Northeast Delta Dental

Delta Dental Individual and Family Plan

Premium

This policy may, at any time within thirty (30) days after its receipt, be returned by delivering it or mailing it back to Delta Dental and requesting the return of your initial premium payment. If you accept the terms and conditions of the policy, simply continue paying the premium to denote this acceptance.

Term and Renewal of policy: This policy begins on the date shown as the Effective Date shown on the Contract Application and continues through the end of the Plan Year. This policy will automatically renew for a new twelve (12) month Plan Year if you continue to pay the premium. 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. This policy is also renewable at the option of Delta Dental. If we send you notice of non-renewal at least sixty (60) days before the end of the Plan Year, your policy will end on the last day of the Plan Year. The policy will not be renewed if this dental program is no longer available.

Notice to Buyer: This policy provides dental benefits only.

This policy is a Preferred Provider Option (PPO) plan and is not designed to satisfy the Pediatric Dental Benefit pursuant to the provisions of the Patient Protection and Affordable Care Act.

Northeast Delta Dental

Delta Dental Plan of New Hampshire

Policies issued in the state of New Hampshire are underwritten by
Delta Dental Plan of New Hampshire
One Delta Drive, PO Box 2002,
Concord, NH 03302-2002
All policies administered in part by Delta Dental of Wisconsin

DELTA DENTAL

Northeast Delta Dental

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

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.

DELTA DENTAL

Northeast Delta Dental

Language Assistance Services

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-5700 (ATS : 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 1-800-832-5700 (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 सवाहरू नःशल्क रूपमा उपलब्ध छ । फोन गनु 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).

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I. Welcome

This is your policy for your dental benefits. Together with your Application for Dental Coverage and the Declaration page, this policy provides the terms and conditions of your dental benefits. You should review this document carefully to be certain that you make the best use of your dental benefits. BE SURE TO KEEP THIS DOCUMENT IN A SAFE PLACE FOR YOUR FUTURE REFERENCE.

Delta Dental welcomes you to the growing number of people receiving benefits through our dental care programs. This booklet describes the benefits of your program and tells you how to use your policy. Please read it carefully to understand the benefits and provisions of your Delta Dental policy. But, before you go on, we would like you to know something about us...

Delta Dental is a not for profit organization 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.

A majority of dentists in New Hampshire participate with Delta Dental through Participating Agreements. In addition, there is a nationwide network of participating dentists available to you.

You are encouraged to take advantage of your Delta Dental policy since good oral health is an important part of your overall general health. You are also encouraged to participate in Northeast Delta Dental's innovative Health through Oral Wellness® (HOW®) program to be eligible for additional preventive dental benefits based upon a clinical risk assessment by your Dentist. Finally, you are also encouraged to obtain your Dental Care from a Participating Dentist to get the best value from your program.

YOUR COVERAGE: The coverage you have selected for your dental benefits policy uses the "Delta Dental PPO℠" network of participating dentists. Delta Dental PPO is a type of "preferred provider option" (PPO) but it allows you to go to any dentist of your choice and receive a level of benefits for covered services.

You will receive the best value from your policy if you visit a Delta Dental PPO dentist. Delta Dental PPO dentists are part of a more limited network of participating dentists who offer lower fees to their Delta Dental PPO patients. PPO dentists agree to accept Delta Dental's payment as payment in full, and further agree not to charge any difference between their fees and Delta Dental's PPO allowances back to their Delta Dental patients. Like all dentists, PPO dentists are allowed to charge for any applicable office visit copay, deductible, co-insurance, or non-covered services.

You will also receive benefits under your policy 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. Where applicable, Premier dentists may balance bill up to Delta Dental's allowance for Premier dentists in the geographic area in which the services were provided.

You may also choose to visit dental professionals who are not members of either the Delta Dental PPO or the Delta Dental Premier networks. You will receive benefits based on the lesser of the submitted charge or Delta Dental's allowance for non-participating dentists or other dental providers in the geographic area in which the services were provided. Non-participating dentists and other dental providers may bill the patient for the difference between their submitted charge and Delta Dental's payment as well as any applicable office visit copay, deductible, co-insurance and non-covered services. When there is not sufficient fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount. You may be requested to bring a claim form for your visit. Claim forms can be downloaded from www.nedelta.com or you may call 1-800-832-5700.

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

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

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

- REGISTER

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

- KNOW YOUR SCORE

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

- SHARE YOUR SCORE WITH YOUR DENTIST

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

II. Information About Your Plan

A. The Plan You Have Selected

The coverage plan you have chosen is Premium.

B. When Your Coverage Begins (the "Effective Date")

Your coverage begins on the date shown on the Declaration page, for you and any eligible dependents you enroll when you first sign up. Your Plan Year begins on the effective date and continues for a twelve (12) month period. Eligible dependents added after your Effective Date will have coverage beginning on the first day of the month following the month in which their enrollment is completed.

C. Who You May Cover Under Your Plan

You may purchase this policy if you are a New Hampshire resident and are eighteen (18) years of age or older and are covered by no other dental benefits plan.

