covered Employee During COBRA Period**

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered a qualified beneficiary provided that, where the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The covered employee or other guardian has the right to elect continuation coverage for the child, provided that the child satisfies the otherwise applicable plan eligibility requirements (for example, regarding age). The covered employee or a family member must notify the Plan Administrator within 30 days of the birth, adoption or placement for adoption to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the employee. (The 30-day grace period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption.) *If the covered employee or family member fails to so notify the Plan Administrator in a timely fashion, then the covered employee will NOT be offered the option to elect COBRA coverage for the child.*

### **Open Enrollment Rights and HIPAA Special Enrollment Rights**

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

### **Termination of COBRA Before the End of Maximum Coverage Period**

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

1. The employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse or dependent child) become covered under another group dental plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a

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12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group dental plan. (Note that under HIPAA, an exclusion or limitation of the other group dental plan might not apply at all to the qualified beneficiary depending on the length of his or her creditable dental plan coverage prior to enrolling in the other group dental plan.)

4. After electing COBRA coverage, you (the employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

**You Must Notify Us About Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes**

If you or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or dependent must promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA rights for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

**Plan Administrator**

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

**For More Information**

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

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### **XIII. General Conditions**

#### **Change of Status:**

The Subscriber shall notify his or her group of any event causing a change in the status of an Eligible Person. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, etc.

#### **Assignment:**

Benefits of Eligible Persons are personal and cannot be transferred.

#### **Right of Recovery:**

Northeast Delta Dental will succeed to the Eligible Person's right of recovery against any third person or organization that may be liable. The Eligible Person will authorize Northeast Delta Dental to do whatever is necessary to secure such rights.

#### **Doctor-Patient Relationship:**

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

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

If an Eligible Dependent loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment.

#### **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. For a copy of Northeast Delta Dental's Notice of Privacy Practices which describes in detail our respective privacy practices, or if you have any questions about the privacy of your health information, please contact:

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

### **XIV. Assignment of Benefits**

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

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

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## **XV. Vermont Mandatory Civil Unions Endorsement**

### **Purpose:**

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

### **Definitions, Terms, Conditions, and Provisions:**

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

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

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

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

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

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

### **Caution: Federal Law Rights May or May Not Be Available**

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

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