# TABLE OF CONTENTS

INTRODUCTION AND GENERAL INFORMATION ........................................................................................................... 1
   (A) INTRODUCTION .................................................................................................................................................. 1
   (B) GENERAL INFORMATION ................................................................................................................................. 1

SECTION I. DEFINITIONS ........................................................................................................................................... 2

SECTION II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE 4
   (A) ELIGIBILITY ...................................................................................................................................................... 4
   (B) ENROLLMENT .................................................................................................................................................. 5
   (C) TERMINATION OF COVERAGE ........................................................................................................................ 8
   (D) CONTINUATION OF COVERAGE ..................................................................................................................... 8

SECTION III. BENEFITS .............................................................................................................................................. 11
   (A) Coverage A - Diagnostic and Preventive Benefits ......................................................................................... 11
   (B) Coverage B - Basic Benefits ........................................................................................................................ 13
   (C) Coverage C - Major Benefits ......................................................................................................................... 15
   (D) Coverage D - Orthodontic Benefits .............................................................................................................. 16

SECTION IV. GENERAL EXCLUSIONS AND LIMITATIONS ....................................................................................... 17
   (A) EXCLUSIONS .................................................................................................................................................. 17
   (B) LIMITATIONS ................................................................................................................................................. 18

SECTION V. CONDITIONS .......................................................................................................................................... 19

SECTION VI. COORDINATION OF BENEFITS (DUAL COVERAGE) ........................................................................... 20

SECTION VII. GENERAL PROVISIONS .................................................................................................................. 21

SECTION VIII. AMENDMENT AND TERMINATION ............................................................................................... 22

DENTAL BENEFIT OPTIONS .................................................................................................................................. 23
INTRODUCTION AND GENERAL INFORMATION

(A)  INTRODUCTION

The purpose of this Plan Document is to provide Participating Groups offering a HealthTrust Dental Plan with a comprehensive description of the Benefits available to Eligible Persons. The actual coverage is based upon the election made by the Participating Group and is identified on the Dental Transmittal provided by HealthTrust to each Participating Group. This coverage is provided by HealthTrust, Inc. (“HealthTrust”), while Delta Dental Plan of New Hampshire (“Delta Dental”) administers the Plan and pays the claims.

HealthTrust has sole and exclusive discretion in interpreting the Benefits covered under the Plan and the other terms, conditions, limitations, and exclusions set out in this Plan Document and in making factual determinations related to the Plan and its Benefits. HealthTrust may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Plan. HealthTrust reserves the right to change, interpret, modify, withdraw, or add benefits to this Plan without prior notice to, or approval by, Participating Groups or Eligible Persons. HealthTrust further reserves the right, at its discretion at any time, to terminate this Plan by giving advance notice of at least 30 days to Participating Groups.

The legal documents governing the Plan consist of the Plan Document and the Dental Plan Description. Any change or amendment to the Plan, its Benefits or its terms and conditions, must be made solely in a written amendment to the Plan, signed by an authorized representative of HealthTrust, as described in Section VII, AMENDMENT AND TERMINATION. No person or entity has any authority to make any oral changes or amendments to the Plan.

(B)  GENERAL INFORMATION

Delta Dental PPO and Delta Dental Premier Dentist National Networks

Delta Dental is affiliated with a national association known as Delta Dental Plans Association which provides dental care programs in all states and U.S. territories.

A substantial majority of Dentists nationwide participate with Delta Dental through Participating Dentist agreements. The Participating Dentist networks under the Plan include both the Delta Dental PPO and Delta Dental Premier networks.

The Benefits described in this Plan Document will be available to Eligible Persons in accordance with the terms and conditions of eligibility and enrollment outlined in Section II.

Plan Year. Each Participating Group will select either a January (January 1 through December 31) or July (July 1 through June 30) Plan Year for its participation in the Plan. The initial Plan Year for each Participating Group will be the period commencing with the first of the month in which participation in the Plan begins and ending with the next December 31 or June 30, depending on whether the Participating Group selects a January or July Plan Year. Thereafter, the Plan Year will be each successive twelve (12) month period.

Selected Benefits. Selected Benefits will be the specific coverage option(s) selected by the Participating Group at the beginning of each Plan Year from the Dental Benefit Options which are available under the Plan. Selected Benefits for the Participating Group are identified on the Dental Transmittal provided by HealthTrust.

Name, business address, and telephone number of HealthTrust:

<table>
<thead>
<tr>
<th>HealthTrust</th>
<th>603.226.2861</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Triangle Park Drive</td>
<td>800.527.5001</td>
</tr>
<tr>
<td>P.O. Box 617</td>
<td></td>
</tr>
<tr>
<td>Concord, NH 03302-0617</td>
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Name, business address, and telephone number of Delta Dental:

<table>
<thead>
<tr>
<th>Delta Dental Plan of New Hampshire</th>
<th>603.223.1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Delta Drive</td>
<td>800.537.1715</td>
</tr>
<tr>
<td>P.O. Box 2002</td>
<td></td>
</tr>
<tr>
<td>Concord, NH 03302-2002</td>
<td></td>
</tr>
</tbody>
</table>

For assistance in understanding this Plan Document, contact either HealthTrust or Delta Dental.
SECTION I. DEFINITIONS

(A) **Anniversary Date** means the first day of the Participating Group’s Plan Year. This means that the Anniversary Date is January 1 for Participating Groups with a January Plan Year and July 1 for Participating Groups with a July Plan Year.

(B) **Benefits** means the classifications of covered Dental Care referred to in this Plan Document and any attached appendices which are to be rendered to Eligible Persons enrolled in the Plan.

(C) **Claims Administrator** means Delta Dental Plan of New Hampshire to whom claims administration of this Plan has been assigned.

(D) **Co-payment** means the amount of Dental Care cost that the Eligible Person is required to pay as specified on the Dental Transmittal.

(E) **Deductible** means the portion of the charge for covered Dental Care which the Eligible Persons must pay before the Plan’s liability begins as specified on the Dental Transmittal for the Participating Group.

(F) **Delta Dental** means Delta Dental Plan of New Hampshire.

(G) **Dental Benefit Options** means the coverage options available under the Plan (as identified on the listing attached hereto) which options include applicable coverage categories, Selected Percentages, Deductibles, and Maximum limitations.

(H) **Dental Care** means dental services ordinarily provided by Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with accepted standards of dental practice at the time the service is rendered.

(I) **Dental Group Application (or Application)** means the form that must be completed, signed, and submitted to HealthTrust. An applicant is enrolled for Benefits under the Plan only upon acceptance of the Dental Group Application by HealthTrust. This form is also used to notify HealthTrust of changes in enrollment information.

(J) **Dental Transmittal** means the document signed by HealthTrust and the Participating Group, which describes the specific Dental Benefit Options and terms and conditions of the coverage selected by the Participating Group.

(K) **Dentist** means a person duly licensed to practice dentistry in the state in which the Dental Care is provided.

(L) **Dependent** means a person who may be enrolled for Benefits under the Plan under the provisions of Section II of this Plan Document.

(M) **Eligible Dependents** means those Dependents who meet the eligibility criteria set forth in Section II of this Plan Document and who are properly enrolled for coverage under the Plan.