The following persons are eligible to be enrolled for coverage under your policy:

1. The spouse to whom you are legally married.
2. Your child, by blood or by law or in the process of adoption or guardianship, under the age of twenty-six (26).
3. The child of your spouse by blood or by law or in the process of adoption or guardianship under the age of twenty-six (26).
4. Children incapable of self-support because of a physical or mental disability are eligible for coverage regardless of age; supporting documentation from a healthcare provider may be required.

See the General Eligibility Rules in Section II: K, which provide further eligibility details and which shall control in any questions regarding eligibility.

Please Note: This policy may provide coverage for eligible dependents under the age of twenty-six (26). The coverage provided under this policy is not designed to satisfy the Pediatric Dental Benefit for dependents to age nineteen (19) pursuant to the provisions of the Patient Protection and Affordable Care Act and any applicable state law.

D. The Way Your Plan Works

1. Office Visit Copay (OVCP): With a few exceptions, each time you, or a person covered under your policy, visits a dentist or other dental provider to receive services covered under your policy, you must pay to the dental provider an office visit copay of fifteen ($15) dollars. The OVCP will be applied after any applicable deductible and co-insurance.

   The OVCP will apply whenever an office visit produces a claim for which services are payable, and benefits are available, under your policy, with the following exceptions:

   - No OVCP will apply for follow-up visits for dental procedures for which no additional charge is allowed under your policy (the OVCP will apply on the first office visit only);
   - No OVCP will apply for visits producing claims for services not covered under your policy, claims for services for which you have not satisfied any applicable waiting period, or claims for services received when you were not eligible for coverage (you are responsible for the full fee);
   - No OVCP will apply for duplicate claims or disallowed services; and
   - No OVCP will apply for claims for which your policy has no annual maximum remaining (you are responsible for the full fee).

2. Deductible: Your policy includes a deductible of $100 per enrolled person, up to a maximum of $300 per family for the life of the policy. The deductible applies only to Basic and Major Restorative Services. Expenses incurred for non-covered services shall not apply toward any applicable deductible.

3. Diagnostic and Preventive Services: When you receive Diagnostic and Preventive services, this plan will pay one hundred percent (100%) of its allowed charge*, minus your office visit copay. There is no waiting period or deductible for these services. The plan payment is not counted toward the maximum amount your plan will pay each year.

4. Basic Restorative Services: There is a three (3) month waiting period under your plan before coverage for Basic Restorative services begins. This means that the enrolled person receiving the services must have been covered under your plan for at least three (3) months immediately before the services are received for the services to be covered. Once the services are eligible for coverage, your plan will pay fifty percent (50%) of the allowed charge* minus any deductible and your office visit copay, and you will be responsible for paying the rest of the charge.

5. Major Restorative Services: There is a six (6) month waiting period under your plan before coverage for Major Restorative services begins. This means that the enrolled person receiving the services must have been covered under your plan for at least six (6) months immediately before the services are received for the services to be covered. Once the services are eligible for coverage, your plan will pay twenty-five percent (25%) of the allowed charge* minus any deductible and your office visit copay, and you will be responsible for paying the rest of the charge.

6. Annual Maximum: This policy has an annual maximum of $1,500 per person per calendar year. Covered Diagnostic and Preventive services are not counted toward this maximum.

*For an explanation of the "allowed charge," see "What Your Plan Pays" section E. For details of the services covered under your plan, and any limitations or conditions that apply to those services, please see Section III, Coverage Details, Conditions and Limitations.

E. What Your Plan Pays

Your policy's payment is based on the "allowed charge" for a covered service received. The allowed charge is determined by whether the provider of the service is a participating provider with Delta Dental and the type of network to which the provider belongs. Clean Written claims must be paid in thirty (30) days; clean electronic claim must be paid within fifteen (15) days.

1. If the provider has signed an agreement to be in the Delta Dental PPO network, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO providers in the geographic area in which the services were provided. The amount you will be responsible for paying will be based on this allowed charge. Your responsibility will be any applicable office visit copay, deductible, co-insurance and non-covered services. The provider cannot receive in total more than Delta Dental's allowance for PPO dentists.

2. If the provider has signed a Delta Dental Premier participating agreement, but has not signed an agreement to be in the Delta Dental PPO network, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO providers in the geographic area in which the services were provided. Your responsibility will be the difference between your plan's payment and Delta Dental's allowance for Premier dentists in the geographic area in which the services were provided, and any applicable office visit copay, deductible, co-insurance and non-covered services. The Premier provider cannot receive more than Delta Dental's allowance for Premier dentists and has agreed not to bill you for more than that amount.

3. If the provider has not signed an agreement to be in a Delta Dental network, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for non-participating dentists or other dental providers in the geographic area in which the services were provided. Your plan's payment will be based on this amount. However, your responsibility will be the difference between your plan's payment and the provider's charge for the service, and any applicable office visit copay, deductible, co-insurance and non-covered services. It is in your best interest to discuss what the charge will be before receiving the service.

4. 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. If the fee for a procedure or service is Disallowed, it is not a benefit covered by Delta Dental, nor is it collectable from the patient by a Delta Dental participating dentist. The Exclusions and Limitations provisions in Section III identify services which are Disallowed. In each instance, a Delta Dental participating dentist agrees not to charge a separate fee.

F. Paying Your Premiums

Your premiums for this policy are shown on the Declaration page. You are responsible for paying your premiums. See Section G below for your options in paying your premiums.

