



Northeast Delta Dental
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 Concord, NH 03302-2002
 Customer Service:
 603-223-1234
 800-832-5700

**Outline of Benefits
 Addison Northeast SU
 Group Number: 7777-1276, 1277, 1278, 1279, 1280, 1281, 1282**

Contract Year for Benefits – July 1 through June 30.

Eligibility – Determined by the employer.

Waiting Periods: N/A

Eligible Persons - Subject to the “Eligibility” provision above, employees and their dependents may be enrolled. Your employer pays a portion of the cost for all enrolled employees. An employee may enroll fewer than all dependents. A newborn child is automatically covered for the first thirty-one (31) days following birth. Coverage will continue if the child is formally enrolled within the first thirty-one days following birth or the child may be enrolled thereafter at any open enrollment or as of the first day of the month following the month of the child’s second birthday.

Benefit Coverages and Percentages Paid by Northeast Delta Dental -

Diagnostic & Preventive	100%
Basic	80%
Major -includes implant services	50%

Maximum Benefit - The maximum amount which your plan will pay is \$1000 per person per Contract Year for Diagnostic & Preventive, Basic and Major Benefits.

Deductible – There is a \$25 deductible per person with a family deductible maximum of \$75. This deductible is applied to Coverage Basic and Major benefits.

Contribution - The employer pays at least 50% for all eligible employees. The dependent coverage is optional.

Benefit percentages shown are based upon the actual charge submitted to a maximum of the Participating Dentist's approved fees or Northeast Delta Dental's allowance for Non-Participating Dentists.

III. Benefits

Diagnostic & Preventive Benefits (Coverage A)

- Diagnostic:** Evaluations and radiographs (x-rays) to determine required dental treatment
- Limited oral evaluation
- Oral evaluation – once in any period of six (6) consecutive months. This can be a comprehensive or periodic evaluation provided by a specialist or a general Dentist.
- Radiographs – complete series or panoramic film once in any period of three (3) consecutive years; bitewing films (x-rays) once in any period of twelve (12) consecutive months; films of individual teeth as necessary
- Preventive:** Specific procedures employed to prevent the occurrence of dental disease
- Prophylaxis (cleaning) – once in any period of six (6) consecutive months (child prophylaxis through age twelve (12), adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance (Coverage B).
- Fluoride treatment – once in any period of twelve (12) consecutive months through age eighteen (18)
- Space Maintainers
- Sealants

NOTE: *The time limitation will be measured from the date the service was last performed. Only those coverage classifications selected by your group shall apply.*

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. Sealant benefit limitation:
 - (a) Sealant benefit is provided only to Eligible Dependents fourteen (14) years of age or younger.
 - (b) Sealant benefit includes the application of sealants to caries free (no decay) and restoration free permanent molars.
 - (c) Sealant benefit is provided no more than once in a lifetime per tooth.
3. A limited oral evaluation, when done in conjunction with a procedure (other than x-rays) on the same visit is considered a part of, and included in the fee for, the procedure. Patient will be responsible for any additional fee.
4. 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 consultants' review. A Delta Dental Participating Dentist agrees not to charge a separate fee.
5. The replacement or repair of space maintainers and orthodontic appliances is not a covered benefit.
6. Space maintainers are a covered benefit for Eligible Dependents fifteen (15) years or younger when a space is being maintained for an erupting permanent tooth.
7. 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 accordingly and a Delta Dental Participating Dentist agrees not to charge a separate fee.

Basic Benefits (Coverage B)

Restorative:	Amalgam (silver) and/or resin (white) restorations (fillings) (anterior teeth only). If Coverage C (Major) is not a covered benefit, and unless otherwise specified in the Outline of Benefits, payment for restorative crowns and onlays will be at the selected Co-payment specified in the Outline of Benefits for a four (4) surface amalgam restoration.
Oral Surgery:	Extractions and covered surgical procedures
Periodontics:	Treatment of diseased tissue supporting the teeth and periodontal maintenance Prophylaxis (cleaning) – once in any period of six (6) consecutive months. This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance (Coverage B).
Endodontics:	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy
Denture Repair:	Repair of removable complete or partial denture to its original condition
Palliative Treatment:	Minor emergency treatment for the relief of pain
Anesthesia:	General anesthesia or intravenous sedation, when administered in conjunction with an extraction; tooth reimplantation; surgical exposure of tooth; surgical placement of implant body (only when implantology is specified as a benefit in the Outline of Benefits); biopsy; transseptal fibrotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

NOTE: *The time limitation will be measured from the date the service was last performed. Only those coverage classifications selected by your group shall apply.*

Coverage B Exclusions and Limitations:

1. A prophylaxis, a full month 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 accordingly and a Delta Dental Participating Dentist agrees not to charge a separate fee.
2. Tooth preparation, bases, copings, sedative fillings, impressions, and local anesthesia, or other services which are part of the complete dental procedure, are considered components of and included in the fee for a complete procedure. A Delta Dental Participating Dentist agrees not to charge a separate fee.
3. Resin restorations in posterior teeth (white fillings in bicuspids and molars) are optional. An allowance will be paid equal to an amalgam (silver) restoration. If a resin restoration is performed, patient is responsible for any additional fee.
4. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Delta Dental Participating Dentist agrees not to charge a separate fee.
5. Routine post operative visits are considered part of, and included in the fee for, the total procedure. A Delta Dental Participating Dentist agrees not to charge a separate fee.
6. Periodontal scaling and root planing is a covered benefit once in any period of twelve (12) consecutive months per quadrant.