(N) **Eligible Persons** means the Subscriber and Eligible Dependent(s) who are enrolled for coverage under the Plan.

(O) **Employee** means any person who is described as an employee in the governing documents applicable to HealthTrust other than a person who is so described solely by reason of being a spouse or dependent. Generally, “Employee” will include, in whole or in part as each Participating Group may determine, any person who is (i) actively engaged in employment with a Participating Group on a Full-Time or a Part-Time basis, (ii) a Retiree or on leave of absence, or (iii) a qualifying publicly elected or appointed official of a Participating Group. For purposes of this definition, a person is employed (a) on a “Full-Time” basis if he or she is working 30 or more hours per week for the Participating Group or otherwise satisfies the definition of a “full-time employee” for purposes of eligibility for the Participating Group’s medical plan, and (b) on a “Part-Time” basis if he or she is working a minimum of 15 hours per week.

(P) **Initial Effective Date** means the first date on which coverage begins under the Plan for a Participating Group as described in the INTRODUCTION AND GENERAL INFORMATION section of this Plan Document.
(Q) **HealthTrust** means HealthTrust, Inc., a New Hampshire voluntary corporation.

(R) **Maximum** means the maximum dollar amount the Plan will pay in any Plan Year (or lifetime for orthodontic Benefits) for covered Benefits as specified in the Dental Transmittal for the Participating Group.

(S) **Non-Participating Dentist** means a Dentist who has not signed a participating agreement with Northeast Delta Dental or another Delta Dental company.

(T) **Northeast Delta Dental** means the association of the Delta Dental Plans of Maine, New Hampshire and Vermont.

(U) **Participating Dentist** means a Dentist who has signed a participating agreement with Northeast Delta Dental. A Participating Dentist will abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental. A Dentist who has signed a participating agreement with a Delta Dental company in another state is also a Participating Dentist.

(V) **Participating Group** means any New Hampshire political subdivision or instrumentality thereof which is a participant of HealthTrust and has elected to provide dental coverage under this Plan to Eligible Persons.

(W) **Plan** means the Participating Group’s HealthTrust Dental Plan as described in this Plan Document and the Dental Plan Description.

(X) **Plan Document** means this document and all attachments and riders including without limitation the Dental Benefit Options and the Dental Transmittal which attachments are incorporated herein by this reference.

(Y) **Plan Year** means the twelve (12) month period selected by the Participating Group as described in the INTRODUCTION AND GENERAL INFORMATION section of this Plan Document and as set forth on the Dental Transmittal.

(Z) **Predetermination** means an administrative procedure where the Dentist submits a treatment plan to Delta Dental in advance of performing Dental Care. Delta Dental recommends that patients ask the Dentist to request Predetermination of proposed services that are considered to be other than brief or routine. Predetermination provides an estimate of what the Plan will pay for the services, which helps avoid confusion and misunderstanding between the patient and the Dentist.

(AA) **Probationary Period** means the period of time as determined by each Participating Group (as referenced on the Dental Transmittal) before an Employee becomes eligible for Benefits under the Plan.

(BB) **Processing Policies** means the policies approved by Delta Dental, as may be amended from time to time, to be used in processing claims for payment and treatment plans for Predetermination of Benefits. Most frequently used Processing Policies are contained in the terms, conditions, limitations and exclusions described in this Plan Document.

(CC) **Rates** means the rates established by HealthTrust for coverage selected by a Participating Group as stated on the Dental Transmittal.

(DD) **Retiree** means a person who has retired from active employment with a Participating Group and whom the Participating Group determines is eligible to continue coverage under the Plan pursuant to NH RSA 100-A:50 and/or the applicable HealthTrust rules governing eligibility for retiree coverage.

(EE) **Selected Benefits** means the specific coverage option(s) selected by the Participating Group at the beginning of each Plan Year from the Dental Benefits Options which are available under the Plan. Selected Benefits for the Participating Group are identified on the Dental Transmittal.

(FF) **Selected Percentage** means the percentage amount of charges for Selected Benefits which the Plan will pay as stated on the Dental Transmittal.

(GG) **Subscriber** means an Employee or Retiree who satisfies the eligibility criteria established by the Participating Group and HealthTrust, and who is properly enrolled for coverage under the Plan.
SECTION II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE

(A) ELIGIBILITY

Participating Groups may choose to have either Employee Only (no Dependent coverage), or Employee and Dependents coverage. In either case, at least 75% of all eligible Employees (who do not otherwise have dental coverage) must be enrolled. If Employee and Dependents coverage is offered, Employees who elect to cover Dependents must enroll all of their eligible Dependents who are under 19 years of age (who do not otherwise have dental coverage) and keep them enrolled for the term of each Plan Year unless there is a qualified family status change (as described later in this Section II). If there is an Employee contribution for Dependents, at least 50% of eligible Employees with Dependents must agree to enroll all of their eligible Dependents who are under 19 years of age (who do not otherwise have dental coverage) and keep them enrolled for the term of each Plan Year unless there is a qualified family status change (as described later in this Section II).

Employees and their Dependents are eligible for coverage under the Plan only if they meet all applicable eligibility requirements, including any Probationary Period established by the Participating Group. HealthTrust may require the Employee to furnish evidence satisfactory to HealthTrust of any Dependent’s eligibility, such as a birth certificate, marriage license, or court decree.

1. Eligible Employee

An Employee who meets the definition of Employee as defined in Section I, DEFINITIONS, is eligible to enroll as a Subscriber on the first day of the calendar month following the date determined by the Participating Group and HealthTrust in accordance with applicable rules and procedures of HealthTrust, provided that the Employee:

(a) has satisfied any applicable Probationary Period; and

(b) is certified as being an eligible Employee or Retiree by the Participating Group.

2. Eligible Dependents (if Dependent Coverage is Offered by the Participating Group)

In addition to the Subscriber, the following persons are also eligible for enrollment under the Plan as Dependents provided that Dependent coverage is offered by the Participating Group (as set forth on the Dental Transmittal):

(a) The Spouse of the Subscriber: A spouse is eligible to enroll unless he or she is legally separated from the Subscriber. Throughout this Plan Document, any reference to “spouse” means:

i. the individual to whom the Subscriber is lawfully married, as recognized under the laws of the state where the Subscriber lives, or

ii. the individual with whom the Subscriber has entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

Throughout this Plan Document any reference to “marriage” means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a marriage or civil union.

Coverage is available for same-sex or opposite-sex domestic partners (including “common law” type relationships and other unmarried couples) only if the Participating Group has purchased a Domestic Partner Rider and only if all of the criteria for domestic partner status and eligibility are met, as stated in the Rider.

(b) A Child of the Subscriber or of the Subscriber’s Spouse who is:

i. at least two (2) and under twenty-six (26) years of age whether married or unmarried; or

ii. An unmarried incapacitated dependent who is 26 years of age or older and physically or mentally incapable of self-support (as certified by a physician), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined
above. The physical or mental incapacity must have occurred before the child reached age 26 and must have occurred while the Dependent was a covered Dependent child. Incapacitated Dependents may remain covered as long as their disability continues and as long as they are financially dependent on the Subscriber and are incapable of self-support. HealthTrust must receive an Application for the incapacitated Dependent child status and medical certification of the incapacity by a physician within 31 days of the date coverage would otherwise end for the child. HealthTrust must approve a Dependent child’s incapacitated status and may periodically request that the incapacitated status of the child be recertified.