Your first premium payment is due on the day your application for coverage is accepted. Thereafter, your payments will be due as shown on the Declaration page.

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which period the policy shall continue in force, subject to the right of Delta Dental to terminate in accordance with the termination provision hereof. If you pay your required premium payment in full before the end of the grace period, your coverage will not be affected.

If Delta Dental terminates your policy for non-payment of your premiums, it may, at its sole option, elect to reinstate your policy within one (1) year of the termination by accepting a premium payment from you. If your policy is reinstated, the effective date of your coverage will be the date the premium is accepted. Pro-rated premium is due for the grace period after the policy is terminated. Claims incurred after the termination of your policy and before the effective date of the reinstatement will not be covered. The time between the termination and reinstatement of your policy will not be applied to any waiting periods that had not been met prior to termination.

Delta Dental will provide written or electronic notice to the Subscriber of any increase in the premium rates for the dental benefits plan at least thirty (30) days prior to the effective date of any such increase.

G. How You May Pay for Your Coverage

You have agreed to purchase your Delta Dental coverage for twelve (12) months. Your premium for this plan may be paid as follows:

1. If you choose to pay by automatic credit card or debit card charges or by direct, automated payments from your bank account (Electronic Funds Transfer or EFT), you may choose to pay monthly, semiannually or annually, on the first day of the period you have chosen.

2. If you wish to pay by personal check, you must pay your annual premium in one payment when you submit your completed application and on each anniversary of your policy thereafter.

H. Termination of Your Plan

1. Termination by you: When you buy this policy, you are committing to keep it for at least twelve (12) months. However, you may qualify to terminate this policy in fewer than twelve (12) months but only for one of the following reasons:
   - (a) If you die, anyone else validly covered under your policy, and eligible to do so, may choose to continue the policy by reapplying for coverage. If a covered person other than you dies, the person's coverage will terminate as soon as you provide notice to Delta Dental.
   - (b) You enter military service. If anyone else covered under your policy enters the military that person's coverage may be terminated, but your policy will otherwise still be in effect.

You or your representative must notify us in writing within thirty (30) days if any of the events described above occur and you want to terminate your policy or coverage for someone under your policy. If we receive the notice within thirty (30) days, coverage under this policy will terminate for you and all persons covered under your policy on the date we receive your termination request and we will refund any unused premium.

Notice of cancellation of this policy should be submitted in writing to:

Delta Dental
PO Box 103
Stevens Point, WI 54481-0103

2. Reapplication for a new policy after termination by you for any reason other than listed below, is prohibited for a period of two (2) years:
   - (a) You became covered under a group dental benefits policy.
   - (b) You entered active duty in the military service.
3. Termination by Delta Dental: By written notice delivered to you at the last address as shown in the records of Delta Dental, Delta Dental may terminate your policy before its renewal for any of the following reasons:
   - (a) You don't pay the policy premiums when due.
   - (b) You, or someone covered under your policy commits, or attempts to commit, fraud having to do with this policy.
   - (c) You are no longer eligible.

This policy will terminate on the day after the grace period if you do not pay your premiums in full during the grace period. The effective date of the termination will be the last day of the grace period. In the event of such termination, Delta Dental will return promptly the unearned portion of any policy premium on a pro-rata basis. Reapplication for a new policy after termination by Delta Dental for any reason is prohibited for a period of two (2) years.

Delta Dental may also terminate coverage for a person covered under your policy if we become aware that the person is no longer eligible for coverage.

4. Effective Date of Termination: Except as specially referenced elsewhere in this Section II. H. or in Section II. I., coverage under this policy will terminate for you and for all persons covered under your policy on the date this policy terminates. The date of termination will be the last day of the month:
   - (a) We receive a termination request from you or your representative.
   - (b) Of your death if no one else covered under your policy wants to continue the policy and is eligible to do so.
   - (c) Of the death of a person covered under this policy, other than you, but only for the deceased person.
   - (d) Of your current policy period if you change your legal residence to a place other than New Hampshire.

I. Renewal and Non-Renewal:

This policy will automatically renew for a new twelve (12) month period if you continue to pay your premiums. If you do not want the policy to be renewed, send written notice to the address shown in Section H. 1. before the policy's renewal date. If you send notice not to renew, this policy will terminate on the last day before the renewal date. If Delta Dental does not intend to renew your policy, we will send you written notice at least sixty (60) days before the renewal date. If we do send you notice of non-renewal, your policy will end on the last day before your renewal date.

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 before the renewal date.

This policy will terminate on the day after the grace period if you do not pay your premiums in full during the grace period. The effective date of the termination will be the last day of the month for which your premiums were paid.

If any renewal premium is not paid within the time granted you for payment, a subsequent acceptance of premium by Delta Dental or by any agent duly authorized by Delta Dental to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if Delta Dental or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by Delta Dental or, lacking such approval, upon the 45th day following the date of such conditional receipt unless Delta Dental has previously notified you in writing of its disapproval of such application. The 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 to any provisions 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. The time between the termination and the effective date of the reinstatement of your policy will not be applied to any waiting periods that had not been met prior to termination.

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

You must notify Delta Dental (888-899-3736) of any event causing a change in your status or that of any other person covered under your policy. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, adoption and legal guardianship.

