Dental

Plan Document

for Benefits Provided by HealthTrust

HealthTrust

DELTA DENTAL®

Northeast Delta Dental

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INTRODUCTION AND GENERAL INFORMATION

(A) INTRODUCTION

This Plan Document provides Participating Groups offering a HealthTrust Dental Plan with a comprehensive description of the terms and conditions of Benefits coverage available to Eligible Persons. The actual coverage under the Plan is based upon the election made by the Participating Group and is set forth in 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 ("Northeast 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 Northeast Delta Dental or other entities or individuals providing services in regard to the Plan. HealthTrust reserves the right to change, interpret, modify, withdraw, or add Benefits to the 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 the Plan by giving advance notice of at least 30 days to the Participating Group.

The legal documents governing the Plan consist of this Plan Document and the Dental Plan Description attached hereto as Appendix B and incorporated herein by reference. Any change or amendment to the Plan shall be made in a written amendment approved by an authorized representative of HealthTrust, as described in Section VII. No individual 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

Northeast Delta Dental is affiliated with a national association known as Delta Dental Plans Association and other Delta Dental companies which provide 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 available Dental Benefit Options as set forth in Appendix A attached hereto and incorporated herein by reference. Selected Benefits for the Participating Group are set forth in the Dental Transmittal provided to the Participating Group by HealthTrust.

Name, business address, and telephone number of **HealthTrust:**

HealthTrust
25 Triangle Park Drive
P.O. Box 617
Concord, NH 03302-0617

603.226.2861
800.527.5001

Name, business address, and telephone number of **Northeast Delta Dental:**

Delta Dental Plan of New Hampshire
One Delta Drive
P.O. Box 2002
Concord, NH 03302-2002

603.223.1000
800.537.1715

For assistance in understanding this Plan Document, contact either HealthTrust or Northeast 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 categories of covered Dental Care available to Eligible Persons enrolled in the Plan as described in this Plan Document (including the Dental Transmittal) and the Dental Plan Description.

(C) **Claims Administrator** means Delta Dental Plan of New Hampshire, also known as Northeast Delta Dental, 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 in the Dental Transmittal.

(E) **Deductible** means the portion of the charge for covered Dental Care that the Eligible Person must pay before the Plan's payment responsibility begins as specified in the Dental Transmittal.

(F) **Delta Dental** means the dental service corporations and not-for-profit dental care companies, including Northeast Delta Dental, that comprise the members of Delta Dental Plans Association and which provide Dental Care programs in all states and U.S. territories.

(G) **Dental Benefit Options** means the coverage options available to Participating Groups (as set forth in Appendix A), which options include applicable coverage categories, Selected Percentages, Deductibles, and Maximum limitations.

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

(I) **Dental Enrollment 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 Enrollment Application by HealthTrust. This form is also used to notify HealthTrust of changes in enrollment information.

(J) **Dental Plan Description (or DPD)** means the document attached hereto as Appendix B and incorporated herein by reference.

(K) **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.

(L) **Dentist** means an individual duly licensed to practice dentistry in the state in which the Dental Care is provided.

(M) **Dependent** means an individual who may be enrolled for Benefits under the Plan pursuant to the provisions of Section II of this Plan Document.

(N) **Eligible Dependents** means those Dependents who meet the eligibility criteria and are properly enrolled for coverage under the Plan pursuant to the provisions of Section II of this Plan Document.

(O) **Eligible Persons** means the Subscriber and Eligible Dependent(s) who are enrolled for coverage under the Plan pursuant to the provisions of Section II of this Plan Document.

(P) **Employee** means any individual who is described as an employee in the governing documents applicable to HealthTrust other than an individual 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 individual who is (i) actively engaged in employment with the 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 the Participating Group. For purposes of this definition, an individual 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 for the Participating Group.

(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.

(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 Delta Dental Plan of New Hampshire, also known as the Claims Administrator.

(U) **Other Dental Provider (ODP)** means an individual, other than a Dentist, who provides dental services and is authorized and licensed to provide such services by the state in which the services are rendered.

(V) **Participating Dentist** means a Dentist who has signed a participating agreement with Northeast Delta Dental or another Delta Dental company. A Participating Dentist agrees to abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental or another Delta Dental company.

(W) **Participating Group** means a New Hampshire municipality, county, school district or other political subdivision or instrumentality thereof which is a participating member of HealthTrust and has elected to provide dental coverage under the Plan to Eligible Persons.

(X) **Plan** means the HealthTrust Dental Plan offered by the Participating Group as described in this Plan Document and the Dental Plan Description.

(Y) **Plan Document** means this document and all appendices and riders including without limitation the Dental Benefit Options, the Dental Plan Description and the Dental Transmittal, which documents are incorporated herein by this reference.

(Z) **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 in the Dental Transmittal.

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

(BB) **Processing Policies** means the policies approved by Northeast 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 the DPD.