In addition, a newborn child will be covered for the initial 31-day period following birth at no additional premium. Coverage may resume on the first day of the month following the child’s second birthday if the child is properly enrolled at that time.

The term “child” means:

i. a natural child or stepchild who is dependent upon the Subscriber for support;

ii. a legally adopted child or a child who has been placed for adoption with the Subscriber or the Subscriber’s spouse. For this purpose, “placed for adoption” means that the child has been placed in the custody of the Subscriber or the Subscriber’s spouse pursuant to an adoption proceeding under the provisions of NH Revised Statutes Annotated 170-B before the adoption becomes final;

iii. a child for whom the Subscriber or the Subscriber’s spouse has been appointed the permanent legal guardian by court order; or

iv. a child otherwise required to be enrolled under the Plan by federal or state law or by court order.

A foster child or grandchild is not eligible for coverage as a Dependent unless the child meets the definition of “child” above.

NOTE: By accepting coverage under the Plan, Subscribers represent that all statements made in their Dental Group Application, or any other documentation provided with respect to eligibility and enrollment of the Subscriber and Eligible Dependents, are true to the best of the Subscriber’s knowledge and belief. Subscribers must give HealthTrust information upon request that HealthTrust deems necessary to verify coverage eligibility. Examples of documentation that HealthTrust may need to decide membership eligibility are information regarding: Dependent child status, incapacitated child status, marital status, divorce, legal separation, adoption or court orders regarding health care coverage for Eligible Dependent children.

HealthTrust reserves the right to retroactively cancel an Eligible Person’s coverage under the Plan if a Subscriber fails to provide verification upon request or misrepresents the eligibility status of the Subscriber or any Dependents.

(B) ENROLLMENT

All eligible Employees and Dependents as set forth in the Dental Transmittal who have satisfied the eligibility requirements set forth in Section II (A) may be enrolled in the Plan. If the Employee does not submit a Dental Group Application (for the Employee or his/her Dependents) when he or she first becomes eligible to enroll, such person(s) will not be eligible to enroll at a later date, except during an open enrollment period or special enrollment period or as provided under “Changes in Enrollment upon Qualified Family Status Changes” in this section. See “Newly Eligible Employees and their Dependents – Initial Enrollment” later in this section for further details.

NOTE: If the Subscriber (and the Subscriber’s Dependents) enroll, the Subscriber (and the Subscriber’s Dependents) must remain enrolled throughout the Plan Year and may be removed only during an open enrollment period, except in the event of a qualified family status change or termination of employment.

1. Open Enrollment Period. There will be an “annual open enrollment period” during the 60 days prior to, and during the month which includes, the Participating Group’s Anniversary Date each year. If the Dental
Group Application is received by HealthTrust on or before the last day of the annual open enrollment period, coverage will become effective on the Anniversary Date. If, however, the Dental Group Application is not received by the end of the annual open enrollment period, the requested enrollment may not be made until the next open enrollment period. Special open enrollment periods may be allowed for a Participating Group at the sole discretion of HealthTrust.

2. **Special Enrollment Period.** A special enrollment period will be offered to eligible Employees and/or their Dependents in the following circumstances:

   (a) **Involuntary Loss of Other Insurance Coverage**

   If an eligible Employee declines enrollment (for the Employee or his/her Dependents) when initially eligible or during an annual open enrollment because the individual(s) was covered under another group dental plan or other dental insurance, the Employee and his/her Dependents will be permitted to enroll in the Plan within 31 days after an involuntary loss of such other insurance coverage. For this purpose, an “involuntary loss” of other insurance coverage means (i) if the other coverage is COBRA continuation coverage, such COBRA coverage has been exhausted, or (ii) if the other coverage is not COBRA continuation coverage, the coverage has been terminated as a result of loss of eligibility (other than loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause), or employer contributions towards the other coverage have been terminated.

   (b) **New Dependents**

   If an Employee is eligible, but not enrolled, under the Plan because he or she previously declined enrollment upon initial eligibility or during an annual open enrollment period, and the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee and his or her Dependents will be permitted to enroll in the Plan within 31 days after the marriage, birth, adoption, or placement for adoption.

   Employees and Dependents who become eligible for enrollment pursuant to Special Enrollment provisions (a or b above) may enroll in the Plan by submitting a completed Dental Group Application in accordance with the terms and conditions for enrollment set forth in the following subsection 3 below. Coverage of such individual(s) will become effective in accordance with that subsection and the applicable event allowing for special enrollment.

   (c) **Loss of Coverage, or Becoming Eligible for Premium Assistance, under Medicaid or a State’s Children’s Health Insurance Program.** If an Employee and/or Dependent(s) are eligible, but not enrolled, under the Plan, they may enroll during the Plan Year in either of the following situations:

   i. An Employee or Dependent loses coverage under a Medicaid plan (under title XIX of the Social Security Act) or under a state Children’s Health Insurance Plan (under title XXI of the Social Security Act) due to loss of eligibility for such coverage; or

   ii. An Employee or Dependent becomes eligible for state funded group health plan premium assistance with respect to this Plan through a state Medicaid or Children’s Health Insurance Program.

   The Subscriber must request enrollment under the Plan by submitting a completed Dental Group Application within 60 days of the date the other coverage is lost or the date the Employee or Dependent is determined to be eligible for premium assistance (whichever is applicable). Coverage of such individual(s) will become effective as of the first of the month following the date coverage is lost or the Dependent(s)' eligibility for premium assistance.

3. **Application and Effective Date of Coverage.** Employees and Dependents who meet the eligibility requirements in Section II (A) may enroll in the Plan by submitting a completed Dental Group Application. An applicant is enrolled only upon acceptance of the Dental Group Application by HealthTrust. The following subsections describe when Benefits become effective.
(a) **Newly Eligible Employees and their Dependents – Initial Enrollment**

An Employee who becomes eligible for Benefits under the Plan may enroll by submitting a Dental Group Application to their Participating Group within 31 days from the date the Employee first satisfies any applicable Probationary Period. If the Employee elects to enroll all eligible Dependents, they must be enrolled at the same time. Coverage of newly eligible Employees and their Dependents will become effective as of the first day of the month following the date the Employee became eligible, provided that HealthTrust receives the Dental Group Application within 31 days. If a Dental Group Application is received by HealthTrust after 31 days but within 60 days from the date the Employee first satisfies any applicable Probationary Period, coverage of the Employee and any eligible Dependents then being enrolled will become effective the first of the month following receipt of the Application. If the Employee does not submit a Dental Group Application within 60 days of initial eligibility, the Employee and his or her Dependents will not be eligible to enroll at a later date, except during an open enrollment period, a special enrollment period, or as provided under “Changes in Enrollment upon Qualified Family Status Changes” immediately below.