K. General Eligibility Rules

1. No person shall be eligible for benefits under this policy unless the person meets the eligibility requirements and is currently enrolled by you as a dependent.
2. A dependent not enrolled in your original Application for Dental Coverage may later be added only as follows:
   - (a) If the dependent was eligible to be enrolled at the time you submitted your original Application for Dental Coverage, such dependent may only be added on an anniversary date of this policy.
   - (b) If a new dependent is acquired as the result of birth, marriage, adoption or a legal guardianship, the new dependent will be eligible to be enrolled as of the first day of the month following the month in which the qualifying event occurs.
3. Newborn children are automatically covered for the first thirty-one (31) days following birth. If you enroll a newborn child during the first thirty-one (31) days, coverage for the child shall continue without interruption. If a newborn child is not enrolled during the first thirty-one (31) days, the child may be enrolled thereafter within the first thirty-one (31) days of the child's first birthday or upon annual renewal of this policy.

4. Eligibility for benefits will terminate for you and all dependents at the earliest of:

   (a) The date of termination of this policy.

   (b) The last day of the month for which payment has been made by you pursuant to the terms of this policy.

   (c) For a dependent, the last day of the month in which the dependent ceases to meet the eligibility requirements for coverage under your policy.

III. Coverage Details, Conditions and Limitations for Your Plan

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. If 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 - Plan Pays 100%

Diagnostic: Oral evaluations – two (2) times in a period of twelve (12) months.

Radiographic images – a complete series or a panoramic image once in a period of five (5) years; bitewings once in a period of twelve (12) months; images of individual teeth as necessary.

Brush biopsy.

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

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

Fluoride treatment – two (2) times in a period of twelve (12) months through age eighteen (18).

Space Maintainers.

Sealants.

NOTE: As a participant in Northeast Delta Dental's Health through Oral Wellness® (HOW®) program, you may be eligible for additional preventive benefits, subject to the annual maximum, deductible, co-insurance and/or co-pays and other standard policy provisions. These additional preventive benefits may include more frequent prophylaxis (cleanings); fluoride treatments' sealants; periodontal maintenance; and full mouth debridement; and availability of caries susceptibility tests; oral hygiene instruction; nutritional counseling; and tobacco cessation counseling.

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

Diagnostic and Preventive benefits are excluded from the annual maximum.

Diagnostic and Preventive Benefits - Conditions and Limitations:

- If the fee for a procedure or service is "**Disallowed**," it is not payable by the Plan, nor collectable from the patient by a participating dentist. Participating dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**," it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a benefit under the Plan.

1. Oral evaluations of any kind are Disallowed if performed within ninety (90) days after periodontal surgery by the same dentist/dental office.
2. Comprehensive oral evaluation and comprehensive periodontal evaluation are a covered benefit once in a lifetime (unless there is history of no care for three (3) years) and is counted toward your oral evaluation benefits. Subsequent comprehensive oral evaluations are covered as a periodic oral evaluation and are subject to frequency limitations.

3. Oral evaluations for patients under age three (3), when performed on the same date of service by the same dentist/dental office as a comprehensive evaluation is Disallowed.
4. Pre-diagnostic services, such as screening and assessment of a patient, are not covered benefits. Payment for a screening and assessment is Disallowed if billed with an oral evaluation.
5. A panoramic radiographic image is a covered benefit once in a five (5) year period for Eligible Persons age six (6) and over. The fee for a panoramic radiographic image performed on patients under the age of six (6) is denied. The patient is responsible for the fee.
6. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings and/or occlusal), is considered a complete series for time limitations and any fee in excess of the fee for a complete series is Disallowed.
7. Payment for additional periapical and/or occlusal radiographic images within a thirty (30) day period of a complete series or panoramic image, unless there is evidence of trauma, is Disallowed.
8. 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.
9. Routine working and final treatment radiographic images taken for endodontic therapy by the same dentist/dental office are considered a component of the complete treatment procedure and separate fees are Disallowed on the same date of service.
10. If the fee for bitewings, periapicals, intraoral occlusal and extraoral radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.
11. Fees for additional radiographic images taken by the same Dentist/dental office within sixty (60) days of vertical bitewings are Disallowed.
12. Cone beam imaging and interpretation are not covered benefits. Cone beam imaging, when performed by the same dentist/dental office as an image interpretation, is combined as a cone beam capture and interpretation. Any fees in excess of the combined code are Disallowed.
13. Cephalometric images, oral/facial photographic images and diagnostic casts are not a covered benefit. The patient is financially responsible.
14. Oral cancer screening, except brush biopsy, is not a covered benefit.
15. Oral Pathology laboratory services are a covered benefit when accompanied by a pathology report. If more than one of these procedures is billed for the same tooth site on the same day, by the same dentist/dental office, payment is allowed for the most inclusive procedure and the less inclusive procedure is Disallowed.
16. A prophylaxis done on the same date by the same dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Disallowed.
17. Laboratory tests for caries susceptibility are not a covered benefit and 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. Benefits for caries risk assessment are Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same dentist/dental office, or if performed with other risk assessments by the same dentist/dental office.
19. Genetic tests for susceptibility to oral diseases are Denied.

