



Northeast Delta Dental

## Insurance Policy Dental Plan Description

### Delta Dental Family - Low Plan

*You may return this contract at any time within thirty (30) days after its receipt by delivering or mailing it back to Delta Dental. Immediately upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded. If you accept the terms and conditions of the contract, continue paying the premium. The contract will not be renewed if this dental program is no longer available.*

*Term and Renewal of Policy: This policy begins on the date shown as the Effective Date on the Contract Application and continues through the end of the calendar year (also referred to as the "Plan Year"). This policy will automatically renew for a new twelve (12) month Plan Year if the policy premium continues to be paid by the Policy Holder. If you do not want the policy to be renewed, send written notice to Delta Dental before the policy's renewal date. If you send notice not to renew, this policy will terminate on the last day of the current Plan Year. If we send you notice of non-renewal at least ninety (90) days before the end of the Plan Year, your policy will end on the last day of the Plan Year. The contract will not be renewed if this dental program is no longer available.*

Northeast Delta Dental does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status.

**Notice to Buyer: This policy provides dental benefits only. This policy uses Delta Dental's PPO Network.**

**Delta Dental Plan of New Hampshire, Inc.**

04912 005.000

Delta Dental Plan of New Hampshire  
NH-OFFHIX-Individual-Family-Low-0418

## 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 Sheila Sarabia, Compliance Manager.

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:

Sheila Sarabia, Compliance Manager  
One Delta Drive  
Concord, NH 03301  
603-223-1127  
TTY: 1-800-332-5905  
Fax: 603-223-1035  
[ssarabia@nedelta.com](mailto:ssarabia@nedelta.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Sheila Sarabia, Compliance Manager, 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>.

### Language Assistance Services

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-5700 (ATS : 1-800-332-5905).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-832-5700 (TTY: 1-800-332-5905).

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: 1-800-332-5905)。

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: 1-800-332-5905).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0075-238-008-1 (رقم هاتف الصم والبكم: 1-800-332-5905).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-832-5700 (телетайп: 1-800-332-5905).

ध्यान दनु होसः तपाइ ले नेपाल बोल्नहन्छ भन तपाइ को निम्त भाषा सहायता सवाहरु नःशल्क रूपमा उपलब्ध छ । फोन गर्नु होसर् 1-800-332-5700 (ट टवाइ : 1-800-332-5905) ।

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: 1-800-332-5905).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-832-5700 (TTY: 1-800-332-5905) まで、お電話にてご連絡ください。

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-832-5700 (TTY: 1-800-332-5905).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-832-5700 (TTY: 1-800-332-5905) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-832-5700 (TTY: 1-800-332-5905).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-832-5700 (TTY: 1-800-332-5905).

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: 1-800-332-5905).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-832-5700 (TTY: 1-800-332-5905).

## TABLE OF CONTENTS

I.	Welcome.....	2
II.	Definitions.....	4
III.	Information About Your Plan.....	7
IV.	How to File a Claim.....	12
V.	Benefits.....	13
	Diagnostic & Preventive Benefits.....	13
	Diagnostic & Preventive Benefits - Exclusions and Limitations.....	13
	Basic Restorative Benefits.....	16
	Basic Restorative Benefits - Exclusions and Limitations.....	16
	Major Restorative Benefits.....	20
	Major Restorative Benefits - Exclusions and Limitations.....	20
	Orthodontic Benefits.....	23
	Medically Necessary Orthodontia.....	23
	Medically Necessary Orthodontic Benefits (for Pediatric Enrollees only) - Exclusions and Limitations.....	23
VI.	Waiting Periods and General Exclusions and Limitations.....	24
VII.	General Claims Inquiry.....	26
VIII.	Disputed Claims Procedure.....	27
IX.	Disputed Claims Review Procedure.....	27
X.	Patients' Bill of Rights.....	28
XI.	General Conditions.....	30
XII.	Assignment of Benefits.....	32
	Appendix A	

## I. Welcome.

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

This Insurance Policy is issued by Delta Dental Plan of New Hampshire, Inc. and delivered in New Hampshire. It describes the benefits of your program and tells you how to use your plan. Please read it carefully to understand the benefits and provisions of your Delta Dental Plan. But, before you turn the page, we'd like you to know something about us.

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

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

Most Dentists in New Hampshire participate with Delta Dental through Participating Agreements. In addition, a nationwide network of Delta Dental Participating Dentists are available to you.

You are encouraged to take advantage of your Delta Dental Plan because good oral health is an important part of your overall general health. You are encouraged to obtain your Dental Care from a Delta Dental PPO Dentist to benefit from your plan.

The dental benefits offered by Delta Dental through this policy are governed by certain policies and procedures of the US Department of Health and Human Services ("HHS") and the New Hampshire Insurance Department ("NHID") for "exchange certified" dental plans offered in compliance with the Patient Protection and Affordable Care Act (the "ACA"). Delta Dental intends to comply with the policies and procedures of the applicable state and federal regulators in the offering and administration of the dental benefits governed by this policy.

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

Delta Dental PPO Dentists are a network of Participating Dentists who offer lower fees to their Delta Dental PPO patients. Delta Dental PPO Dentists are reimbursed by Delta Dental based on the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. PPO Dentists agree to accept Delta Dental's allowance for PPO Dentists as payment in full, and agree not to charge the 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 Deductibles, Co-Payments, Coinsurance, or services not covered under your plan.

You will also receive benefits if you choose to visit a Delta Dental Premier Dentist. Delta Dental Premier Dentists are reimbursed by Delta Dental based on the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. You, as the Enrollee, when using a Delta Dental Premier Dentist, will be responsible for the difference in the cost of services between the "allowed charge" (based upon Delta Dental's allowance for PPO Dentists) and Delta Dental's allowance for Premier Dentists, in addition to any applicable Deductible, Co-payment, and Coinsurance. Premier Dentists agree to accept such allowance for Premier Dentists as payment in full and further agree not to charge any difference between their fees and the Premier allowance back to their Delta Dental patients. Any payments you make to Premier Dentists do not accrue to the Maximum Out-of-Pocket (MOOP) for Pediatric Enrollees.

You may also choose to visit dental professionals who are not Delta Dental PPO Dentists and who do not participate with Delta Dental as a Premier Dentist. Such dental professionals are referred to as Non-Participating Dentists or Other Dental Providers (ODPs). You will receive benefits based on the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. The Non-Participating Dentist or ODP may balance bill up to their submitted charge. When there is not enough fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount.

Any payments you make to Non-Participating Dentists do not accrue to the Maximum Out-of-Pocket (MOOP) for Pediatric Enrollees. You may be asked to bring a claim form to your visit. Claim forms can be downloaded from [www.nedelta.com](http://www.nedelta.com) or you may call 800-832-5700.

Remember: All Delta Dental Participating Dentists agree to:

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

## II. Definitions.

1. **Adult Enrollee.** The Subscriber if nineteen (19) years of age or older on the effective date of your dental plan, and any enrolled Eligible Dependent who is nineteen (19) years of age or older on the effective date of your dental plan.
2. **Agreement.** The contractual relationship between the Policy Holder and Delta Dental to provide dental benefits to Enrollees. The Agreement includes this document and the Contract Application.
3. **Co-Payments.** The amount of Dental Care cost you are required to pay due to the Office Visit Co-Pay.
4. **Coinsurance.** The amount of the Dental Care cost which you are required to pay after application of Coinsurance Percentages.
5. **Coinsurance Percentage.** The percentage specified in the Agreement as the amount covered by this dental plan for Diagnostic and Preventive Benefits (100%), Basic Restorative Benefits (60%), Major Restorative Benefits (50%), and Medically Necessary Orthodontia Benefits (50%) respectively.
6. **Coverage.** The Dental Care referred to in the Agreement.
7. **Coverage Period.** As specified on the Contract Application.
8. **Deductible.** The portion of the charge for covered Dental Care which you or the Enrollee must pay before Delta Dental's payment responsibility begins. The Deductible for your Coverage is \$150 per Enrollee per Plan Year.
9. **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.
10. **Denied.** If the fee for a procedure or service is Denied and chargeable to the patient, the procedure or service is not a benefit of the patient's plan. The approved amount is not payable by Delta Dental, but is collectable from the patient.
11. **Dental Care.** Services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practices at the time the service is provided.
12. **Dental Plan Description (DPD).** This document which serves as your Insurance Policy. This Dental Plan Description is part of the Agreement which provides the terms and conditions under which Delta Dental shall administer your dental benefits program.
13. **Dentist.** A person duly licensed to practice dentistry in the state in which the Dental Care is provided.
14. **Denturist.** A person licensed to practice denturism by the state in which the services are provided. The practice of denturism includes:
  - (a) The taking of denture impressions and bite registration for the purpose of or with a view to the making, producing, reproducing, construction, finishing, supplying, altering or repairing of a complete maxillary (upper) or complete mandibular (lower) prosthetic denture, or both, to be fitted to an edentulous arch or arches;
  - (b) The fitting of a complete maxillary (upper) or mandibular (lower) prosthetic denture, or both, to an edentulous arch or arches, including the making, producing, reproducing, constructing, finishing, supplying, altering and repairing of dentures; and
  - (c) The procedures incidental to the procedures specified in paragraphs (a) and (b), as defined by the applicable state licensing board.