(b) **Changes in Enrollment upon Qualified Family Status Changes**

A Subscriber may enroll or remove Dependents and/or change coverage type during a Plan Year provided that such change is due to and consistent with a qualified family status change. A “qualified family status change” will include:

i. marriage, divorce, or legal separation of the Subscriber;

ii. adoption, placement for adoption or a change in legal custody of a child who is at least two (2) years of age, or a change in a child’s eligibility under SECTION II (A) 2 (b);

iii. death of a spouse or a Dependent child;

iv. a change in employment status of the Subscriber or spouse that affects dental benefits coverage (e.g., termination or commencement of employment, a change from part-time to full-time status or vice versa, an unpaid leave of absence, a strike or lockout);

v. a significant change in the Subscriber’s dental plan cost or coverage, or that of the Subscriber’s spouse’s, relating to that individual’s employment status or coverage;

vi. the Subscriber’s spouse’s employer holds open enrollment at a time other than the Subscriber’s employer – and, as a result of its benefit offerings, the Subscriber would like to make a change (if the Participating Group recognizes this as a qualified change in status); or

vii. an involuntary loss of, or becoming newly eligible for, other dental insurance coverage.

A Subscriber may enroll or remove Dependents and/or change coverage type by submitting a Dental Group Application to their Participating Group within 31 days of the qualified family status change. The Application must include any requested change in coverage type. If a Dental Group Application requesting to enroll Dependent(s) and/or to change coverage type is received by HealthTrust within 31 days of a qualified family status change, the requested change(s) will take effect on the first of the month following the date of the event. If the Dental Group Application is not received by HealthTrust within the 31 days but is received within 60 days from the date of the qualified family status change event, the requested change will become effective the first of the month following receipt of the Dental Group Application. If a request is not made within 60 days, coverage of Eligible Dependents and coverage type may not be changed until the next open enrollment or special enrollment period.

4. **Retroactivity Limit on Additions or Removal of Enrolled Dependents**

The Subscriber must request any desired change in coverage type and must promptly notify the Participating Group and HealthTrust of any Dependent(s) to be added to or removed from coverage under the Plan. HealthTrust is not responsible for automatically changing a Subscriber’s coverage type
or adding or removing Dependents upon a qualified family status change event. Except as otherwise provided for in this Plan Document, additions or terminations of enrolled Dependents or changes of coverage type may not be made more than 31 days retroactively.

(C) TERMINATION OF COVERAGE

This section describes circumstances under which an Eligible Person’s coverage under the Plan will terminate. Whether or not the Eligible Person or the Participating Group contacts HealthTrust to affect any of the terminations in this section, HealthTrust will administer the terminations if HealthTrust has knowledge of the termination event. In no event are Benefits available for Dental Care rendered or delivered after the date coverage under the Plan terminates.

Subject to any right to continue coverage under the Plan as described later in CONTINUATION OF COVERAGE, coverage of an Eligible Person will automatically terminate on the earliest of the following dates:

1. The date HealthTrust ceases to offer any dental benefit plans to Participating Groups;
2. The date specified by HealthTrust in the event that the Participating Group terminates its participation in the Plan;
3. The end of the month during which the Eligible Person ceases to be eligible as a Subscriber or Eligible Dependent, or such other date specified in written notice by the Participating Group to HealthTrust to terminate coverage of the Eligible Person(s) (in accordance with applicable rules and procedures of HealthTrust);
4. The date specified by HealthTrust that the Eligible Person’s coverage will end because the Participating Group failed to pay any required contribution for coverage under the Plan;
5. The date of the Eligible Person’s enrollment in the Plan if HealthTrust or the Claims Administrator determines that the Subscriber has made a material misrepresentation on the Dental Group Application or used fraud in obtaining or maintaining coverage under the Plan;
6. The date specified in a notice of cancellation or nonrenewal of the Participating Group’s participation in the Plan or in HealthTrust, sent to the Participating Group by HealthTrust, due to the Participating Group’s failure to meet the Plan’s minimum Employee participation requirements or other requirements under the Participating Group’s participation agreement with HealthTrust; or
7. The date established by HealthTrust for other causes as permitted by law. Cause may include failure to disclose other dental plan coverage, fraud committed by an Eligible Person in connection with any claim filed under the Plan, or if an unauthorized person is allowed to use any Eligible Person’s identification card or if an Eligible Person otherwise cooperates in the unauthorized use of such Eligible Person’s identification card.

(D) CONTINUATION OF COVERAGE

1. Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) – COBRA is a federal law which requires the Participating Group to offer Eligible Persons (“qualified beneficiaries”) the opportunity to continue group coverage under the Plan for a temporary period, at the Eligible Person’s expense, when coverage would otherwise end because of certain “qualifying events.” COBRA continuation rights under the Plan are available only through the Participating Group. HealthTrust assists the Participating Group with certain COBRA notice and other administrative requirements. Subscribers and covered spouses will receive a separate document, which describes the continuation rights in further detail, upon initial enrollment in the Plan.

2. Qualifying Events – Eligible Persons will become qualified beneficiaries if their coverage under the Plan would otherwise end due to one of the following qualifying events:
   • The Subscriber’s hours of employment are reduced; or
   • The Subscriber’s employment ends for any reason other than gross misconduct.

Additionally, Eligible Dependents will become qualified beneficiaries if their coverage would otherwise end due to one of the following qualifying events:
• The Subscriber dies;
• The Subscriber divorces or legally separates;
• The Subscriber becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• In the case of an Eligible Dependent, he or she no longer meets the eligibility requirements for coverage under the Plan.

3. **Notices and Election Rights** – COBRA coverage is available under the Plan to qualified beneficiaries only after the Participating Group and HealthTrust have been notified that a qualifying event has occurred. **The Subscriber or an Eligible Dependent who is a qualified beneficiary must notify the Participating Group within 60 days of the date coverage under the Plan would otherwise end due to divorce, legal separation or a child losing Dependent status.** If the Subscriber or an Eligible Dependent fails to provide notice within this 60-day notice period, any Eligible Person who loses coverage will not be offered the right to elect continuation coverage.

Once the Participating Group is notified of a qualifying event, the Participating Group must then notify HealthTrust. The Participating Group also must notify HealthTrust of other qualifying events including the Subscriber’s death, termination of employment, reduction in hours of employment, or Medicare entitlement.

After HealthTrust receives notice that a qualifying event has occurred, HealthTrust will provide notice to eligible qualified beneficiaries of their right to elect COBRA continuation coverage.

Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the later of the following dates to make their election:

- 60 days after the date their coverage would otherwise end due to the qualifying event; or
- 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

4. **Nature and Duration of COBRA Coverage** – If a qualified beneficiary elects COBRA, the qualified beneficiary generally will receive the same coverage and enrollment rights as are provided to similarly situated active employees of the Participating Group and their family members.

COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage will depend on the nature of the qualifying event as follows:

- **18 months** if the qualifying event is the Subscriber’s termination of employment or reduction in hours of employment (the 18-month period may be extended to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA coverage); or
- **36 months** if the qualifying event is the Subscriber’s death, divorce or legal separation, Medicare entitlement, or a child losing Dependent status.