20. The replacement or repair of space maintainers and orthodontic appliances is not a covered benefit. The patient is financially responsible.

21. Space maintainers are a covered benefit once in a lifetime per tooth for eligible dependents fifteen (15) years of age or younger when a space is being maintained for an erupting permanent tooth.

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 seven (7) and younger. Fees for distal shoe space maintainers performed on patients eight (8) and older are Denied.

24. Sealant benefit limitation:

    (a) The sealant benefit is provided only to eligible dependents eighteen (18) years of age or younger.

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

    (c) The sealant benefit is provided no more than once in a three (3) year period per tooth.

    (d) Sealants are Disallowed within two (2) years of initial placement on the same tooth by the same dentist/dental office. A sealant is Disallowed if performed by the same dentist/dental office, on the same date of service as a restoration which includes the occlusal surface.

25. 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.

26. Nutritional counseling, tobacco counseling and oral hygiene instructions are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

Basic Restorative Benefits - Plan Pays 50%

Restorative:	Amalgam (silver) restorations (fillings). Resin restorations are a covered benefit on anterior teeth and the buccal surface of bicuspids only. Prefabricated stainless steel crowns.
Periodontal Maintenance:	Prophylaxis (cleaning) – two (2) times in a period of twelve (12) months (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive Benefits, or periodontal maintenance under Basic Restorative benefits. A full mouth debridement under Diagnostic and Preventive Benefits is covered once in a lifetime and, when performed, is counted towards your prophylaxis benefit.
Clinical Crown Lengthening:	Once per tooth per lifetime.
Oral Surgery:	Routine extractions and covered surgical procedures.
Denture Repair:	Repair of removable complete or partial denture to its original condition.
Palliative Treatment:	Minor emergency treatment for the relief of pain.
Anesthesia:	General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with: an extraction; a tooth reimplantation; surgical exposure of a tooth; surgical placement of an implant body; biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

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

Basic Restorative benefits available after a three (3) month waiting period.

Basic Restorative Benefits - Conditions and Limitations:

- If the fee for a procedure or service is "**Disallowed**," it is not payable by the plan, nor collectable from the patient by a participating dentist. Participating dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**," it is not payable by the plan, but is chargeable to the patient as the procedure or service is not a benefit under the plan.

1. Restorations are a covered benefit only once per surface in a period of twenty-four (24) months, irrespective of the number or combination of procedures performed. The replacement of amalgam (silver) or resin (white) restorations within twenty-four (24) months by the same dentist/dental office is Disallowed.
2. Resin restorations in posterior teeth (white fillings in bicuspids and molars) are not covered unless specified as a covered benefit in the Outline of Benefits. If a resin restoration is performed on posterior teeth, other than the buccal surface of bicuspids, an allowance will be paid equal to an amalgam (silver) restoration, and the patient will be responsible for any additional fee.
3. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Delta Dental participating dentist agrees not to charge a separate fee.

4. Protective restorations are Disallowed if performed on the same date of service as a definitive restoration or palliative treatment by the same dentist/dental office.

5. Prefabricated stainless steel crowns are a covered benefit once in a period of two (2) years. The fee for replacement of a stainless steel crown by the same dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Disallowed.

6. A prefabricated resin crown is a covered benefit on primary anterior teeth only. If performed on primary posterior teeth, an allowance will be paid equal to the fee for a prefabricated stainless steel crown.

7. A prophylaxis done on the same date by the same dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Disallowed.

8. Fees for periodontal maintenance, when billed within three (3) months of periodontal therapy by the same dentist/dental office, is Disallowed.

9. Clinical crown lengthening is a covered benefit once per tooth per lifetime and only when performed in a healthy periodontal environment, on natural teeth only, in which bone must be removed for placement of the restoration, 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 final restoration placement.

10. 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.

11. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure and is Disallowed.

12. Alveoloplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same dentist/dental office, in the same surgical area on the same date.

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

14. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Additional pins in the same tooth are Disallowed. Pin retention is Disallowed when billed in conjunction with a core build-up.

15. Exploratory surgical services are not a covered benefit. The patient is financially responsible.

16. The fee for repairs of complete or partial dentures cannot exceed half the fees for a new appliance. Any excess fee billed by the same dentist/dental office is Disallowed on the same date of service.

17. The fee for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same dentist/dental office is Disallowed.

18. A frenulectomy or frenuloplasty is a covered benefit once per site per lifetime and is Disallowed when billed on the same date as any other surgical procedure, including soft tissue graft, in the same surgical area by the same dentist/dental office.

19. 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.

20. Adjustment or repair of a denture is a covered benefit twice in a twelve (12) month period for patients age sixteen (16) and older. Fees for an adjustment or repair of a denture is Disallowed if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is Disallowed on the same date of service.

21. The fee for palliative treatment is Disallowed when submitted with all procedures except radiographic images and diagnostic codes and is performed by the same dentist/dental office on the same date.

22. 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.

23. 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.

24. 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 and are Disallowed.

25. Local anesthesia in conjunction with any procedure by the same dentist/dental office is considered part of the overall procedure and fees are Disallowed.

26. A consultation is a covered benefit only if performed by a dentist that is not performing further treatment. 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. Recementation of a space maintainer is a covered benefit once in a lifetime per appliance.