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

(DD) **Retiree** means an individual 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 options selected by the Participating Group at the beginning of each Plan Year from the available Dental Benefit Options. The Selected Benefits for the Participating Group are set forth in the Dental Transmittal.

(FF) **Selected Percentage** means the percentage amount of charges for Selected Benefits which the Plan will pay as set forth in 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 pursuant to the provisions of Section II of this Plan Document.

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 (other than Dependent children age 19 and over) 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). In addition, if there is an Employee contribution for Dependents, at least 50% of Subscribers with Dependents must enroll all of their eligible Dependents (other than Dependent children age 19 and over) 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 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) is certified as being an eligible Employee or Retiree by the Participating Group; and

(b) has satisfied any applicable Probationary Period.

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

In addition to the Subscriber, the following individuals are also eligible for enrollment under the Plan as Dependents provided that Dependent coverage is offered by the Participating Group (as set forth in 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 state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages; 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 Domestic Partner 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;

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 Enrollment 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 coverage 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 Enrollment Application (for the Employee or his or her Dependents) when the employee first becomes eligible to enroll, such individual(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.

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 Enrollment 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 Enrollment 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 and/or his or 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/or his or 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. These special enrollment rights are in addition to a Subscriber's right to add Dependents to existing coverage as described in subsection 3(b) below.

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 Enrollment Application in accordance with the above timeframes and 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 Enrollment 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 Enrollment Application. An applicant is enrolled only upon acceptance of the Dental Enrollment 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 Enrollment 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 Enrollment Application within 31 days. If a Dental Enrollment 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 Enrollment 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. a change in a child's eligibility under Section II (A) 2 (b) due to age (turning age 2 or 26) or incapacity;

iii. adoption, placement for adoption or a change in legal custody of a child who is at least two (2) years of age;

iv. death of a spouse or a Dependent child;

v. 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);

vi. 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;

vii. 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 and the Participating Group recognizes this as a qualified change in status; or

viii. the Subscriber's or a Dependent's involuntary loss of, or becoming newly eligible for, other dental insurance coverage.

HealthTrust is not responsible for automatically changing a Subscriber's coverage type or adding or removing Dependents upon a qualified family status change event. 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.

A Subscriber may enroll or remove Dependents and/or change coverage type by submitting a Dental Enrollment 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 Enrollment 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 Enrollment 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 Enrollment 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.

(c) Retroactivity Limit on Addition or Removal of Enrolled Dependents

Except as otherwise provided for in this Plan Document, addition or removal 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 effect 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 in Section II (D), coverage of an Eligible Person will automatically terminate on the earliest of the following dates:

1. The date HealthTrust ceases to offer the Plan to Participating Groups;
2. The date as of which the Participating Group (or a subunit of 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 omitted or made a material misrepresentation of fact on the Dental Enrollment Application (or other required documentation) 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 HealthTrust's or 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, if an unauthorized individual 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 Participating Group and HealthTrust are not notified of these qualifying events 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 the 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 have access to 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 at ***www.deltadentalcoversme.com*** or at ***www.healthcare.gov***.

SECTION III. BENEFITS

HealthTrust Agrees:

To provide Benefits to Eligible Persons in accordance with the terms and conditions of this Plan Document and the Dental Plan Description (DPD), and in accordance with the rules, regulations and Processing Policies (including applicable American Dental Association (ADA) dental terminology and CDT codes) of the Claims Administrator, as amended from time to time.

The various coverage categories of dental benefits that may be selected under a HealthTrust Dental Plan, including applicable exclusions and limitations, are described in Sections IV and V of the DPD attached as Appendix B. **Eligible Persons will only be entitled under the Plan to those Benefit coverage categories selected by the Participating Group as set forth in the Dental Transmittal.**

SECTION IV. 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) the actual submitted charge, or (b) Northeast Delta Dental's allowance for Dentists participating in the Delta Dental PPO network in the geographic area in which the services were provided. 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) the actual submitted charge, or (b) Northeast Delta Dental's allowance for Dentists participating in the Delta Dental Premier network in the geographic area in which the services were provided. 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 or ODP, the Claims Administrator will pay the applicable Selected Percentage of the lesser of either (a) the actual submitted charge, or (b) Northeast Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. The Non-Participating Dentist or ODPs may balance bill up to their submitted charge. When there is not sufficient fee information available for a specific dental procedure, the Claims Administrator will determine an appropriate payment amount. An Eligible Person may be requested to bring a claim form for his or her visit. Claim forms are available at ***www.nedelta.com*** or by calling 800.832.5700.

   Payment will be made directly to the Subscriber unless the state in which the services are rendered requires that assignment 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 or ODP both the amount received by the Subscriber from the Claims Administrator and also any portion of the Non-Participating Dentist's or ODP's fee which is not discharged by such payment from the Claims Administrator.