**Additional non-COBRA continuation period for former or surviving spouses** – In addition to the maximum COBRA coverage period, the following continuation periods are available under the Plan:

- If the qualifying event is divorce or legal separation and the former spouse is a qualified beneficiary age 55 or older at the time of the relevant court decree, the maximum continuation period will extend until the former spouse becomes eligible for coverage under another group dental plan or Medicare; or
- If the qualifying event is the Subscriber’s death and the Subscriber’s surviving spouse is a qualified beneficiary age 55 or older at the time of the death, the maximum continuation period will extend until the surviving spouse becomes eligible for coverage under another group dental plan or Medicare.

**NOTE:** The Plan does not provide additional continuation coverage rights to former spouses under NH RSA 415:18, VII-b.
COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under COBRA law. Eligibility for COBRA coverage under the Plan will end if the Participating Group terminates participation in the Plan for its active employees.

5. **Cost of Continuation Coverage** – Qualified beneficiaries will be obligated to pay the full cost for COBRA or other continuation coverage unless the Participating Group has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium cost and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event. The Participating Group will be responsible for collecting the applicable premium payment for continuation coverage from qualified beneficiaries and submitting the payment to HealthTrust unless the Participating Group has contracted with HealthTrust to administer COBRA billing services.

6. **Continuation of Coverage Due to Military Service (USERRA)** – In the event the Subscriber is no longer actively at work because he or she is called to military service in the Armed Forces of the United States, the Subscriber may elect to continue coverage for the Subscriber and Eligible Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). “Military service” means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

The Subscriber may elect to continue to cover the Subscriber and Eligible Dependents (if any) under the Plan. The Subscriber may be obligated to pay the full premium cost (and any applicable administrative fee) for continuation coverage under the Plan. This may include the amount the Participating Group normally pays on the Subscriber’s behalf. If the Subscriber’s military service is for a period of less than 31 days, the Subscriber may not be required to pay more than the active employee contribution, if any, for the continuation coverage. If continuation is elected under this provision, the maximum period of continuation coverage under the Plan shall be the lesser of:

- 24 months; or
- The Subscriber’s period of military service (measured from the date the military service begins and ending on the day after the date on which the Subscriber fails to apply for re-employment or returns to employment with the Participating Group).

Whether or not the Subscriber elects continuation coverage, if the Subscriber returns to employment with the Participating Group, the Subscriber and his or her eligible Dependents’ coverage under the Plan will be reinstated. No Probationary Period or exclusions may be imposed on the Subscriber or the Subscriber’s Eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of military service.

7. **Availability of Individual Coverage** – When an Eligible Person’s group coverage under the Plan through a Participating Group terminates, including at the end of any continuation of coverage period, the Eligible Person may apply for an individual plan with Northeast Delta Dental. Individual policies will be subject to terms, conditions, and limitations set forth in the individual policy. Applications will be subject to Northeast Delta Dental’s normal underwriting requirements. Application forms and information are available by calling Northeast Delta Dental at 800.537.1715.
SECTION III. BENEFITS

HealthTrust Agrees:

To provide Benefits and Dental Care to Eligible Persons in accordance with the rules, regulations and Processing Policies of the Claims Administrator and in accordance with the terms and conditions of this Plan Document including, but not limited to, the following classifications, exclusions and limitations.

Only those coverage classifications selected by the Participating Group will apply. Time limitations will be measured from the date the service was last performed.

(A) **Coverage A - Diagnostic and Preventive Benefits**

1. **Diagnostic:** Evaluations and radiographs (x-rays) to determine required dental treatment.
   
   Limited oral evaluations - problem focused.
   
   Oral evaluations twice in a calendar year. This can be a comprehensive or periodic evaluation provided by a specialist or a general Dentist.
   
   Radiographs - a complete series or panoramic film (x-ray) once in any period of three (3) consecutive years; bitewing films (x-rays) once in a calendar year; and films (x-rays) of individual teeth as necessary.
   
   Oral cancer screening such as a brush biopsy once in a calendar year, no age limit.

2. **Preventive:** Specific procedures employed to prevent the occurrence of dental disease.
   
   Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age twelve (12), adult prophylaxis thereafter), as recommended by the Dentist. A prophylaxis can be routine (Coverage A) or periodontal maintenance under Coverage B - Basic Benefits.
   
   A full mouth debridement is covered once in a lifetime and, when performed, is counted towards your prophylaxis benefit.
   
   Fluoride treatment twice in a calendar year through age eighteen (18). Space Maintainers through age fifteen (15).
   
   Sealants through age eighteen (18).

**Coverage A - Exclusions and Limitations**

1. A panoramic film, with or without accompanying bitewings, is considered the same as a complete series and is paid as such.

2. Cone beam imaging is not a covered Benefit.

3. Sealant Benefit limitation:
   
   (a) Sealant Benefit is provided only to Eligible Dependents through age eighteen (18).
   
   (b) Sealant Benefit includes the application of sealants to caries-free (no decay) and restoration-free permanent molars only.
   
   (c) Sealant Benefit is provided no more than once per tooth in any period of three (3) consecutive years.

4. A limited oral evaluation, when done in conjunction with a procedure (other than radiographs) on the same visit, is considered a part of, and included in the fee for, the procedure. A limited oral evaluation - problem focused, when done with a procedure (other than radiographs) on the same visit, is not a covered Benefit. The patient is responsible for any separate fee.

5. One oral cancer screening procedure such as a brush biopsy is covered in a twelve (12) month period. Associated pathological laboratory fees for these services are not a covered Benefit. The patient is responsible for any separate fee.
6. Payment for additional periapical radiographs within a thirty-day (30-day) period of a complete series or panoramic film, unless there is evidence of trauma, is subject to a consulting Dentist’s review. A Participating Dentist agrees not to charge a separate fee.

7. The replacement or repair of space maintainers is not a covered Benefit unless performed by a Dentist who did not perform the original placement.

8. Space maintainers are a covered Benefit for Eligible Dependents through age fifteen (15) when a space is being maintained for an erupting permanent tooth.

9. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for a periodontal scaling and root planing and a Participating Dentist agrees not to charge a separate fee.
**Coverage B - Basic Benefits**

1. **Restorative:** Amalgam (silver) and/or resin (white) restorations (fillings). If Coverage C - Major Benefits is not offered, and unless otherwise specified on the Dental Transmittal, payment for restorative crowns and onlays will be at the selected Co-payment percentage specified on the Dental Transmittal for a four (4) surface amalgam restoration.

2. **Oral Surgery:** Extractions and covered surgical procedures.

3. **Periodontics:** Treatment of diseased tissue supporting the teeth and periodontal maintenance.
   - Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age twelve (12), adult prophylaxis thereafter), as recommended by the Dentist. A prophylaxis can be routine under Coverage A - Diagnostic and Preventive Benefits or periodontal maintenance (Coverage B).
   - A full mouth debridement under Coverage A - Diagnostic and Preventive Benefits is covered once in a lifetime and, when performed, is counted towards your prophylaxis Benefit.

4. **Endodontics:** Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.

5. **Denture Repair:** Repair of a removable complete or partial denture to its original condition.

6. **Clinical Crown Lengthening**

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

8. **Anesthesia:** General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body (only when Coverage C – Major Benefits is specified on the Dental Transmittal); biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.
   - General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients:
     (a) A child under the age of six (6) who is determined by a licensed Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or
     (b) A person who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician, which place the person at serious risk.