28. Recementation of an inlay, onlay, crown or partial coverage restoration is a covered benefit once per tooth per lifetime. Payment is Disallowed when performed within six (6) months of the initial placement by the same dentist/dental office.

29. Recementation of a cast or prefabricated post and core is a covered benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same dentist/dental office, or if performed on the same date of service of a crown recementation by the same dentist/dental office.

30. Interim caries arresting medicament application is not a covered benefit.

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

Major Restorative Benefits - Plan Pays 25%

Restorative Crowns and Onlays:	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.
Endodontics:	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.
Periodontics:	Scaling and root planing; gingivectomy; gingival flap procedure; osseous surgery; distal wedge; and soft tissue graft.
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and reline of such prosthetic appliances; core build-ups; cast and prefabricated posts and cores; and crown repairs.
Implant Services:	Surgical placement of an endosteal implant body including healing cap.
Implant Supported Prosthetics:	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

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

Major Restorative benefits available after a six (6) month waiting period.

Major Restorative Benefits - Conditions and Limitations:

- If the fee for a procedure or service is "**Disallowed**," it is not payable by the plan, nor collectable from the patient by a participating dentist. Participating dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**," it is not payable by the plan, but is chargeable to the patient as the procedure or service is not a benefit under the plan.

1. Onlays or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not covered benefits for eligible dependents under the age of twelve (12).
2. Time limitations:
   (a) One (1) complete or immediate maxillary (upper) and one (1) complete or immediate mandibular (lower) denture in a period of seven (7) years.
   (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in a period of seven (7) years.
   (c) A removable or fixed partial denture in a period of seven (7) years unless the loss of additional teeth requires the construction of a new appliance.
   (d) Crowns, onlays, core build-ups, and post and cores are a covered benefit once per tooth in a period of seven (7) years.
   (e) The period of seven (7) years referred to in (a), (b), (c), and (d) above is to be measured from the date the service was last performed.
3. Inlays are not a covered benefit. An allowance will be paid equal to an amalgam (silver) restoration. If an inlay is performed, the patient is responsible for any additional fee.
4. Periodontal scaling and root planing is a covered benefit per quadrant (maximum of two (2) quadrants per office visit) once in a period of twenty-four (24) months. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same dentist/dental office. The fee for periodontal scaling and root planing is Disallowed if performed within four (4) weeks of periodontal surgery by the same dentist/dental office or if more than two (2) quadrants are treated in one office visit.

5. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. The fee for surgical re-entry by the same dentist/dental office within three (3) years is Disallowed.
6. A prophylaxis done on the same date by the same dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures and the fee is Disallowed.
7. When more than one periodontal surgical procedure is provided on the same teeth on the same day, benefits will be based upon, but not limited to, the most inclusive procedure.
8. An apexification or an apicoectomy is a covered benefit once per tooth in a period of three (3) years. Retreatment by the same dentist/dental office within twenty-four (24) months is Disallowed.
9. 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.
10. Retrograde fillings are a covered benefit once per root per three (3) years. Retreatment within twenty- four (24) months of the original procedure by the same dentist/dental office is Disallowed.
11. Periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same dentist/dental office as an apicoectomy, retrograde filling and/or root amputation is Disallowed.
12. Root canal therapy is a covered benefit once in a period of three (3) years. Retreatment of root canal therapy by the same dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same dentist/dental office are Disallowed.
13. Anterior deciduous root canal therapy is not a covered benefit.
14. Root canal therapy is not a benefit in conjunction with overdentures and benefits are Denied. The patient is responsible for the additional fee.
15. 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.
16. Direct or indirect pulp caps are a covered benefit once in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same dentist/dental office is considered part of a single complete restorative procedure and the fee for the pulp cap is Disallowed.
17. 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.
18. 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.
19. A partial pulpotomy is a covered benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within thirty (30) days on the same tooth by the same dentist/dental office as root canal therapy.
20. 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.

21. Gingivectomy, gingival flap procedure, bone replacement graft in conjunction with flap surgery, mesial/distal wedge, connective tissue graft or soft tissue graft procedure is a covered benefit once in a period of three (3) years on natural teeth. The charge for surgical re-entry by the same dentist/dental office within three (3) years is Disallowed.

22. 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.

23. Root amputation performed in conjunction with an apicoectomy by the same dentist/dental office is Disallowed.

24. Removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same dentist/dental office.

25. A core build-up is a covered benefit once in a seven (7) year period per tooth for patients age twelve (12) and older. The fees for core build-ups are Disallowed when build-ups are performed in conjunction with inlays, 3/4 crowns or onlays.

26. An indirectly fabricated and prefabricated post and core in addition to a crown is payable only on an endodontically treated tooth and is a covered benefit once in a seven (7) year period for patients age twelve (12) and older. Fees for post and cores are Disallowed when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth.

27. Fees for a crown, inlay and onlay repair completed on the same date of service as a new crown, inlay or onlay are Disallowed. Fees for crown, inlay and onlay repair are Disallowed within twenty-four (24) months of the original restoration.

28. A provisional crown or provisional implant crown is considered part of a crown procedure when performed by the same dentist/dental as a permanent crown, and a separate fee is Disallowed.