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

15. **Dependent.**
- (a) The spouse to whom the Policy Holder is legally married.
  - (b) A child of the Policy Holder or of the spouse of the Policy Holder by natural birth or legal adoption, a child in the process of adoption or guardianship and in the custody of the Policy Holder or the spouse of the Policy Holder, a foster child legally placed by order of a court or agency having competent jurisdiction and/or a stepchild, under the age of twenty-six (26).

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

A newborn child is 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. The child may be enrolled thereafter at any open enrollment or special enrollment period.

16. **Disallowed.** If the fee for a procedure or service is Disallowed, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. The Exclusions and Limitations provisions in Section V identify services for which charges are Disallowed. In each instance, a Delta Dental Participating Dentist agrees not to charge a separate fee.
17. **Eligible Dependent(s).** Those Dependents who meet the eligibility requirements of the Agreement and are enrolled by the Subscriber as either Adult Enrollees or Pediatric Enrollees.
18. **Eligible Person(s):** the Subscriber and Dependent(s) (as defined herein).
19. **Enrollees.** The Adult Enrollee(s) and the Pediatric Enrollee(s) (as defined herein).
20. **Explanation of Benefits (EOB).** The notice which explains the benefits that were paid on your behalf. The EOB lets you know if any services are Denied or Disallowed, and gives you the reason(s) for the denial or disallowance.
21. **Maximum.** The Maximum dollar amount Delta Dental will pay for each Adult Enrollee within any Plan Year for covered benefits. The Maximum for each Adult Enrollee under this dental plan is \$1,000 per Plan Year. All benefits paid, including benefits for Diagnostic and Preventive services, are counted toward an Adult Enrollee's Plan Year Maximum. The Maximum does not apply to Pediatric Enrollees.
22. **Maximum Out-of-Pocket (MOOP).** The maximum amount you are required to pay for Co-Payments, Deductibles and Coinsurance for covered services on behalf of each Pediatric Enrollee. The MOOP for each Pediatric Enrollee under this dental plan is \$350 per Plan Year up to a maximum for all Pediatric Enrollees in one family covered by this plan of \$700 per Plan Year. The MOOP does not apply to Adult Enrollees.
23. **Medically Necessary Orthodontia.** Orthodontic services to correct handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth. Examples of conditions causing such deformities include, but are not limited to, cleft palate, Treacher-Collins syndrome, Pierre-Robin syndrome, Marfan syndrome and Crouzon syndrome. Such conditions often require a combined pre- or post-orthognathic surgery/orthodontic treatment approach.
24. **Non-Participating Dentist.** A Dentist who has not signed a Participating Agreement with Delta Dental Plan of New Hampshire or another Delta Dental company.
25. **Office Visit Co-pay (OVCP).** With a few exceptions, each time you, or a person covered under this dental plan, visits a Dentist or Other Dental Provider to receive services covered under this plan, you must pay to the dental provider an Office Visit Co-pay of \$30. The OVCP will be applied after any applicable Deductible and Coinsurance Percentage.
26. **Other Dental Providers (ODP).** A person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are provided.



27. **Participating Dentist.** A Dentist who has signed a Delta Dental Participating Agreement. A Dentist who has signed a Participating Agreement with a Delta Dental company in another state also is considered a Participating Dentist.
28. **Pediatric Enrollee.** The Subscriber if under the age of nineteen (19) on the effective date of your dental plan, and any enrolled Eligible Dependent under the age of nineteen (19) on the effective date of your dental plan.
29. **Plan Year.** The time period commencing with enrollment through the end of the calendar year.
30. **Policy Holder.** The individual named in the Contract Application.
31. **Predetermination.** A procedure by which the Dentist submits a treatment plan to Delta Dental in advance of performing Dental Care. Delta Dental recommends that you ask your Dentist to request a Predetermination of proposed services that are considered to be other than brief or routine. A Predetermination provides an estimate of what Delta Dental will pay for the services which helps avoid confusion and misunderstanding between you and your Dentist.
32. **Prior Authorization.** A required procedure by which the Dentist submits a treatment plan to Delta Dental in advance of performing certain specified procedures for approval based upon Delta Dental review.
33. **Processing Policies.** Policies approved by 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 Prior Authorization or Predetermination. Most frequently used Processing Policies are contained in the terms, conditions, exclusions, and limitations described in this DPD.
34. **Subscriber.** The Policy Holder if he/she enrolls in the dental plan.

### III. Information About Your Plan.

#### The Way Your Plan Works.

1. Covered Services. Section V of this DPD provides details of the dental benefits covered by this plan. A summary of the coverages follows:
  - (a) Diagnostic and Preventive Services. This plan will pay 100% of the allowed charge. The Deductible does not apply to these services.
  - (b) Basic Restorative Services. This plan will pay 60% of the allowed charge once the Plan Year Deductible has been met.
  - (c) Major Restorative Services. This plan will pay 50% of the allowed charge once the Plan Year Deductible has been met.
  - (d) Medically Necessary Orthodontic Services (for Pediatric Enrollees only). This plan will pay 50% of the allowed charge. The Deductible does not apply to these services.
2. Plan Year Deductible. This plan includes a one-time Deductible of \$150 per Enrollee per Plan Year. The Deductible applies only to Basic and Major Restorative Services. The Deductible does not apply to Medically Necessary Orthodontic procedures available to Pediatric Enrollees. Expenses incurred for non-covered services do not apply toward any applicable Deductible.
3. Annual Maximum. This plan has an annual Maximum for each Adult Enrollee per Plan Year in the amount of \$1,000. The Annual Maximum does not apply to Pediatric Enrollees.
4. Maximum Out-of-Pocket (MOOP). The plan includes an annual MOOP that limits the amount you are required to pay for covered services on behalf of Pediatric Enrollees only. The annual MOOP is \$350 for each Pediatric Enrollee per Plan Year up to a maximum for all Pediatric Enrollees in one family covered by this plan of \$700 per Plan Year. Excluded from the MOOP are any payments you make to any dental providers who are not Delta Dental PPO Dentists, and any expenses for non-covered services. The annual MOOP does not apply to Adult Enrollees.

#### Summary of Benefits follows.

**Summary of Benefits:** The following summary of benefits provides a very brief description of the important features of your policy. This policy sets forth in detail the rights and obligations of both you and Delta Dental and the policy provisions will control. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

The table below summarizes the way your plan works for Pediatric Enrollees and Adult Enrollees, respectively. Please refer to Sections V and VI of this policy for details regarding the benefits, exclusions, limitations, and waiting periods.