**Coverage B - Exclusions and Limitations**

1. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made for the periodontal scaling and root planing and a Participating Dentist agrees not to charge a separate fee.

2. Tooth preparation, bases, copings, sedative fillings, impressions, local anesthesia, or other services that are part of a complete dental procedure are considered components of, and included in the fee for, the complete procedure. A Participating Dentist agrees not to charge a separate fee.

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

4. Benefits are not paid for the replacement of an amalgam restoration within twelve (12) months of its placement or for a resin restoration within twenty-four (24) months of its placement.
5. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Participating Dentist agrees not to charge a separate fee.

6. Periodontal scaling and root planing is a covered Benefit per quadrant once in any period of twelve (12) consecutive months. Benefits are paid for a maximum of two (2) quadrants per office visit.

7. Exploratory surgical services are not a covered Benefit. The patient is financially responsible.

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

9. Root canal therapy on a tooth is a Benefit once in any period of three (3) consecutive years.

10. An indirect pulp cap, when rendered at the same time as the final restoration, is considered a base and is not a Benefit when billed as a separate procedure. A Participating Dentist agrees not to charge a separate fee.

11. Clinical crown lengthening is a covered Benefit once per tooth per lifetime and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown.

12. Clinical crown lengthening is not a covered Benefit when performed on the same day as a crown preparation, restoration or osseous surgery. A Participating Dentist agrees not to charge a separate fee.

13. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a consulting Dentist’s review. Payment will be based on the most comprehensive procedure.

14. Recementation of a crown, inlay, onlay and/or partial restoration is a Benefit once in any period of twelve (12) consecutive months.

15. Recementation of a cast or prefabricated post and core is a Benefit once in any period of twelve (12) consecutive months.

16. Anterior deciduous root canal therapy is not a covered Benefit.

17. A partial pulpotomy is a covered Benefit on permanent teeth only.

18. A root canal or apexification procedure that is performed within thirty (30) days of a partial pulpotomy, and is performed by the same Dentist, will have the payment for the procedure reduced by the payment for the partial pulpotomy. A Participating Dentist agrees not to charge a separate fee.

19. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, distal wedge, or soft tissue graft procedure is a Benefit once in any period of three (3) consecutive years. A gingivectomy for the removal of hypoplastic tissue is not a covered Benefit unless diseased tissue is present.
(C) **Coverage C - Major Benefits**

1. **Restorative Crowns and Onlays:** Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.

2. **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 post and cores; and fixed partial denture and crown repairs.

3. **Implant Services:** Surgical placement of an endosteal implant body, including healing cap.

4. **Implant Supported Prosthetics:** Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

**Coverage C - Exclusions and Limitations**

1. Onlays or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal (where the metal is high noble metal, titanium, noble metal or predominantly base metal) are not Benefits for Eligible Dependents under the age of twelve (12).

2. Tissue conditioning is not a covered Benefit.

3. **Coverage C - Major Benefits time limitations:**
   
   (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of seven (7) consecutive years.
   
   (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of seven (7) consecutive years.
   
   (c) A removable or fixed partial denture in any period of seven (7) consecutive years unless the loss of additional teeth requires the construction of a new appliance.
   
   (d) Crowns, onlays, core buildups, and post and cores are a Benefit once per tooth in any period of seven (7) consecutive years.
   
   (e) The period of seven (7) consecutive years referred to in (a), (b), (c) and (d) above is to be measured from the date the service was last performed.
   
   (f) Implant body and implant abutment are Benefits once in a lifetime per site.

4. Inlays are not a covered Benefit.

5. A core buildup or post and core performed on the same day as an inlay or onlay is not a covered Benefit. A Participating Dentist agrees not to charge a separate fee.

6. Removable or fixed partial dentures are not Benefits for patients under the age of twelve (12).

7. 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.

8. Recementation of a fixed partial denture is a Benefit once in any period of twelve (12) consecutive months.

9. The relining of a denture is a Benefit once in any period of three (3) consecutive years.

10. Implant services are not a Benefit for patients under the age of sixteen (16).

11. 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.

12. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is not a covered Benefit. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a consulting Dentist.
**Coverage D - Orthodontic Benefits**

1. **Orthodontics:** Necessary treatment and procedures required for the correction of malposed (crooked) teeth for Eligible Dependent children until the end of the month of their nineteenth (19) birthday or as specified on the Dental Transmittal.

   Placement of device to facilitate eruption of an impacted tooth.

**Coverage D - Exclusions and Limitations**

1. Orthodontic Benefit limitations:

   (a) Orthodontic Benefits are provided until the end of the month of the Eligible Dependent’s nineteenth (19) birthday. Subscribers, spouses, and Eligible Dependents age nineteen (19) and over will not be eligible for orthodontic Benefits unless adult coverage is specified on the Dental Transmittal.

   (b) For treatment commenced while a patient is eligible for orthodontic Benefits, the Claims Administrator will initiate payment of its liability up to the orthodontic Maximum specified on the Dental Transmittal once bands or orthodontic devices are placed.

   (c) For patients who become eligible after orthodontic treatment has commenced, the Claims Administrator will pro-rate the Plan’s liability based on the number of remaining months of active treatment compared to the total number of months of active treatment.

   (d) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.

2. Clear orthodontic appliances are included in orthodontic Benefits provided that upon the consulting Dentist’s review of pretreatment radiographs it is indicated that the patient has full adult dentition.

   Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. The patient is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.

3. The Plan’s payment for orthodontic Benefits shall be limited to the lifetime Maximum per patient specified on the Dental Transmittal. The Claims Administrator will make one (1) payment at the start of treatment for the Plan’s total liability.

4. For Participating Groups with orthodontic Benefits, placement of an appliance must take place for the Claims Administrator to make payment on diagnostic records. Diagnostic casts, photographs and other diagnostic records are included in the total case fee. If banding does not take place, the Plan has no liability beyond its share of the allowable fee for a comprehensive oral evaluation.

5. The replacement or repair of an orthodontic appliance is not a covered Benefit if done by the same orthodontist who placed the appliance. If performed by an orthodontist who did not originally place the appliance, payment will be made for one repair per lifetime.

**NOTE:** For Coverages B, C, and D, HealthTrust and the Claims Administrator strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan’s payment and the Eligible Person’s financial obligation to the Dentist.
SECTION IV. GENERAL EXCLUSIONS AND LIMITATIONS

(A) EXCLUSIONS

Unless otherwise specified on the Dental Transmittal, the dental Benefits provided by the Plan will not include the following:

1. Services for injuries or conditions compensable under workers’ compensation or employer’s liability laws.

2. Services that are determined by the Claims Administrator 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.)

3. Services, including but not limited to endodontics and prosthodontics (including restorative crowns and onlays), started prior to the date the Subscriber or Eligible Dependent became enrolled in the Plan.

4. 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.

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

6. Charges for: (a) hospitalization; (b) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section III (B), Coverage B - Basic Benefits); (c) preventive control programs; (d) periodontal splinting; (e) myofunctional therapy; (f) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (g) equilibration; and (h) gnathological reporting.