29. Removable or fixed, complete or partial dentures are not covered benefits for patients under the age of sixteen (16).

30. The relining of a denture is a covered benefit twice in a period of twelve (12) months for patients age sixteen (16) and older. The fee for reline of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the dentist/dental office is Disallowed on the same date of service.

31. The rebase of a denture is a covered benefit once in a period of seven (7) years for patients age sixteen (16) and older. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is Disallowed on the same date of service.

32. The reline or rebase of a denture is Disallowed if performed within six (6) months of initial placement by the same dentist/dental office.

33. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are covered benefits. The patient will be responsible for any additional fee.

34. Recementation of a fixed partial denture is a covered benefit once in a lifetime. Fees for recementation of fixed partial dentures are Disallowed if done within six (6) months of the initial placement by the same dentist/dental office.

35. An interim complete denture is not a covered benefit. Fees are Disallowed if billed in conjunction with a permanent appliance.

36. An interim partial denture is a covered benefit for eligible dependents through age sixteen (16) on anterior permanent teeth only. The fee for an interim partial denture is Disallowed if billed in conjunction with a permanent appliance on the same day by the same dentist/dental office.

37. 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 a dental consultant's review.

38. Tissue conditioning is a covered benefit two (2) times in a period of three (3) years. The fee for tissue conditioning is Disallowed if performed on the same date of service as a denture rebase or reline by the same dentist/dental office.

39. An implant body, including healing cap, is a covered benefit once in a lifetime per site. The fees for an implant are Disallowed if the implant is part of a fixed partial denture on natural teeth.

40. Implant services, when covered, are not a covered benefit for patients under the age of sixteen (16).

41. When implant services are covered, eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. The patient will be responsible for any additional fee.

42. Removal of an implant is a covered benefit once in a lifetime per tooth site.

43. Bone replacement graft for ridge preservation is not a covered benefit.

44. Cleaning and inspection of a removable complete or partial denture is not a covered benefit. The fee for cleaning and inspection of a removable complete or partial denture is Disallowed when done by the same dentist/dental office on the same date of service as a reline or rebase of the denture.

45. Post removal is Disallowed if performed within thirty (30) days of an endodontic treatment by the same dentist/dental office performing the endodontic retreatment.

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

IV. General Conditions and Limitations

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

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

   (b) Services that are determined by Delta Dental to be rendered for cosmetic reasons, such as bleaching or whitening of teeth, placement of veneers, correction of congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)

   (c) Services completed when you or the enrolled dependent were not covered under the 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 that are not within the scope of the license of the dentist or of the license of the person supervised by the dentist, unless otherwise required New Hampshire by law.

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

   (f) Charges for: (i) hospitalization; (ii) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section III., Basic Restorative Benefits); (iii) preventive control programs; (iv) provisional splinting; (v) myofunctional therapy; (vi) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (vii) equilibration; and (viii) gnathological reporting.

   (g) Charges for failure to keep a scheduled visit with the dentist.

   (h) Charges for completion of forms. Such charges shall not be made to a subscriber or eligible dependent by Delta Dental participating dentists.

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

   (j) Dental care or supplies which are not within the classification of benefits for the option selected.

   (k) Appliances, procedures, or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, restoring, or maintaining occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv) correcting congenital or developmental malformations; or (v) esthetic purposes. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.

   (l) Payments of benefits incurred by the subscriber and/or eligible dependent(s) after the date on which the subscriber 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) All services, including evaluations and radiographs, performed for orthodontic purposes.

   (p) Temporary services or incomplete treatment.

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

   (r) Consultation with medical health care professional and dental case management for addressing appointment compliance barriers and care coordination are part of the overall 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.

(s) Case presentation and treatment planning.

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

(u) Maintenance and cleaning of a maxillofacial prosthesis (extra-oral or intra-oral).

2. The dental benefits provided by Delta Dental shall be limited as follows unless otherwise required by law:

(a) Dental care rendered by anyone other than a dentist shall not be a covered benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as the treatment is rendered under the supervision and guidance of a dentist, in accordance with generally accepted dental practice standards.

(b) Optional Dental Care: In all cases in which the subscriber or eligible dependent agree, after consultation with their dentist, to more expensive dental care than is customarily provided, Delta Dental will pay based on the applicable co-insurance percentage for the dental care which is customarily provided to restore the tooth to contour and function. The subscriber or eligible dependent shall be responsible for the remainder of the dentist's fee.

(c) Predetermination does not guarantee payment. Payment is based upon eligibility, benefits selected, allowable charges at the time the dental care is rendered and the dentist's participating status with Delta Dental.

(d) Services completed or in progress at the subscriber's or eligible dependent's date of death will be paid in full to the limit of 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) Maximum Payment:

(i) The maximum amount payable in any calendar year, or any portion thereof, for benefits under Basic Restorative and Major Restorative Benefits shall be limited to $1,500.

(ii) Delta Dental's payment shall be reduced by any applicable deductible, co-insurance and copay.

(g) Specialized techniques including, but not limited to, precision attachments, overdentures and procedures associated therewith, and personalizations or characterization are excluded. Patient will be responsible for part of or the entire fee for these services.

(h) Diagnostic casts (study models) and/or photographs are not a covered benefit by Delta Dental.