<b>Delta Dental Family - Low Plan</b>			
Benefits/Features	Pediatric Enrollees (under age 19)		Adult Enrollees (over age 19)
	Benefits prior to reaching the Maximum Out-of-Pocket	Benefits after reaching the Maximum Out-of-Pocket	
Plan Year Maximum Out-of-Pocket <sup>1</sup>	\$350	N/A	None
Diagnostic & Preventive (Coverage A) <sup>2</sup>	100%	100%	100%
Basic Restorative (Coverage B) <sup>2</sup> (Deductible applies)	60%	100%	60% <sup>3</sup>
Major Restorative (Coverage C) <sup>2</sup> (Deductible applies)	50%	100%	50% <sup>4</sup>
Medically Necessary Orthodontia <sup>2</sup>	50%	100%	N/A
Plan Year Deductible Per Person (Basic and Major coverages only)	\$150	\$0	\$150
Office Visit Co-pay (Diagnostic & Preventive, Basic and Major coverages only)	\$30	None	\$30
Plan Year Maximum Per Person	None	None	\$1,000
<p><sup>1</sup>Only out-of-pocket expenses incurred by enrollees under the age of 19 for covered services received from Delta Dental PPO Dentists are counted toward the Plan Year Maximum Out-of-Pocket. MOOP capped at \$700 per family. Enrollees will keep the Under Age 19 benefits through the end of the Plan Year in which they turn 19. <sup>2</sup>Delta Dental's liability is based upon the Coinsurance Percentage of the "allowed charge" as described in this policy. <sup>3</sup>After a 3-month waiting period. <sup>4</sup>After a 6-month waiting period.</p>			

## **A. What Your Plan Pays.**

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

1. If the Dentist is a Delta Dental PPO Dentist, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Co-Payment and Coinsurance. The Dentist cannot receive in total more than Delta Dental's allowance for PPO Dentists.
2. If the Dentist is a Delta Dental Premier Dentist, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Co-Payment, and Coinsurance, and any difference between your plan's payment and Delta Dental's allowance for Premier Dentists in the geographic area in which the services were provided. The Premier Dentist cannot receive more than such allowance for Premier Dentists and has agreed not to bill you for more than that amount.
3. If the Dentist is a Non-Participating Dentist or Other Dental Provider, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Co-Payment, and Coinsurance, and any difference between your plan's payment and the provider's charge for this service. It is in your best interest to discuss what the charge will be before receiving the service.

## **B. Paying Your Premiums.**

This policy is being offered as an "exchange certified" dental benefits plan in compliance with the ACA. You may choose to pay the required monthly premiums by automatic credit card or debit card charges, or by direct, automated payments from your bank account (Electronic Funds Transfer or EFT) by establishing an account with Delta Dental or its third party service provider.

If you choose to pay by personal check, you must pay the premium for the entire Plan Year (calendar year) in one payment when you submit your completed application. If the effective date of your policy is other than January 1, the Plan Year premium will be pro-rated.

You have a thirty-one (31) day premium grace period for any monthly premium payment you must make. If you pay your required premium payment in full before the end of the applicable grace period, your coverage will not be affected. If you do not pay your premium in full by the end of your grace period, your coverage will end on the last day of the grace period.

Delta Dental will provide written or electronic notice to the Subscribers of any increase in the premium rates for the dental benefits plan at least sixty (60) days prior to the effective date of any such increase.

## **C. Eligibility and Enrollment.**

1. Effective Date of Eligibility:
  - (a) Initial Effective Date. Subject to the terms and conditions hereof, coverage under this dental plan will commence on the date determined by Delta Dental. Delta Dental will notify the Policy Holder of such effective date.
  - (b) After the initial Effective Date. For all Dependents (if any) not eligible for benefits as of the Effective Date, eligibility for benefits will commence on the date determined and as notified by Delta Dental. All eligible Dependents (if any) shall be eligible for benefits in accordance with Delta Dental policies and procedures governing qualifying events for special enrollment.

Any person meeting the requirements of a “Dependent” as defined in Section II of this Insurance Policy may be enrolled for coverage under this dental plan, subject to the enrollment and termination provisions hereof, and applicable law.

2. The Policy Holder may add an eligible Dependent.
  - (a) On the anniversary date of this policy if the Dependent was eligible to be enrolled at the time you submitted your original Contract Application.
  - (b) Within sixty (60) days of the occurrence of a qualifying event such as marriage, divorce, birth, or adoption.
  - (c) On such other date as may be approved by Delta Dental.

Dependents added after a qualifying event will have coverage effective on the date determined by Delta Dental, and Delta Dental will notify the Dependent of the effective date of coverage.

#### **D. Termination of Your Plan.**

1. Termination by you. When you buy this policy, you commit to keep it for the Plan Year. However, you may qualify to terminate this policy earlier than the end of the Plan Year, but only for one of the following reasons:
  - (a) The Enrollee becomes covered under a group dental policy or obtains minimum essential coverage.
  - (b) If an Enrollee dies, the person’s coverage will terminate after you or your personal representative provide notice to Delta Dental.

If you want to terminate your policy because the Enrollee became covered under a group dental plan or obtained minimum essential coverage, you must notify us in writing at least fourteen (14) days in advance of the requested effective date of termination of coverage for the Enrollee. If you provide the fourteen (14) day notice, coverage will terminate for the Enrollee on the date you request. If you do not specify an effective date, the policy will terminate fourteen (14) days after you request termination or an earlier date if you request earlier termination and Delta Dental can effectuate termination in fewer than fourteen (14) days.

If any Enrollee dies, you or your personal representative shall promptly notify Delta Dental in writing and the effective date of termination of coverage shall be the date of death.

If you cancel your policy, Delta Dental or its third party service provider shall promptly return any unearned portion of the premium within thirty (30) days. The earned premium shall be computed on a pro-rata basis.

2. Termination by Delta Dental. By required written notice delivered to you at the address last shown in the records of Delta Dental, Delta Dental may terminate your policy before the end of the Plan Year for any of the following reasons:
  - (a) You do not pay the policy premiums when due, including applicable grace periods.
  - (b) You or the Enrollee commits, or attempts to commit, fraud or material misrepresentation having to do with this policy and coverage is lawfully rescinded pursuant to applicable law.
  - (c) This plan terminates or is decertified by HHS or the NHID.
  - (d) The Enrollee changes from this policy to another plan that includes minimum essential coverage.

Delta Dental may also terminate coverage for an Enrollee under your policy if we become aware that the Enrollee is no longer eligible for coverage under this policy.

In the event of termination by Delta Dental, Delta Dental or its third party service provider will promptly return the unearned portion of any policy premium on a pro-rata basis.

3. **Effective Date of Termination.** Except as specifically referenced in this Section D., coverage and benefits under this policy will terminate for the Enrollees on the date this policy terminates. The effective date of termination will be:
  - (a) The last day of the month following receipt by the Policy Holder of required notice and the expiration of the applicable grace period in the event premiums are not paid when due.
  - (b) The last day of your current Plan Year if you change your legal residence to a place other than New Hampshire.
  - (c) Following receipt of thirty (30) days written notice of termination due to fraud or material misrepresentation.
  - (d) The last day of your current Plan Year in which this plan terminates or is decertified; or
  - (e) The effective date of the replacement coverage through another plan including minimum essential coverage.

**E. Renewal and Non-Renewal.**

This policy will continue for a new twelve (12) month Plan Year if the premium continues to be paid by the Policy Holder. If you do not want the policy to be renewed, send written notice to Delta Dental before the policy's renewal date. If you send notice not to renew, this policy will terminate on the last day of the current Plan Year. If we send you notice of non-renewal at least ninety (90) days before the end of the Plan Year, your policy will end on the last day of the Plan Year.

Prior to renewal, Delta Dental will provide at least thirty (30) days written notice of any premium adjustment. If the Policy Holder sends written notice to Delta Dental, before the policy's renewal date, your policy will terminate as of the last day of the Plan Year.

If either you or Delta Dental provides the required written notice that your policy will not be renewed, your policy will terminate on the last day of the Plan Year as set forth in the Contract Application.

If any renewal premium is not paid within the time granted for payment, your policy will be reinstated if Delta Dental or a duly authorized agent accepts a premium payment, without requiring an application for reinstatement. If Delta Dental or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, the policy will be reinstated upon approval of such application by Delta Dental. The policy will be reinstated upon the 45th day following the date of such conditional receipt unless Delta Dental has previously notified you in writing of its disapproval of your application.