7. Charges for failure to keep a scheduled visit with the Dentist.

8. Charges for completion of forms. Such charges will not be made to an Eligible Person by Participating Dentists.

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

10. Dental Care or supplies which are not within the classification of Benefits defined in this Plan Document and selected by the Participating Group on the Dental Transmittal.

11. Appliances, procedures, or restorations for: (a) implant services (unless the Participating Group offers Coverage C - Major Benefits); (b) increasing vertical dimension; (c) analyzing, altering, restoring, or maintaining occlusion; (d) replacing tooth structure lost by attrition or abrasion; (e) correcting congenital or developmental malformations; or (f) esthetic purposes.

12. Payments of Benefits incurred by the Subscriber and/or Eligible Dependent(s) after the date the Subscriber becomes ineligible for Benefits under the Plan.

13. Charges for Dental Care or supplies for which no charge would have been made in the absence of dental Benefits.

14. 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.

15. All services, including evaluations and radiographs, performed for orthodontic purposes where the Participating Group does not offer Coverage D - Orthodontic Benefits. If services are rendered they should be done so with the agreement of the patient to assume additional cost.

16. Temporary services.

17. A consultation unless performed by a practitioner who is not performing further services.

18. Case presentation and treatment planning. The patient will be responsible for any additional fee.

19. Athletic mouthguards and occlusal guards (nightguards).

20. Pulp vitality tests.
18

Incomplete treatment.

(B) LIMITATIONS

Unless otherwise specified on the Dental Transmittal, the Dental Care Benefits provided by the Plan will be limited as follows:

1. Dental Care rendered by other than a Dentist will not be a Benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist will be a Benefit, if the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted dental practice standards.

2. Optional Dental Care: In all cases in which the Eligible Person selects more expensive Dental Care than is customarily provided, the Plan will pay the Selected Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. The Subscriber or Eligible Dependent will be responsible for the remainder of the Dentist’s fee.

3. Predetermination does not guarantee payment. Payment is based upon eligibility, Benefits selected by the Participating Group and allowable charges at the time the Dental Care is rendered. If Coordination of Benefits is involved, the amount of payment is subject to change dramatically pending payment by the primary carrier.

4. 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 the Plan’s liability.

5. When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, the Claims Administrator will review the claim to determine the payment, if any, due each Dentist.

6. Maximum Payment:
   (a) The Maximum amount payable in any Plan Year, or portion thereof, will be limited to the amount specified on the Dental Transmittal.
   (b) The Plan’s payment will be reduced by any Deductible as specified on the Dental Transmittal.

7. Specialized techniques including, but not limited to, precision attachments, implant services (unless the Participating Group offers Coverage C - Major Benefits), overdentures (and associated procedures), personalizations or characterization, are limited. The patient will be responsible for part of or the entire fee for these services.

8. Diagnostic casts (study models) and/or photographs are not a covered Benefit under the Plan unless done for orthodontic purposes for those Participating Groups that offer Coverage D - Orthodontic Benefits. The charge for such services should be included in the total case fee.

9. Benefits are paid for amalgam (silver) or resin (white) restorations for treatment of caries. If a tooth can be restored with amalgam or resin, use of gold, an inlay, an onlay, or a crown is at the option of the patient and the patient will be responsible for any additional fee.

10. A claim (or satisfactory written proof acceptable to the Claims Administrator) must be furnished to the Claims Administrator at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on a claim with dates of service in excess of the twenty-four (24) month limitation.

11. The date of incurred liability refers to the date a service is subject to the applicable Deductible, Co-payment, Maximum Benefit, and limitations. The total cost of the service is applied to the Plan Year during which the service is incurred, irrespective of the Plan Year in which the service is completed.

The Plan’s date of incurred liability for multiple visit procedures is as follows:
   (a) Restorative Crowns and Onlays – Total cost for crowns and onlays will be incurred on the date that the tooth is prepared.
   (b) Fixed Partial Dentures (abutment crowns and pontics) – The total cost for fixed partial dentures will be incurred on the date that the teeth are prepared to receive said appliance.
(c) Removable Complete and Partial Dentures – Total cost for removable complete and partial dentures will be incurred on the date that the final impressions are taken for said appliance.

(d) Endodontics – Total cost for endodontic treatment will be incurred when the pulp chamber of the tooth is opened.

(e) Implant Body – Total cost for the implant body, including healing cap, will be incurred on the date of surgical placement.

(f) Implant Prosthetics – Total cost for the prosthetic portion of an implant will be incurred on the date the final impression is taken for said appliance.

(g) Orthodontics – Total cost for orthodontic treatment will be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the patient’s mouth.

SECTION V. CONDITIONS

HealthTrust Agrees:

(A) Nothing herein will require the Claims Administrator to provide a recommendation of a Dentist to an Eligible Person.

(B) Subject to the provisions of this Plan Document and to such uniform requirements as are deemed proper by the Claims Administrator, to make payments through the Claims Administrator for Benefits in the following manner:

1. For Benefits provided to an Eligible Person by a Dentist participating in Delta Dental’s PPO network, the Claims Administrator will pay to such Participating Dentist the applicable Selected Percentage of the lesser of either (a) Delta Dental’s allowance for Dentists participating in the Delta Dental PPO network in the geographic area in which the services were provided, or (b) the actual submitted charge. Such payment, together with the Eligible Person’s applicable Co-payment, will discharge in full the claim of such Participating Dentist for the Benefits provided.

2. For Benefits provided to an Eligible Person by a Dentist participating in Delta Dental’s Premier network, the Claims Administrator will pay to such Participating Dentist the applicable Selected Percentage of the lesser of either (a) Delta Dental’s allowance for Dentists participating in the Delta Dental Premier network in the geographic area in which the services were provided, or (b) the actual submitted charge. Such payment, together with the Eligible Person’s applicable Co-payment, will discharge in full the claim of such Participating Dentist for the Benefits provided.

3. For Benefits provided to an Eligible Person by a Non-Participating Dentist within the geographic area of Northeast Delta Dental (Maine, New Hampshire and Vermont), the Claims Administrator will pay the applicable Selected Percentage of the lesser of either (a) the actual submitted charge, or (b) the Claims Administrator’s allowance for Non-Participating Dentists located in the tri-state region. Payment will be made directly to the Subscriber unless the state in which the services are rendered requires that assignments of Benefits be honored and the Claims Administrator receives written notice of an assignment on the claim form before payment of Benefits is made. Unless assignment of Benefits applies, the Subscriber will be responsible for paying the Non-Participating Dentist both the amount received by the Subscriber from the Claims Administrator and also any portion of the Non-Participating Dentist’s fee which is not discharged by such payment from the Claims Administrator.

