Northeast Delta Dental

Delta Dental Individual and Family Plan

Premium

This policy may, at any time within ten (10) 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 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 Vermont

Policies issued in the state of Vermont are underwritten by
Delta Dental Plan of Vermont, Inc.
One Delta Drive, PO Box 2002
Concord, NH 03302-2002
All policies administered in part by Delta Dental of Wisconsin d/b/a Wyssta Services

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VTIAF-Premium 0917

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 1-800-832-0075 (رقم هاتف الصم والبكم: 1-800-233-5095).

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 होस:् 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 Vermont 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. 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 Vermont resident and are eighteen (18) years of age or older.

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

1. The spouse to whom you are legally married;
2. Your partner in a civil union recognized as valid under state law;
3. Your child, by blood or by law or in the process of adoption or guardianship, under the age of twenty-six (26);
4. The child of your spouse, or your partner in a civil union recognized as valid under state law, by blood or by law or in the process of adoption or guardianship under the age of twenty-six (26);
5. 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 twenty-one (21) 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.
   - No OVCP will apply for claims for which your policy has no annual maximum remaining (you are responsible for the full fee).

2. Lifetime Deductible: Your plan includes a lifetime deductible of $100 per enrolled person, up to a maximum of $300 per family. 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 the 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 claims 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.

You have a ten (10) day premium grace period for any monthly premium payment you must make, and you have a thirty-one (31) day premium grace period if you pay premiums annually or semi-annually. If you pay your required premium payment in full before the end of the grace period, your coverage will not be affected. If you don't pay your premium in full by the end of your grace period, your coverage will end on the last day of the applicable grace period. Pro-rated premium is due for the grace period.

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.

The effective date of termination of your policy shall be the last day of the applicable grace period in the event you do not pay the policy premium when due, and in all other cases, not be less than five (5) days after written notice of termination from Delta Dental. 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 effective date of termination will be the last day of the month:

   (a) Of your death if no one else covered under your policy wants to continue the policy and is eligible to do so.

   (b) Of the death of a person covered under this policy, other than you, but only for the deceased person.

   (c) Of your current policy period if you change your legal residence to a place other than Vermont.

I. Renewal and Non-Renewal:

1. 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.

2. 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.

3. 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 other 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 sixty (60) days following birth. If you enroll a newborn child during the first sixty (60) days, coverage for the child shall continue without interruption. If a newborn child is not enrolled during the first sixty (60) 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.

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, are 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. 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.

17. 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.

18. 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 same the dentist/dental office is Disallowed on the same date of service.

19. 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.

20. 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.

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 if 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 buildups; 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 office 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. Otherwise, the fee for cleaning and inspection of a removable complete or partial denture is Denied.

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 by Vermont 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 Vermont 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. If Coordination of Benefits is involved, the amount of payment may change dramatically depending on the payment made by the primary carrier.

(d) Services completed or in progress at the subscriber's or eligible dependent's date of death will be paid in full to the limit of 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 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. Coordination of Benefits (Dual Coverage)

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

When a person covered under your policy is covered under another health care program, the following rules shall be followed to establish the order of determining liability.

1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.

2. The plan covering the person solely as the Subscriber shall determine its benefits before the plan which covers the person solely as a dependent.

3. The plan covering the person solely as a dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the person solely as a dependent child of the parent whose birthdate occurs later in a calendar year (the "Birthday Rule"). A parent's year of birth is not relevant. If both parents have the same birthdate (month and day), the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. If the other health care program does not use the Birthday Rule, then that plan's provisions will determine the order of liability.

4. If paragraphs 2 and 3 above do not establish an order of benefit determination, the benefits of the plan which has covered the person for the longer period of time shall be determined first.

5. The order of payment for the claims of an enrolled dependent child of divorced or legally separated parents will be as follows:

   (a) The plan of the parent with custody.

   (b) The plan of the spouse/civil union partner of the parent with custody (step-parent).

   (c) The plan of the parent without custody.

   (d) If the parents have joint legal custody, paragraph 3 above will apply.

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

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

   (a) Delta Dental may use reasonable efforts to determine the existence of other benefit programs but shall be under no obligation to do so.

   (b) The person covered under your policy is required to furnish Delta Dental with information relative to any other health care program in order to determine liability.

7. For the purposes of determining the applicability and implementing the terms of this provision in the Agreement, Delta Dental may release or obtain from any third party, without consent or notice, any information which it deems to be necessary to determine its liability. Delta Dental shall be free from any liability that might arise in relation to such action.

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

VI. 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.

VII. 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 recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, 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 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 VIII. Your claim will remain in a Denied status pending the outcome of the review.

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

The Vermont Department of Financial Regulation
Insurance Division, Consumer Services
(800) 964-1784 (toll free in Vermont)

The Office of Health Care Ombudsman
1-800-917-7787 (toll free in Vermont)

VIII. Disputed Claims Review Procedure

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

You or your duly authorized representative may appeal to the Review Committee by filing a request for review 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 recommended 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 specifically 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 review no later than 120 days after receiving this notice.

Call the Insurance Division of Vermont Department of Financial Regulation, consumer insurance assistance line at (800) 964-1784 to ask for this review. If it is not an emergency, call between 7:45 a.m. and 4:30 p.m., Monday through Friday. If it is urgent or an emergency, call 24 hours a day, 7 days a week, including holidays. The recording will tell you how to reach the person on call.

Vermont Department of Financial Regulation
Insurance Division
89 Main Street
Montpelier, Vermont 05620-3601 (800) 964-1784

The Department of Health Care Ombudsman also can provide information and help with appeals.

The Office of Health Care Ombudsman
P.O. Box 1367
264 North Winooski Avenue
Burlington, Vermont 05402
Voice: Toll-free: (800) 917-7787 or (802) 863-2316
TTY: Toll-free: (888) 884-1955 or (802) 863-2473

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 assignments 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 Vermont and its regulations.

(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 an executive officer on behalf of Delta Dental.

(c) Notice of Legal Action: No action may be brought to recover a claim under this Policy prior to the expiration of sixty (60) days after the claim has been filed in accordance with the requirements of this policy. In no event shall any action be brought on a claim more than three (3) years after the completed claim has been filed.

(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 remaining provisions of this policy.

(f) After three (3) 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 three (3) year period.

(g) In consideration of waiving physical examination of you or your eligible dependent and as a condition precedent to the approval of claims hereunder, Delta Dental shall be entitled to receive, to such extent as may be lawful and at its own expense, from any attending or examining dentist or from hospitals in which a dentist's service is rendered, such information and records relating to attendance of, or examination of, or treatment rendered to such person as may be required in the administration of such claim. At its own expense, Delta Dental may require that you or your eligible dependent be examined by a dental consultant retained by Delta Dental in or near his community or residence. Delta Dental shall, in every case, preserve the confidentiality of such information except as is necessary for the proper administration of Delta Dental programs.

XII. Vermont Mandatory Civil Unions

Purpose:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This provision is to comply with Vermont law.

Definitions, Terms, Conditions, and Provisions:

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

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

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

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

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

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

Caution: Federal Law Rights May or May Not Be Available

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

Northeast Delta Dental
Delta Dental Plan of Vermont, 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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