A reinstated policy shall only cover claims after the date of reinstatement. In all other respects you and Delta Dental shall have the same rights thereunder as each had under the policy immediately before the due date of the defaulted premium in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

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

You must notify Delta Dental (800-832-5700) of any event causing a change in your status or that of an Enrollee covered under your policy. Events that can affect status include marriage, birth, adoption, death, divorce, an Enrollee reaching nineteen (19) years of age, a Dependent child reaching twenty-six (26) years of age, and change of address.

## IV. How to File a Claim.

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

This Dental Plan Description describes the benefits and provisions of your dental plan. Please read it carefully.

Ask your Dentist if he/she is a Delta Dental PPO Dentist or participates as a Delta Dental Premier Dentist; visit Delta Dental's website at [www.nedelta.com](http://www.nedelta.com), refer to the Delta Dental Participating Dentist Directory for a PPO Dentist, or call Delta Dental for information.

When you visit your dental office, inform them that you are covered under a Northeast Delta Dental program. Provide your identification card or other means of verifying Northeast Delta Dental coverage. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Northeast Delta Dental for payment for covered services. Clean written claims must be paid in 30 days; clean electronic claims must be paid within 15 days.

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

**Non-Participating Dentists or Other Dental Providers.** Delta Dental provides coverage regardless of your choice of Dentist. When visiting a Non-Participating Dentist or ODP, 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 Delta Dental. Payment will be made directly to you. Some states may require that assignment of benefits 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 by a Non-Participating Dentist or ODP will be limited to the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which services were provided. It is your responsibility to make full payment to the Dentist or ODP. When there is not enough fee information available, Delta Dental will determine an appropriate payment amount.

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

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

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

**Predetermination of Benefits.** Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist. A Predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office.

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

Questions concerning Prior Authorization and Predetermination should be directed to Delta Dental's Customer Service Department at 800-832-5700 or 603-223-1234.

## V. Benefits.

In this section of your policy, we give you the details of what services your policy covers and the conditions and limitations on those services. **This section includes significant dental terminology adopted by the American Dental Association. We encourage you to discuss proposed services and treatment plans with your Dentist/dental office.** In addition, should you have any questions regarding those services, you may call Customer Service at 800-832-5700 Monday through Friday from 8:00 a.m. to 4:45 p.m. EST excluding holidays.

### Diagnostic & Preventive Benefits.

#### Diagnostic.

Oral evaluations are covered one time in a period of six (6) months. Evaluations can be comprehensive, limited or periodic and may be provided by a specialist or a general Dentist.

Radiographic images are covered with limitations. Complete series or panoramic image are covered once in a period of five (5) years. Bitewings are covered once in a period of six (6) months. Images of individual teeth are covered as necessary.

Caries risk assessment is covered one time in a period of three (3) years for Eligible Persons age three (3) and older.

#### Preventive.

Prophylaxis (cleaning) is covered one time in a period of six (6) months. A child cleaning is through age thirteen (13); an adult cleaning is thereafter). A cleaning can be routine under Diagnostic and Preventive Benefits or a periodontal maintenance under Basic Restorative Benefits.

A full mouth debridement is a covered benefit, once in a lifetime, under Diagnostic & Preventive Benefits. When performed, it is counted towards your cleaning benefit.

Fluoride treatments are covered two (2) times in a period of twelve (12) months for Pediatric Enrollees only.

Sealants are a covered benefit for Pediatric Enrollees only.

Space maintainers are a covered benefit for Pediatric Enrollees only.

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

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

*All covered services for Pediatric Enrollees containing an age or frequency limitation are available for age exception or more frequent treatment with Prior Authorization.*

### Diagnostic & Preventive Benefits - Exclusions and Limitations.

- If the fee for a procedure or service is **“Disallowed”**, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is **“Denied”**, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient’s plan.
1. Charges for oral evaluations of any kind are Disallowed, if performed within ninety (90) days after periodontal surgery, by the same Dentist/dental office.
  2. Charges for oral evaluations for patients under age three (3) are Disallowed when performed on the same date of service by the same Dentist/dental office as a comprehensive evaluation.
  3. Pre-diagnostic services, such as screening and assessment of a patient, are not covered benefits. Payment for a screening or assessment is Disallowed if billed with an oral evaluation.



4. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings and/or occlusal), is considered a complete series for time limitations. Any fee in excess of the fee for a complete series is Disallowed.
5. Charges for additional periapical and/or occlusal radiographic images within a thirty (30) day period of a complete series or panoramic image is Disallowed, unless there is evidence of trauma.
6. Fees for additional radiographic images taken by the same Dentist/dental office within sixty (60) days of vertical bitewings are Disallowed.
7. When benefits are requested for a panoramic radiographic image in conjunction with a complete series by the same Dentist/dental office, fees for the panoramic radiographic image are Disallowed as a component of the complete series on the same date of service.
8. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure. Separate fees are Disallowed on the same date of service.
9. The fee for a full mouth debridement is Disallowed when performed by the same Dentist/dental office on the same date of service as a comprehensive evaluation, detailed and extensive oral evaluation or a comprehensive periodontal evaluation.
10. If the fee for bitewings, periapicals, intraoral occlusal and extraoral occlusal radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.
11. Cone beam imaging is not a covered benefit. Cone beam imaging, when performed by the same Dentist/dental office as an image interpretation, is combined as a cone beam capture and interpretation. Any fees in excess of the combined codes are Disallowed.
12. Cephalometric images, oral/facial photographic images and diagnostic models are covered once every two (2) years when performed for potential Medically Necessary Orthodontic treatment only.
13. Oral cancer screening, except brush biopsy, is not a covered benefit.
14. 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 payment for the less inclusive procedure is Disallowed.
15. 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. The fee is Disallowed.
16. Cleanings (a Diagnostic & Preventive benefit) are included in both full mouth debridement (a Diagnostic & Preventive benefit) and periodontal maintenance (a Basic Restorative benefit). As a result, each of these procedures is counted toward your cleaning benefit of once in a six (6) month period.
17. Laboratory tests for caries susceptibility are not a covered benefit. Fees are Disallowed when billed with an oral evaluation for children under the age of three (3).
18. Caries risk assessment is a covered benefit once in a period of three (3) years for Eligible Persons age three (3) and older. Fees for caries risk assessment are Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.
19. The replacement of space maintainers is not a covered benefit. The patient is financially responsible.
20. The repair of space maintainers is not a covered benefit. The patient is financially responsible.
21. Recementation of a space maintainer is a covered benefit once in a lifetime per appliance.

22. Removal of a space maintainer is included as part of the total treatment. Charges for removal of a space maintainer are Disallowed if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.
23. Distal shoe space maintainers are a covered benefit for Eligible Persons age eight (8) and younger. Fees for distal shoe space maintainers performed on patients nine (9) and older are Denied.
24. Sealant benefit limitation.
  - (a) The sealant benefit is a covered benefit for Pediatric Enrollees only.
  - (b) The sealant benefit is for the application of sealants to caries-free and restoration-free, occlusal (biting) surface of permanent molars only.
  - (c) The sealant benefit is provided no more than once in a three (3) year period per tooth.
  - (d) Charges for sealants are Disallowed within two (2) years of initial placement on the same tooth by the same Dentist/dental office. Charges for a sealant are Disallowed if performed on the same tooth, by the same Dentist/dental office, on the same date of service as a restoration which includes the occlusal surface.
25. Preventive resin restorations are a covered benefit one (1) time per tooth in a period of three (3) years on permanent molars for Pediatric Enrollees only. Fees are Disallowed if replaced by the same Dentist/dental office within twenty-four (24) months. Fees for a preventive resin restoration is Disallowed if performed on the same tooth, by the same Dentist/dental office on the same date of service as another restoration.
26. The fee for preventive resin restoration is Disallowed if performed on the same date of service as a conventional restoration or palliative treatment by same Dentist/dental office.
27. Pulp vitality tests are a covered benefit only when done in conjunction with a radiographic image, a limited oral evaluation, a palliative treatment or a protective restoration. Payment is otherwise Disallowed.
28. Palliative treatment is a covered benefit. The third palliative treatment claim received in 180 days is subject to a dental consultant's review.
29. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office and a separate fee is Disallowed.
30. The fee for palliative treatment is Disallowed when submitted with all procedures performed by the same Dentist/dental office on the same date, except radiographic images and diagnostic codes.
31. Viral culture tests and saliva tests are not covered benefits. The patient is financially responsible.
32. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits. The patient is financially responsible.
33. TMJ related services are not covered benefits. The patient is financially responsible.