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7. Exploratory surgical services are not a covered benefit. Patient is financially responsible.
 8. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Delta Dental Participating Dentist agrees not to charge a separate fee.
 9. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years.
 10. Periodontal services are a non covered benefit when done for crown lengthening.
 11. 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 in conjunction with the final restoration. A Delta Dental Participating Dentist agrees not to charge a separate fee.
 12. Recementation of a crown, inlay, onlay, and/or partial coverage restoration is a benefit once in any period of twelve (12) consecutive months.
 13. Recementation of a cast or prefabricated post and core is a benefit once in any period of twelve (12) consecutive months.
 14. Anterior deciduous root canal therapy is not a covered benefit.
 15. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, or soft tissue graft procedure is a benefit once in any period of three (3) consecutive years.

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

Major Benefits (Coverage C)

Restorative Crowns and Onlays:	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and relining of such prosthetic appliances; core buildups; cast and prefabricated posts and cores; and fixed partial denture and crown repairs
Implant Services:	If specified in the Outline of Benefits, surgical placement of an endosteal implant body including healing cap
Implant Supported Prosthetics	

NOTE: *The time limitation will be measured from the date the service was last performed. Only those coverage classifications selected by your group shall apply.*

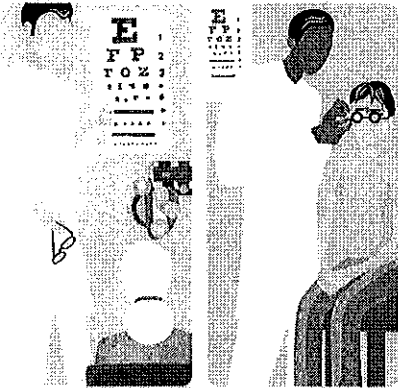
Coverage C Exclusions and Limitations:

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 time limitations:
 - (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of five (5) consecutive years.
 - (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of five (5) consecutive years.
 - (c) A removable or fixed partial denture in any period of five (5) 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 five (5) consecutive years.
 - (e) The period of five (5) consecutive years referred to in (a), (b), (c), and (d) above is to be measured from the date the service was last performed.
4. Removable or fixed partial dentures are not benefits for patients under the age of twelve (12).
5. When covered, implant body including healing cap is a benefit once in a lifetime per site.
6. Implantology, when covered, is not a benefit for patients under the age of sixteen (16).
7. When implantology is covered, eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. If performed, patient is responsible for any additional fee.
8. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are covered benefits. Patient will be responsible for any additional fee.
9. Recementation of a fixed partial denture is a benefit once in any period of twelve (12) consecutive months.
10. The relining of a denture is a benefit once in any period of three (3) consecutive years.

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Vision Discount Program

This vision discount program is available free to all Northeast Delta Dental subscribers and their dependents.



VISION WELLNESS

Regular eye examinations play a crucial role in ensuring healthy vision and overall health.

- An eye examination can not only detect vision problems, but also can detect the early stages of serious health problems such as diabetes and hypertension.
- One in four children has an undetected vision problem that can interfere with learning, according to the Vision Council of America.
- Undetected eye diseases can lead to worsening eyesight and in some cases irreversible vision loss.

Great Savings— Up to 35% off eyewear

Choose from any available frame including quality name-brand products such as Brooks Brothers®, Ann Klein®, Vogue® and more at provider locations.

With EyeMed Vision Care, Northeast Delta Dental members have access to **over 46,000 vision care providers nationwide at 22,000 locations** including optometrists, ophthalmologists, opticians, and the nation's leading optical retailers:

LENSCRAFTERS®

PEARLE VISION®



It's easy! To request your discount, simply present your Delta Dental member ID card or this flyer when you arrive at the provider office or location. Your EyeMed provider will take care of the rest!

To learn more about the EyeMed Vision Care Discount Plan, please visit our Web site at www.nedelta.com.

For additional copies of this flyer, visit our Web site at www.nedelta.com

See Other Side for the Program Description.

Program Description

SAVE up to 35% OFF Frames, Lenses and Lens Options

Please take a few minutes to review the description of your Vision Discount Plan in detail. Remember, you can use this program as often as you wish—there is no limit to your savings!

Vision Care Services	Member Pays
Exam with Dilation as Necessary:	\$5 off comprehensive exam \$10 off contact lens exam
Complete Pair Glasses Purchase: <ul style="list-style-type: none"> • The following Frame, Lenses, and Lens Options discounts & fees apply only if a complete pair is purchased in same transaction. • Items purchased separately will be discounted 20% off the retail price. 	
Standard Plastic Lenses including Standard Scratch: Single Vision Bifocal Trifocal	\$75 \$95 \$125
Frames: Any frame available at provider location	30% off retail price
Lens Options: Standard UV Standard Tint Standard Polycarbonate Standard Anti-reflective Coating Standard Progressive (add-on to bifocal)	\$15 \$15 \$40 \$45 \$70
Contact Lenses: (Discount applied to materials only) Conventional	15% off retail price
Laser Vision Correction: LASIK or PRK	15% off retail price - or - 5% off promotional price

Frequency
All Services

Unlimited

THIS IS NOT INSURANCE

Replacement Contact Lens By Mail Service:

Members may receive replacement contact lenses at competitive prices via the Internet and have them mailed directly to their home. Simply visit www.eyemedcontacts.com to order.

Members will receive a 20% discount on those items purchased at participating providers that are not specifically covered by this Discount design. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Please note, all dependents are eligible for discounts with all discount plans.

**LASIK and PRK correction procedures are provided by the U.S. Laser Network, owned by LCA-Vision. Members must first call 1-877-552-7376 for the nearest laser facility and to receive authorization for the discount.