SECTION V. COORDINATION OF BENEFITS (DUAL COVERAGE)

In the event that any Eligible Person is entitled to benefits for Dental Care under any health care benefit program other than this Plan, the Coordination of Benefits provisions as set forth in Section VI of the DPD will determine the sequence and the extent of payment of Benefits under this Plan. Such other benefit programs may include any other group or individual plan providing benefits for Dental Care in which the Eligible Person is enrolled.

SECTION VI. 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 or her employees or agents, or any individual 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 individual 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 or 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 Northeast 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, except as otherwise required by law. 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 third party 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) Northeast 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 Northeast 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, please visit HealthTrust's website (***www.healthtrustnh.org)*** or Northeast Delta Dental's website (***www.nedelta.com)***. Alternatively, for a copy of the Notice of Privacy Practices, or for any questions about their privacy practices, please contact:

Privacy Officer
HealthTrust
25 Triangle Park Drive
PO Box 617
Concord, NH 03302-0617
800.527.5001

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

(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, as amended (ERISA).

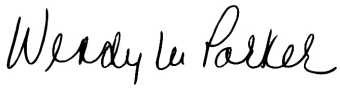
(K) The Plan and this Plan Document shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

(L) On occasion, HealthTrust may, at its option, choose not to enforce all the terms and conditions of the Plan; however, HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of HealthTrust or Northeast Delta Dental has the right to change or waive any of the provisions of the Plan without the approval of an authorized representative of HealthTrust. Any condition, limitation, exclusion or other provision of this Plan Document which is found to be illegal or unenforceable for any reason will not affect the remaining provisions of this Plan Document.

SECTION VII. AMENDMENT AND TERMINATION OF PLAN

HealthTrust may, at its sole discretion at any time, amend or modify the Plan or this Plan Document through a written amendment approved by a duly authorized representative of HealthTrust. Upon the approval of any such amendment, it will become effective in accordance with its terms as to the Participating Group and all Eligible Persons. No individual or entity has any authority to make any oral changes or oral amendments to the Plan or this Plan Document. HealthTrust reserves the right to terminate the Plan at any time by giving advance notice of at least thirty (30) days to the Participating Group.

HealthTrust, Inc.



By: Wendy Lee Parker
Executive Director

APPENDIX A - DENTAL BENEFIT OPTIONS

HealthTrust
Available Dental Benefit Options (as of 7/1/15)

	1	1A	1B	1C*	1E	1F*	1G	1I*	1J	1L*	1O*	1P*	1Q	1R
A	100	100	100	100	100	100	100	100	100	100	100	100	100	100
B	80	80	80	80	80	80	80	80	80	80	80	80	80	80
C	50	50	50	50	50	50	50	60	50	60	50	60	80	50
D	50	50	50	50	50	50	50	60	50	60	50	50	50	50
DED	25/75	0	25/75	0	50/150	50/150	0	50/150	0	50/150	25/75	0	25/75	25/75
MAX	1,000	1,000	1,250	1,000	1,000	1,000	750	1,000**	1,500	1,500**	1,500**	1,500**	1,000	1,000**
	1S	**2**	**2A**	**3**	**3A**	**3B**	**3C**	**3D**	**3E**	**4**	**4A**	**4B**	**4C**	**4D**
A	100	100	100	100	100	100	100	100	100	100	100	100	100	100
B	80	80	80	80	80	80	80	80	80	80	80	80	80	80
C	50	50	50	50	50	50	50	50	50	0	0	0	0	0
D	50	0	0	0	0	0	0	0	0	0	0	0	0	0
DED	0	25/75	0	25/75	0	0	50/150	0	25/75	25/75	0	50/150	0	25/75
MAX	2,000	750	750	1,000	1,000	1,250	1,500	2,000	1,500	750	750	750	1,000	1,000
	5	**6**	**6A**	**6B**	**6C**	**6E**	**6F***	**8**	**8A**	**8B**	**10**	**10A**	**10B**	**12**
A	50	100	100	100	100	100	100	100	100	100	100	100	100	100
B	50	100	100	100	100	100	100	80	80	80	75	75	75	70
C	0	50	50	50	50	50	50	70	70	70	50	50	50	60
D	0	0	0	50	50	50	50	0	50	50	0	0	0	0
DED	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MAX	500	1,000	750	1,500	1,000	1,500**	1,000**	1,500	1,500**	2,000**	1,000	750	1,250	750
	13	**13A**	**15**	**15A**	**15C**	**15D**	**16**	**17**	**17A**	**18**	**18A**			
A	100	100	100	100	100	100	100	100	100	100	100			
B	70	70	60	60	60	60	60	50	50	50	50			
C	50	50	50	50	50	50	0	50	50	50	50			
D	0	0	0	0	0	0	0	50	50	0	0			
DED	0	0	0	0	0	25/75	0	25/75	0	25/75	0			
MAX	2,000	750	1,500	1,250	750	1,000	750	750	1,500**	750	1,500			

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