## Basic Restorative Benefits.

- Restorative.** Amalgam (silver) restorations (fillings) are a covered benefit.  
Resin restorations are a covered benefit on anterior teeth and the buccal surface of bicuspid only.  
Prefabricated stainless steel crowns are a covered benefit.  
Recementation of an inlay or crown is a covered benefit.  
Protective restorations.
- Periodontal Maintenance.** A periodontal maintenance procedure is a covered benefit after active periodontal therapy four (4) times in a twelve (12) month period and when performed, is counted toward the prophylaxis benefit
- Periodontics.** Periodontal scaling and root planing is a covered benefit once in a period of twenty-four (24) months.
- Endodontics.** Pulpotomy and pulpal therapy.
- Oral Surgery.** Extractions and covered surgical procedures.
- Prosthodontic Services.** Denture repair, adjustment, rebase and relines.
- Tissue conditioning.** Two (2) times in a three (3) year period.

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

**Anesthesia (Pediatric Enrollees only).** General anesthesia or intravenous sedation are covered benefits when done in conjunction with other covered services.

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

*All covered services for Pediatric Enrollees containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.*

## Basic Restorative Benefits - Exclusions and Limitations:

- If the fee for a procedure or service is “**Disallowed**”, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is “**Denied**”, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient’s plan.
1. Resin or amalgam 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. Charges for the replacement of amalgam (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office are Disallowed.
  2. Resin restorations in posterior teeth (white fillings in bicuspid and molars) are optional. If a resin restoration is performed on posterior teeth, other than the buccal surface of bicuspid, an allowance will be paid equal to an amalgam (silver) restoration and the patient will be responsible for any additional fee.
  3. Resin based composite crowns on anterior teeth are a covered benefit once in a period of two (2) years per tooth for patients age twelve (12) and older. Fees are Disallowed if replaced within two (2) years by the same Dentist/dental office.
  4. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Participating Dentist agrees not to charge a separate fee.

5. Prefabricated stainless steel crowns are a covered benefit once in a period of twenty-four (24) months. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement. A separate fee is Disallowed.
6. Prefabricated porcelain crowns are a covered benefit on primary teeth only, once in a period of twenty-four (24) months.
7. Recementation of a metallic inlay or onlay, or a crown or partial coverage restoration is a covered benefit once in a lifetime. Payment for recementation of an inlay, onlay, crown or partial coverage restoration is Disallowed when performed within six (6) months of the initial placement by the same Dentist/dental office.
8. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Participating Dentist agrees not to charge a separate fee.
9. Fees for protective restorations are Disallowed if performed on the same date of service as a palliative treatment by the same Dentist/dental office.
10. Cleanings (a Diagnostic & Preventive benefit) are included in both full mouth debridement (a Diagnostic & Preventive benefit) and periodontal maintenance (a Basic Restorative benefit). As a result, each of these procedures is counted toward your cleaning benefit of once in a six (6) month period.
11. 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. The fee is Disallowed.
12. Fees for periodontal maintenance are Disallowed when billed within three (3) months of periodontal therapy by the same Dentist/dental office.
13. Periodontal scaling and root planing is a covered benefit per quadrant once in a period of twenty-four (24) months. Benefits are paid for a maximum of two (2) quadrants per office visit. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. If treatment is done by a different Dentist within twenty-four (24) months, benefits are Denied. The patient is responsible for the fee.
14. A partial pulpotomy is a covered benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within forty-five (45) days on the same tooth by the same Dentist/dental office as root canal therapy.
15. 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.
16. 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.
17. Pulpal debridement is a covered benefit once in a lifetime. The fee for pulpal debridement is Disallowed if performed within thirty (30) days of a root canal treatment by the same Dentist/dental office.
18. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Participating Dentist agrees not to charge a separate fee.
19. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Fees for additional pins in the same tooth are Disallowed. The fee for pin retention is Disallowed when billed in conjunction with a core buildup.
20. Post-operative treatment of complications from oral surgery is a covered benefit once per surgical site, subject to a dental consultant's review. The fee for post-operative treatment of complications is Disallowed if performed within thirty (30) days by the same Dentist/dental office as the oral surgery.

21. The fee for removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same Dentist/dental office.
22. Alveoplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office in the same surgical area on the same date.
23. A frenulectomy or frenuloplasty is a covered benefit once per site per lifetime. The fee is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office.
24. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered benefit. Payment is Disallowed if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.
25. An internal root repair is a covered benefit once in a lifetime on permanent teeth only. If performed on a primary tooth the benefit is Denied. The fee for an internal root repair is Disallowed if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.
26. A consultation performed by a Dentist who is not performing further services is a covered benefit. The fee for a consultation is Disallowed if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.
27. Exploratory surgical services are not a covered benefit. The patient is financially responsible.
28. 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.
29. The fee for repairs of complete or partial dentures cannot exceed half the fee for a new appliance. Any excess fee billed by the same Dentist/dental office on the same date of service is Disallowed.
30. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office are Disallowed.
31. Adjustment or repair of a denture is a covered benefit twice in a twelve (12) month period. Fees for an adjustment or repair of a denture is Disallowed if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance. Any excess fee by the same Dentist/dental office on the same date of service is Disallowed.
32. The relining of a denture is a covered benefit two (2) times in a period of twelve (12) months. The fee for reline of a denture cannot exceed one-half of the fees for a new appliance. Any excess fee by the Dentist/dental office is Disallowed.
33. The rebase of a denture is a covered benefit once in three (3) years. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance. Any excess fee by the same Dentist/dental office is Disallowed.
34. The fee for a reline or rebase of a denture is Disallowed if performed within six (6) months of initial placement by the same Dentist/dental office.
35. Rebase and reline include adjustments required within six (6) months of delivery. When an adjustment is billed within six (6) months of a rebase or reline by the same Dentist/dental office, fees for the adjustment are Disallowed.
36. Recementation of a fixed partial denture is a covered benefit once in a period of twelve (12) months. Fees for recementation of fixed partial dentures are Disallowed if done within six (6) months of the initial placement by the same Dentist/dental office.

37. Cleaning and inspection of a removable complete or partial denture is not a covered benefit. The fee for cleaning and inspection of a removable complete or partial denture is Disallowed when done by the same Dentist/dental office on the same date of service as a reline or rebase of the denture.
38. Bone replacement graft for ridge preservation is a covered benefit, once per site per lifetime.
39. Recementation of a prefabricated post and core is a covered benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.
40. Tissue conditioning is a covered benefit two (2) times in a three (3) year period. The fee for tissue conditioning is not a benefit if performed on the same day the denture is delivered or a reline/rebase is provided by the same Dentist/dental office and is Disallowed.
41. Tooth preparation, bases, copings, protective restorations, 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. Separate fees are Disallowed.
42. Therapeutic drug injections are a covered benefit subject to a dental consultant's review.
43. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure. Separate fees are Disallowed.
44. Excision of lesions is not a covered benefit. The patient is financially responsible.
45. Interim caries arresting medicament application is not a covered benefit.

***Please note: Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

## Major Restorative Benefits.

<b>Restorative Crowns and Onlays.</b>	Crowns and metallic inlays and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.  Core buildups, prefabricated post and cores and crown, inlay, onlay and veneer repairs for enrollees age twelve (12) and older.
<b>Endodontics.</b>	Root canal therapy, apicoectomy, apexification, root amputation, and hemisection.
<b>Periodontics.</b>	Gingivectomy, gingivoplasty, gingival flap procedure, clinical crown lengthening, osseous surgery, and soft tissue graft.
<b>Prosthodontics.</b>	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures.
<b>Implant Services.</b>	Surgical placement of an implant body, including healing cap, for enrollees age sixteen (16) and older.
<b>Implant Supported Prostheses.</b>	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device for enrollees age sixteen (16) and older.
<b>Occlusal Guard.</b>	Once in a twelve (12) month period for patients age thirteen (13) and older.