4. For Benefits provided to an Eligible Person by a Non-Participating Dentist outside the geographic area of Northeast Delta Dental (Maine, New Hampshire and Vermont), the Claims Administrator will pay the applicable Selected Percentage of the lesser of either (a) the actual submitted charge, or (b) an amount equal to a selected percentile of a nationally recognized database for the zip code in which the services were provided. When there is not sufficient fee information available for a specific dental procedure, the Claims Administrator will determine an appropriate payment amount. Payment will be made directly to the Subscriber unless the state in which the services are rendered requires that assignments of Benefits be honored and the Claims Administrator receives written notice of an assignment on the claim form before payment of Benefits is made. Unless assignment of Benefits applies, the Subscriber will be responsible for paying the Non-Participating Dentist both the amount received by the Subscriber from the Claims Administrator.
SECTION VI. COORDINATION OF BENEFITS (DUAL COVERAGE)

In the event that any Eligible Person is entitled to Benefits under any dental benefit program other than that described in this Plan Document, the following Coordination of Benefits provisions will determine the sequence and the extent of payment of Benefits under this Plan Document. Such other benefit programs may include any other group sponsored dental plan in which the Eligible Person is enrolled.

When an Eligible Person is covered under another dental benefit program the following rules will establish the order of determining liability:

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

2. The plan covering the Eligible Person solely as an employee will determine its benefits before the plan that covers the Eligible Person solely as a dependent.

3. The plan covering the Eligible Person solely as a dependent of the parent whose birthday occurs earlier in a calendar year will determine its benefits before the plan covering the Eligible Person solely as a dependent of the parent whose birthday occurs later in a calendar year (“Birthday Rule”). A parent’s year of birth is not relevant. If both parents have the same birthday (month and day), the benefits of the plan which covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time. If the other dental benefit program does not use the “Birthday Rule” then that plan’s provisions will determine the order of liability.

4. Notwithstanding paragraph (3) above, the order of payment for the claims of a Dependent child of divorced or legally separated parents will be as follows:
   (a) the plan of the parent with custody;
   (b) the plan of the spouse of the parent with custody (step-parent);
   (c) the plan of the parent without custody; or
   (d) if the parents have joint custody, paragraph (3) above will apply.

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

5. If paragraphs (1) through (4) above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time will be determined first.

6. When this Plan is the first to determine its Benefits under paragraphs (1) through (5) above, Benefits hereunder will be paid without regard to coverage under any other plan. When this Plan is not the first to determine its Benefits and there are remaining expenses of the type allowable hereunder, the Claims Administrator will pay up to the amount the Plan 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.

The Claims Administrator may use such reasonable efforts as it deems suitable to determine the existence of other benefit programs but will be under no obligation to do so.

The payment of Benefits under this Plan will be affected by the benefits that would be payable under any and all other plans only to the extent that the Claims Administrator is furnished with information relative to such other plans by the Participating Group or an employee of any other insurance company, or other organization or person.

7. For the purposes of determining the applicability and implementing the terms of this SECTION (VI) or any provisions of similar purpose of any other plan, the Claims Administrator may, without the consent
8. Multiple Coverage. In coordinating benefits with any other dental plan, time limitations and frequency of service limitations will not change. Coverage for services, when a specified number are provided per a specified time period, will 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 two cleanings in a calendar year, the combined plans will still only cover two cleanings in any calendar year. If a cleaning is covered under this Plan, but has been paid for, whether in full or part, by another plan, the cleaning will count toward the maximum number of cleanings allowed under this Plan.

SECTION VII. GENERAL PROVISIONS

(A) Participating Dentists are independent contractors and neither HealthTrust nor the Claims Administrator will be liable for any act or omission of any Participating Dentist, his/her employees or agents, or any person furnishing Dental Care or other professional services to Eligible Persons under the Plan.

(B) All Eligible Persons receiving Dental Care services under this Plan are bound by all the terms and conditions of this Plan Document.

(C) In consideration of waiving physical examination of an Eligible Person and as a condition precedent to the approval of claims hereunder, the Claims Administrator will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist’s care is rendered, such information and records relating to attendance to, or examination of, or treatment rendered to such person as may be required in the administration of such claim. The Claims Administrator may require that an Eligible Person be examined by a dental consultant retained by the Claims Administrator in or near his/her community. The Claims Administrator will, in every case, preserve the confidentiality of such information except when disclosure is necessary for the proper administration of the Plan or is permitted by law. Any disclosure of confidential information will be in compliance with applicable federal and state law requirements.

(D) Right of Recovery. HealthTrust and the Claims Administrator have the right to recover excess payments made for Benefits from the payee.

(E) Any notice required or permitted to be given by the Claims Administrator hereunder will be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to a Subscriber or a Dentist at the last address of record at Delta Dental. Such notice will be deemed to be given when personally delivered or mailed.

(F) The Benefits to be provided under the Plan are for the personal benefit of Eligible Persons and cannot be transferred or assigned. Any attempt to so assign the Benefits will automatically terminate all rights hereunder. No rights of an Eligible Person to payment from, or claim or cause of action against, the Plan may be assigned to any Dentist. All payments made by the Plan will be subject to this provision.

(G) In the event of any payments for Dental Care under the Plan, HealthTrust and the Plan will be subrogated to all of the Eligible Person’s rights of recovery thereof against any person or organization and the Subscriber or Eligible Dependent will execute and deliver such instruments and papers and do whatever else is necessary to secure such rights. The Claims Administrator will, on behalf of HealthTrust and the Plan, diligently pursue the subrogation rights under the provisions of this paragraph.

(H) Delta Dental has established a procedure for resolving all questions raised by a Dentist in regard to claims for Dental Care and Benefits allowed or rejected pursuant to the terms of the Plan. Such procedure will be utilized both for the initial determination of such questions and also for the resolution of appeals made on the basis of such initial determinations. Resolution of claims disputes of Eligible Persons will be in accordance with the procedures as established by Delta Dental. However, HealthTrust will have the right of final determination of any disputed claim.
(I) HealthTrust and Northeast Delta Dental respect and carefully preserve the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

For a copy of either HealthTrust’s or Northeast Delta Dental’s Notice of Privacy Practices, which describes in detail their respective privacy practices, or for any questions about their privacy practices, please contact:

<table>
<thead>
<tr>
<th>HealthTrust</th>
<th>Northeast Delta Dental</th>
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<tbody>
<tr>
<td>Privacy Officer</td>
<td>Privacy Officer</td>
</tr>
<tr>
<td>25 Triangle Park Drive</td>
<td>One Delta Drive</td>
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<tr>
<td>PO Box 617</td>
<td>PO Box 2002</td>
</tr>
<tr>
<td>Concord, NH 03302-0617</td>
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<tr>
<td>800.527.5001</td>
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(J) Non-ERISA Governmental Plan. The Plan is a governmental plan established and maintained by the Participating Group and HealthTrust, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974 (ERISA).

(K) The Plan and this Plan Document shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

SECTION VIII. AMENDMENT AND TERMINATION

HealthTrust reserves the right, at its sole discretion at any time, to amend, modify, or terminate the Plan, or any part of the Plan, by written instrument executed by an authorized representative of HealthTrust. Upon execution of such instrument, such instrument will become effective in accordance with its terms as to all Subscribers and all persons having or claiming any interest hereunder.

HealthTrust, Inc.

By: Peter Bragdon
Executive Director
## DENTAL BENEFIT OPTIONS

### HealthTrust
Available Dental Benefit Options (as of 1/1/15)

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* Coverages with Adult Ortho
** $1,500 Maximum on Ortho (rather than traditional $1,000)
*** $750 Maximum on Ortho (rather than traditional $1,000)