(i) Benefits are paid for amalgam (silver) restorations for the treatment of caries. Resin (white) restorations of posterior teeth are optional and the patient will be responsible for any additional fee. If the teeth can be restored with such materials, any gold restorations, crowns, inlays, or onlays are also considered optional. You or your enrolled dependent will be responsible for any additional fee.

(j) Written notice of sickness or of injury must be given to Delta Dental at its principal office, or to any authorized agent of 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.

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

(m) The Date of Incurred Liability refers to the date a covered service is subject to the applicable office visit co-pay, deductible, co-payment percentage, maximum benefit, and limitations. The total cost of the service is applied to the coverage period during which the service is completed, irrespective of the coverage period 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 and Onlays — Total cost for crowns and onlays shall be incurred on the date that the crown or onlay is cemented.

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

(iii) Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the said appliance is delivered to the patient.

(iv) Endodontics — Total cost for endodontic treatment shall be incurred when the canal is filled to completion.

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

(vi) Implant Prosthetics — Total cost for the prosthetic portion of an implant shall be incurred on the date that the said appliance is cemented or delivered to the patient.

V. General Claims Inquiry

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

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

VI. 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, Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002. You may also submit your request by standard mail.

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

The Director, Professional Relations, or his/her designee, may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is Denied in any respect, you will be furnished with a written notice of the decision within thirty (30) days after receipt of the disputed claim. The written notice will include:

1. The specific reason(s) for denial.
2. The specific reference to the provision of this Agreement upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the Director, Professional Relations' response.

If you have not received a written response within thirty (30) days as noted above and/or disagree with the notice received, you may proceed to the Disputed Claims Review Procedure in Section VII. 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 the New Hampshire Insurance Department at: 21 South Fruit Street, Suite 14, Concord, New Hampshire 03301 or call (800) 852-3416 (toll-free).

VII. Disputed Claims Review Procedure

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

You or your duly authorized representative may appeal to the Review Committee by filing a request for review within one hundred eighty (180) days from receipt of the Director, Professional Relations' notice denying the claim, or, if no date is given, within six (6) months of the notice. 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 the response of Northeast Delta Dental's Director, Professional Relations or his/her designee was incorrect. Within thirty (30) days after receipt of your request, the Review Committee will provide its written decision, including specific reasons for the decision.

In addition, or as an alternative to the written request, you may request a hearing from the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by a lawyer or other representative, to request a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. You or your representative may review the 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
www.nh.gov/insurance

VIII. 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:

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 or 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 or 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 or 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 or 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.

IX. General Conditions

Transfer of Benefits Prohibited:

Benefits under your policy are personal to you and the persons enrolled under your policy and cannot be transferred to any other individual.

Subrogation/Right of Recovery:

Delta Dental will succeed to the right of any person covered under your policy to recover for expenses paid under your policy from any third person or organization that may be liable. You, or the person covered under your policy having the right to recover such expenses, are required to authorize Delta Dental to do whatever is necessary to secure such rights.

Doctor-Patient Relationship:

Any person enrolled under your policy has the freedom to choose any dentist. Dentists rendering services under this policy are independent contractors and will maintain the traditional doctor-patient relationship. The dentist will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment:

If anyone enrolled under your policy loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment.

Maintaining Your Privacy:

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

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

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

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

X. Assignment of Benefits

For benefits provided to you or a person enrolled under your policy for covered services provided outside the Delta Dental geographic area, benefits will be paid directly to the covered service provider if the provider is a participating dentist with the local Delta Dental company. If the dentist does not participate with the local Delta Dental company, payment will be made to you unless the state in which the services are rendered requires that assignment of benefits be honored and Delta Dental receives written notice of an assignment to the provider on the claim form before payment for benefits is made.

XI. General Policy Provisions

(a) 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.

(b) Entire Policy; Changes: This policy, including the Declaration page, constitutes the entire insurance policy between you and Delta Dental. Changes to this policy may only be made by written amendments signed by Delta Dental.

(c) Notice of Legal Action: No action at law or in equity shall be brought to recover a claim on this policy prior to the expiration of sixty (60) days after the claim has been filed or written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(d) 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.

(e) Any condition, limitation or other provision of this policy which is found to be illegal or unenforceable for any reason will not affect the rendering provisions of this policy.

(f) Incontestability: After two (2) years from the date of issue of this policy, no misstatements, except fraudulent 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.

Northeast Delta Dental
Delta Dental Plan of New Hampshire, Inc.
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
www.nedelta.com

Delta Dental Covers Me
www.deltadentalcoversme.com

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

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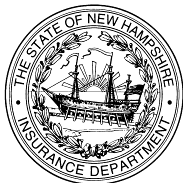


The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

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), 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 20th 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 40th 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, 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.

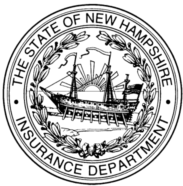
☐ If requesting an Expedited External Review, the treating Provider's Certification Form.

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.

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Continued on next page

Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes ____ No ____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select “Yes” below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

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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.

____ __________________

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

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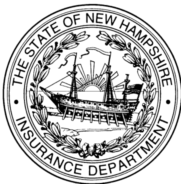
Before submitting this application, please verify that you have …

☐ 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