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

*All covered services for Pediatric Enrollees containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.*

## Major Restorative Benefits - Exclusions and Limitations.

- If the fee for a procedure or service is “**Disallowed**”, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is “**Denied**”, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient’s plan.
1. Inlays and onlays (metallic) and crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not benefits for Enrollees under the age of twelve (12) without a Prior Authorization.
  2. Time limitations.
    - (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in a period of five (5) years.
    - (b) One (1) immediate maxillary (upper) and one (1) immediate mandibular (lower) denture in a five (5) year period.
    - (c) A removable or fixed partial denture in a period of five (5) years unless the loss of additional teeth requires the construction of a new appliance.
    - (d) Metallic onlays, crowns, core buildups, and post and cores are a benefit once per tooth in a period of five (5) years.
  3. A core buildup is a covered benefit once in a five (5) year period per tooth for patients age twelve (12) and older. The fees for core buildups are Disallowed when performed in conjunction with inlays,  $\frac{3}{4}$  crowns or onlays and indirectly fabricated and prefabricated post and cores.

4. 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. A separate fee is Disallowed.
5. An indirectly fabricated or prefabricated post and core is payable only on an endodontically treated tooth and is a covered benefit once in a five (5) year period for patients age twelve (12) and older. Fees for post and cores are Disallowed when radiographic images 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 Disallowed.
6. A core buildup or indirectly fabricated and prefabricated post and cores in conjunction with a fixed partial denture crown are a covered benefit once in a seven (7) year period per tooth for Eligible Persons age sixteen (16) and older.
7. Scaling and debridement 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 Disallowed if performed within twelve (12) months of restoration or within twenty-four (24) months of initial therapy by the same Dentist/dental office. If performed by a different Dentist/dental office, the fee is Denied.
8. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is Disallowed 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.
9. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is Disallowed when performed in conjunction with a cleaning, periodontal maintenance or scaling of moderate or severe gingival inflammation.
10. 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 Disallowed.
11. Root canal therapy is a covered benefit once per tooth in a period of twenty-four (24) months. Retreatment of root canal therapy or retreatment of apical surgery by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed.
12. Anterior deciduous root canal therapy is not a covered benefit.
13. Root canal therapy is not a benefit in conjunction with overdentures. Benefits are Denied.
14. Post removal is Disallowed if performed within thirty (30) days of an endodontic treatment by the same Dentist/dental office performing the endodontic retreatment.
15. Direct or indirect pulp caps are a covered benefit once per tooth 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. The fee for the pulp cap is Disallowed.
16. The fee is Disallowed for root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office.
17. 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.
18. Periodontal surgical procedures include all necessary post-operative care, finishing procedures, evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. When a surgical procedure is billed within three (3) months of the initial surgical procedure by the same Dentist/dental office, the fee for the surgery is Disallowed.



19. Gingivectomy, gingivoplasty, gingival flap procedure, bone replacement graft in conjunction with flap surgery, mesial/distal wedge, connective tissue graft or soft tissue graft procedure are covered benefits 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 Disallowed.
20. 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 Disallowed 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.
21. An apexification or an apicoectomy is a covered benefit once per tooth in a period of three (3) years. The fee for retreatment by the same Dentist/dental office within twenty-four (24) months is Disallowed.
22. Retrograde fillings are a covered benefit once per root per three (3) years. The fee for retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Disallowed.
23. The fee is Disallowed for periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling and/or root amputation.
24. Clinical crown lengthening is a covered benefit once per tooth in a three (3) year period 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 Disallowed if performed on the same date of service by the same Dentist/dental office as the crown placement.
25. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure. A Participating Dentist agrees not to charge a separate fee.
26. 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.
27. An interim complete denture is not a covered benefit. Fees are Disallowed if billed in conjunction with a permanent appliance.
28. 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 Disallowed if billed in conjunction with a permanent appliance on the same day by the same Dentist/dental office.
29. 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. The patient will be responsible for any additional fee.
30. The fee for sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is Disallowed. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a dental consultant.
31. An implant body, including healing cap, is a covered benefit once in a five (5) year period for enrollees age sixteen (16) and older.
32. Implant services and implant supported prosthetics are not a covered benefit for patients under the age of sixteen (16).
33. Removal of an implant is a covered benefit once in a five (5) year period per tooth site.

***Please note: Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

## Orthodontic Benefits.

### Medically Necessary Orthodontia.

Medically Necessary Orthodontic treatment and procedures (subject to Prior Authorization) required for the correction of malposed (crooked) teeth for Pediatric Enrollees only.

Placement of device to facilitate eruption of an impacted tooth for Pediatric Enrollees only.

### Medically Necessary Orthodontic Benefits (for Pediatric Enrollees only) - Exclusions and Limitations.

- If the fee for a procedure or service is “**Disallowed**”, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
  - If the fee for a procedure or service is “**Denied**”, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient’s plan.
1. For Medically Necessary Orthodontic treatment commenced while a Pediatric Enrollee is eligible for orthodontic benefits under this policy, Delta Dental will initiate payment of its liability once bands or orthodontic devices are placed. Delta Dental requires dental consultant review to determine if orthodontic treatment is medically necessary.
  2. For Medically Necessary Orthodontic treatment commenced prior to becoming eligible under this policy, Delta Dental will pro-rate its liability based on the number of remaining months of active treatment compared to the total number of months of active treatment. Delta Dental requires a dental consultant’s review to determine if orthodontic treatment was medically necessary at the start of treatment.
  3. 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.
  4. Delta Dental will make one (1) payment of twenty-five percent (25%) of the allowed charge at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of thirty-six (36) months for its total liability. “Start of treatment” means the date of initial banding or a segment thereof, or a device is placed in the patient’s mouth. Periodic monthly payments will continue based upon the continuing eligibility of the Pediatric Enrollee.
  5. Cephalometric images, oral/facial photographic images and diagnostic models are a covered benefit with Medically Necessary Orthodontic treatment only.
  6. The replacement of an orthodontic appliance is a covered benefit once per arch in a lifetime.
  7. The repair of an orthodontic appliance is not a covered benefit. The patient is financially responsible.
  8. Rebonding or recementing of a fixed retainer is a covered benefit once in a lifetime if performed by a different Dentist than the Dentist who placed the appliance. Rebonding or recementing of a fixed retainer by the same Dentist/dental office who placed the original appliance is Disallowed.
  9. Repair of a fixed retainer (including reattachment) is a covered benefit once in a lifetime per patient if performed by a different Dentist/dental office than the one who placed the appliance. Repair of a fixed retainer by the same Dentist/dental office who placed the original appliance is Disallowed.
  10. Occlusal orthotic device adjustments are not a covered benefit.

***Please note: Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid confusion regarding Delta Dental’s payment and your financial obligation to the Dentist.***

## VI. Waiting Periods and General Exclusions and Limitations.

### 1. Waiting Periods Generally.

A waiting period of three (3) months applies to Adult Enrollees only and only in connection with Basic Restorative Benefits. A waiting period of six (6) months applies to Adult Enrollees only and only in connection with Major Restorative Benefits. There are no waiting periods for Adult Enrollees in connection with Diagnostic and Preventive Benefits. There are no waiting periods for Pediatric Enrollees.

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

If you had dental coverage for at least six (6) months and within thirty (30) days prior to the Effective Date of your coverage under this dental plan, waiting periods for the same Basic Restorative Benefits and Major Restorative Benefits will be deemed satisfied under this plan for each Adult Enrollee also covered under your prior coverage.

### 3. The dental benefits provided by Delta Dental shall not include the following services.

- (a) Services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws.
- (b) Services that are determined by Delta Dental to be provided for cosmetic reasons, such as bleaching or whitening of teeth (unless discolored by previous endodontic therapy), placement of veneers, correction of congenital malformations, or cosmetic surgery. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.
- (c) Services completed when Enrollees were not covered under this policy. Such services include, but are not limited to, endodontics and prosthodontics (including restorative crowns and onlays).
- (d) Services not provided by a Dentist, or under the supervision of a Dentist, or not within the scope of the license of the Dentist or of the license of the person supervised by the Dentist, unless otherwise required by law.
- (e) Prescription drugs or the application of anti-microbial agents.
- (f) Charges for: (i) hospitalization; (ii) preventive control programs; (iii) myofunctional therapy; (iv) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (v) equilibration; and (vi) gnathological reporting.
- (g) Charges for failure to keep a scheduled visit with the Dentist.
- (h) Charges for completion of forms. Such charges shall not be made to an Enrollee 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 not within the benefits for the option selected.
- (k) Appliances, procedures, or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, or restoring occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv) correcting congenital or developmental malformations; or (v) esthetic purposes. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.
- (l) Payments of benefits incurred by you or the Enrollee after the date on which the Enrollee becomes ineligible for benefits.
- (m) Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.
- (n) Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- (o) Temporary services or incomplete treatment.

- (p) A consultation unless performed by a Dentist who is not performing further services.
- (q) 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 Disallowed. 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 Disallowed.
- (r) Case presentation and treatment planning. You or the Enrollee will be responsible for any additional fee.
- (s) Athletic mouthguards.
- (t) The fees for transmitting data via teledentistry are considered inclusive in the overall dental procedure(s) being performed and separate fees are Disallowed.

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

- (a) Unless required by law, Dental Care provided by anyone other than a Dentist shall not be a benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as the treatment is provided 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 you or the Enrollee agree, after consultation with your Dentist, to more expensive Dental Care than is customarily provided, Delta Dental will pay the selected applicable Coinsurance Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. You and the Enrollee shall be responsible for the remainder of the Dentist's fee.
- (c) Predetermination and Prior Authorization do not guarantee payment. Payment is based upon eligibility, benefits selected, and allowable charges at the time the Dental Care is actually provided.
- (d) Services completed or in progress at the Enrollee's date of death will be paid in full to the limit of Delta Dental's liability.
- (e) When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, Delta Dental will review the claim to determine the payment, if any, due each Dentist.
- (f) Specialized techniques including, but not limited to, precision attachments, overdentures and procedures associated therewith, and personalizations or characterization are excluded. You and the Enrollee will be responsible for part of or the entire fee for these services.
- (g) Interpreter services are a covered benefit when performed in conjunction with other covered services for Pediatric Enrollees only.
- (h) Delta Dental programs provide amalgam (silver) and resin (white) restorations for treatment of caries. If a resin restoration is performed, an allowance of the cost of an amalgam restoration will be paid towards the resin restoration and the patient will be responsible for payment of the balance. If the teeth can be restored with such materials, any gold restorations, or crowns are considered optional. You and the Enrollee will be responsible for any additional fee.

- (i) Written notice of sickness or of injury must be given to Delta Dental within twenty (20) 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.
- (j) Delta Dental, upon receipt of a notice of claim, will furnish to you such forms usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you shall be deemed to have complied with the requirements of this policy with the time fixed in the policy for filing claims. Notice given by or on behalf of you to Delta Dental, or to any authorized agent of Delta Dental, with information sufficient to identify you, shall be deemed notice to Delta Dental.
- (k) A completed claim (or satisfactory written proof acceptable to Delta Dental) must be furnished to Delta Dental at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on claims with dates of service in excess of the twenty-four (24) month limitation. Benefits payable under this policy for any claim will be paid promptly upon receipt of written notice of claim.
- (l) The Date of Incurred Liability is the date a service is subject to the applicable Deductible, Co-Payment, Coinsurance Percentage, and limitations. Except as otherwise noted, the total cost of the service is applied to the Plan Year during which the service is completed, regardless of the Plan Year in which the service is started.  
For services covered, Delta Dental's date of incurred liability for multiple visit procedures is as follows.
  - (i) Restorative Crowns. The total cost for crowns shall be incurred on the date that the crown or onlay is cemented. Pediatric Enrollees under the age of twelve (12) require a Prior Authorization.
  - (ii) Fixed Partial Dentures, abutment crowns and pontics. The total cost for fixed partial dentures shall be incurred on the date that the appliance is cemented.
  - (iii) Removable Complete and Partial Dentures. The total cost for removable complete and partial dentures shall be incurred on the date that the appliance is delivered to the patient.
  - (iv) Endodontics. The total cost for endodontic treatment shall be incurred when the canal is filled to completion.
  - (v) Implant Body for Adult Enrollees and Pediatric Enrollees age sixteen (16) and older. The total cost for the implant body, including healing cap, shall be incurred on the date of the surgical placement.
  - (vi) Implant Prosthetics for Adult Enrollees and Pediatric Enrollees age sixteen (16) and older. The total cost for the prosthetic portion of an implant shall be incurred on the date that the appliance is cemented or delivered to the patient.

## VII. General Claims Inquiry.

After a claim is submitted by your Dentist and processed by Delta Dental, you or the Enrollee will be sent or have access to an Explanation of Benefits. This notice will explain the benefits paid on your behalf, let you know of any Denied or Disallowed services, and give you the reason for any denial or disallowance.

If you have any questions regarding your benefits, you may call 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. If that information is not available, please provide the Subscriber's identification number and date of treatment. This will enable a quick response to your inquiry.

## VIII. Disputed Claims Procedure.

If you have reason to believe your benefit determination was not in accordance with the terms of 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 date 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, 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. 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 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 response from the Director, Professional Relations or his/her designee.

If you have not received a written response (within thirty (30) days as noted above), and/or disagree with the response received, you may proceed to the Disputed Claims Review Procedure in Section IX. Your claim will remain in a Denied status pending the outcome of the review.

If you have any problem securing a review of your claim, you may also contact:

**New Hampshire Insurance Department**  
21 South Fruit Street, Suite 14  
Concord, NH 03301  
603-271-2261  
Fax: 603-271-1406  
TTY: 603-735-2964  
<http://www.nh.gov/insurance>

## IX. Disputed Claims Review Procedure.

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

You or your duly authorized representative may appeal to the Review Committee by filing a request for review within one hundred eighty (180) days after denial of your claim following the Disputed Claims Procedure. We recommend that your written request should 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 response of the Northeast Delta Dental 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 policy 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 hundred eighty (180) days after receiving the notice of internal review denial.**

Included in Appendix A attached hereto for your reference are two (2) relevant documents from the New Hampshire Insurance Department: (1) Consumer Guide to External Appeal; and (2) External Review Application Form.

Contact the New Hampshire Insurance Department to inquire about Independent External Review.

**New Hampshire Insurance Department**

21 South Fruit Street, Suite 14

Concord, NH 03301

603-271-2261

Fax: 603-271-1406

TTY: 603-735-2964

<http://www.nh.gov/insurance>

**X. Patients' Bill of Rights.**

The policy describing the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider, shall include, as a minimum, the following rights.

1. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.
2. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.
3. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
4. The patient shall be fully informed by a health care provider of his/her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his/her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, Dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

5. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.
6. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
7. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
8. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
9. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
10. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed \$15 for the first 30 pages or \$.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.
11. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.
12. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.
13. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
14. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
15. The patient shall be entitled to privacy for visits and, if married, to share a room with his/her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
16. The patient shall not be Denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be Denied on account of the patient's sexual orientation.
17. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.



18. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
19. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
20. The patient shall not be Denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.
21. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his/her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

## **XI. General Conditions.**

### **Transfer of Benefits Prohibited.**

Benefits of Enrollees are personal and cannot be transferred.

### **Right of Recovery.**

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

### **Physical Examinations.**

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

### **Doctor-Patient Relationship.**

The Enrollee has the freedom to choose any Dentist or ODP. Dentists and ODPs providing services covered 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 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. 17. of this policy.

### **Maintaining Your Privacy.**

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

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 Delta Dental's Notice of Privacy Practices which describes in detail our privacy practices, please visit our website [www.nedelta.com](http://www.nedelta.com). If you wish to have a copy mailed to you or have any questions about the privacy of your personal 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 Insurance Policy, together with the Contract Application, constitutes the entire contract of insurance. This Insurance Policy is subject to NHID and HHS requirements and modifications. 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 Policy. Any material change in this Insurance Policy shall be valid only if approved by NHID and an executive officer of Delta Dental. Any material change in this Insurance Policy shall be valid only if approved by NHID and an executive officer of 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 Insurance Policy 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 New Hampshire and its regulations. This dental plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

**Notice of Legal Action.**

You may not bring a legal action against Delta Dental under this policy until thirty (30) days after the notice of claim. No such action shall be brought after the expiration of three (3) years after the time written notice of claim is required to be furnished.

**Nonwaiver of Rights: Severability.**

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

**Incontestability.**

After two (2) years from the date of issue of this policy, no misstatements made by you in the application for such policy shall be used to void the policy or to deny a claim (as defined in the policy) commencing after the expiration of such two (2) year period.

## **XII. Assignment of Benefits.**

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

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



## The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301  
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

# CONSUMER GUIDE TO EXTERNAL APPEAL

### **What is an External Appeal?**

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, **External Appeal**, External Health Review or simply External Review.

### **What are the eligibility requirements for External Appeal?**

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.
  - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
  - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.
- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

### **What types of health insurance are excluded from External Appeal?**

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers
  - Note: Some self-funded plans provide external appeal rights which are administered by the employer.

### **Can someone else represent me in my External Appeal?**

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

### **Submitting the External Appeal:**

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website ([www.nh.gov/insurance](http://www.nh.gov/insurance)), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

### **Please submit the following documentation:**

- The completed External Review Application Form - signed and dated on page 6.
  - \*\* The Department cannot process this application without the required signature(s) \*\*
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.
- A copy of the insurance company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review.
- If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

### **Mailing Address:**

New Hampshire Insurance Department  
Attn: External Review Unit  
21 South Fruit Street, Suite 14  
Concord, NH 03301

#### **Expedited External Review Applications**

- May be faxed to (603) 271-1406, or
- Sent by overnight carrier to the Department's mailing address.

## **What is the Standard External Appeal Process and Time Frame for receiving a Decision?**

It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
  - If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.
- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20<sup>th</sup> calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
  - To request a “teleconference,” complete Section VII of the application form entitled “Request for a Telephone Conference” or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40<sup>th</sup> calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall a) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO’s review decision.

## **What is an Expedited External Appeal?**

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider’s Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient’s life or health or would jeopardize the patient’s ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer’s Expedited Internal Appeal.

**What happens when the Independent Review Organization makes its decision?**

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

**Have a question or need assistance?**

**Staff at the Insurance Department is available to help.  
Call 800-852-3416 to speak with a consumer services officer.**



## The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301  
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

### **INDEPENDENT EXTERNAL REVIEW**

#### **Appealing a Denied Medical or Dental Claim**

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at [www.nh.gov/insurance](http://www.nh.gov/insurance), or call 800-852-3416 to speak with a Consumer Services Officer.

**Have a question or need assistance?**

**Staff at the Insurance Department is available to help.  
Call 800-852-3416 to speak with a consumer services officer.**



## **SUBMITTING A REQUEST FOR EXTERNAL REVIEW**

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

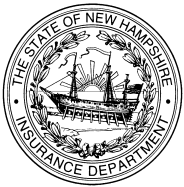
- The enclosed, completed application form - signed and dated on page 6.  
**\*\* The Department cannot process this application without the required signature(s) \*\***
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

### **Mailing Address:**

New Hampshire Insurance Department  
Attn: External Review Unit  
21 South Fruit Street, Suite 14  
Concord, NH 03301

**Expedited External Review applications may be faxed to (603) 271-1406 or sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.**



**The State of New Hampshire  
Insurance Department**

21 South Fruit Street, Suite 14; Concord, NH 03301  
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

**EXTERNAL REVIEW APPLICATION FORM**  
Request for Independent External Appeal of a Denied Medical or Dental Claim

**Section I – Applicant Information**

Patient's Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Applicant's Email: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Applicant's Phone Number(s): Daytime: (\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_

---

---

**Section II – Appointment of Authorized Representative**

**\*\* Complete this section, only if someone else is representing the patient in this appeal \*\***

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize \_\_\_\_\_ to pursue my appeal on my behalf.

\_\_\_\_\_  
Signature of Enrollee (or legal representative – Please specify relationship or title)

\_\_\_\_\_  
Date

Representative's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Representative's Phone Number(s): Daytime: (\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_

### **Section III - Insurance Plan Information**

Member's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Member's Insurance ID #: \_\_\_\_\_ Claim/Reference #: \_\_\_\_\_

Health Insurance Company's Name: \_\_\_\_\_

Insurance Company's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance Company's Phone Number: (\_\_\_\_) \_\_\_\_\_

Name of Insurance Company representative handling appeal: \_\_\_\_\_

Is the member's insurance plan provided by an employer? Yes \_\_\_\_ No \_\_\_\_

- Name of employer: \_\_\_\_\_
- Employer's Phone Number: (\_\_\_\_) \_\_\_\_\_
- Is the employer's insurance plan self-funded? Yes\* \_\_\_\_ No \_\_\_\_

**\* If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

#### **New Hampshire Premium Assistance Program**

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes \_\_\_\_ No \_\_\_\_

***If yes, please provide the Medicaid ID number & complete the following records release:***

Medicaid ID Number: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

**Section IV – Information about the Patient’s Health Care Providers**

Name of Primary Care Provider (PCP): \_\_\_\_\_

PCP’s Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

PCP’s Phone Number: (\_\_\_\_) \_\_\_\_\_

Name of Treating Health Care Provider: \_\_\_\_\_

Provider’s clinical specialty: \_\_\_\_\_

Treating Provider’s Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Treating Provider’s Phone Number: (\_\_\_\_) \_\_\_\_\_

---

---

**Section V – Health Care Decision in Dispute**

Describe the health insurer company’s decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

**Please attach the following:**

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

---

---

---

---

---

---

---

---

---

---

*Continued on next page*





## VIII – Authorization and Release of Medical Records

I, \_\_\_\_\_, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

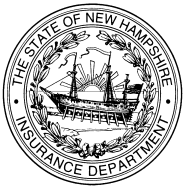
Sign Here 

\_\_\_\_\_  
Signature of Enrollee (or legal representative – Please specify relationship or title)

\_\_\_\_\_  
Date

### **Before submitting this application, please verify that you have ...**

- Completed all relevant sections of the External Review Application Form
  - If appointing an authorized representative, the patient must complete Section II.
  - If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
  - If requesting a telephone conference, Section VII must be completed.
- Signed and dated the External Review Application Form in Section VIII.
- Attached the following documents:
  - A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
  - A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
  - Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
  - If requesting an Expedited External Review, the treating Provider's Certification Form.



# The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301  
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

## PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

### NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**\*\* Expedited External Review is not available, when services have already been rendered \*\***

### GENERAL INFORMATION

Name of Treating Health Care Provider: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Licensure and Area of Clinical Specialty: \_\_\_\_\_

Name of Patient: \_\_\_\_\_



## **PROVIDER CERTIFICATION**

I hereby certify that I am a treating health care provider for \_\_\_\_\_ (hereafter referred to as “the patient”); that adherence to the time frame for conducting a standard review of the patient’s external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function; and that for this reason, the patient’s appeal of the denial by the patient’s health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (\_\_\_\_\_) \_\_\_\_\_.

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

\_\_\_\_\_  
Treating Health Care Provider’s Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*Northeast Delta Dental  
Delta Dental Plan of New Hampshire, Inc.  
One Delta Drive  
PO Box 2002  
Concord, NH 03302-2002  
[www.nedelta.com](http://www.nedelta.com)*

*Customer Service  
603-223-1234  
800-832-5700  
TTY/Hearing Impaired  
800-332-5905*

*Corporate Office  
603-223-1000  
800-537-1715  
Fax: 603-223-1199*