



**Town of Bristol  
Request for Proposal  
Health Insurance**

The Town of Bristol, NH seeks proposals from qualified health insurance providers for health insurance coverage.

**Instructions:** Two copies of the proposal should be submitted in a sealed envelope to:  
Cassandra Pearce, Finance/Human Resource Director, 230 Lake Street, Bristol, NH  
03222. **Proposals must be received at this address  
no later than 12:00PM on Friday, November 4<sup>th</sup>, 2016.**

Proposal prices must be effective for the period from January 1, 2017 through December 31, 2017 for Health Insurance and July 1, 2017 through June 30, 2018 for Dental Insurance. Contact Cassandra Pearce, at 603-744-3354 ext. 11 to request more information or visit our website at [www.townofbristolnh.org](http://www.townofbristolnh.org).

**\*\* The Town of Bristol reserves the right to accept or reject any and all proposals or parts thereof, to accept the proposal they deem to be in the best interest of the Town, and to waive any bid formality.\*\***



The information below is provided for developing a proposal for the Town of Bristol's health insurance coverage. For additional information, please contact Cassandra Pearce, Finance/Human Resource Director, at 603-744-3354 ext. 11 or [finance@townofbristolnh.org](mailto:finance@townofbristolnh.org).

The Town of Bristol currently receives its health insurance through Inter Local and dental insurance through Health Trust. The Town currently offers one health insurance plan to eligible employees:

Harvard Pilgrim Best Buy HMO \$1,000/\$3,000

Current enrollment:

Individual: 6 subscribers

Two-person: 7 subscribers

Family: 9 subscribers

Retiree's: 6 subscribers (2 are Medicare Enhance and 4 are HMOs of these there are 3 Individual plans and 3 two-person plans).

Delta Dental Option 17 – Basic Coverage – Paid 100% by Employees

Current Enrollment:

Individual: 6 subscribers

Two-person: 4 subscribers

Family: 7 subscribers

*(Please see the attached benefit summaries)*

**Proposal Requirements:**

- 1) Please propose health and dental plans which closely resembles the Town's current plan offerings and suggest alternatives which may be considered.
- 2) Medical subsidy payments are administered by the Carrier Provider through New Hampshire Retirement System (NHRS) to eligible employees. Proposals must include direct billing options to NHRS.

- 3) COBRA is administered by the Carrier Provider and the Town would like to continue this practice. Please include this requirement in the proposal.
- 4) Proposals prices must be effective for the period of January 1<sup>st</sup>, 2017 through December 31, 2017 for Health Insurance and July 1, 2017 through June 30, 2018.





# TOWN OF BRISTOL

230 Lake Street, Bristol, NH 03222

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## Health & Dental Insurance Rates (2016)

The Town participates in the *Harvard Pilgrim Best Buy HMO Plan* administered by Interlocal Trust. The Town pays 90% of the premium and the employee is responsible for the remaining 10%. (Rates and contributions are subject to change at the discretion of the Select Board annually.)

The following monthly premiums are broken down by plan:

Single: \$539.33

Two-person: \$1,077.86

Family: \$1,457.24

The Town also offers a basic preventative dental plan through HealthTrust which is paid for 100% by the employee. The following monthly costs are broken down by plan:

### *Delta Dental – Option 17*

Single: \$31.23

Two-person: \$60.42

Family: \$110.54

02/16

*“Gateway to Newfound Lake”*

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Phone: 603-744-3354 ~ Fax: 603-744-2521 ~ [www.townofbristolnh.org](http://www.townofbristolnh.org)





Harvard Pilgrim  
Health Care of New England

New Hampshire

## The Harvard Pilgrim Best Buy HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 02/01/2016 — 01/31/2017

Coverage for: Individual + Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.harvardpilgrim.org/LGsampleEOC](http://www.harvardpilgrim.org/LGsampleEOC) or by calling 1-888-333-4742.

Important Questions	Answers	Why this matters:
What is the overall deductible?	\$1,000 per member per calendar year / \$3,000 per family per calendar year The deductible applies to benefits cited in the chart starting on Page 3, for other benefits see your Plan document.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Durable Medical Equipment Deductible: \$100 per member per calendar year	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$2,000 per member per calendar year / \$5,000 per family per calendar year Separate out-of-pocket limit applies to Pharmacy; see "If you need drugs to treat your illness or condition".	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Please see your Schedule of Benefits for out-of-pocket maximum exclusions for your plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

Questions: Call 1-888-333-4742 or visit us at [www.harvardpilgrim.org](http://www.harvardpilgrim.org). If you are not clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.harvardpilgrim.org/fhcr](http://www.harvardpilgrim.org/fhcr) or call 1-888-333-4742 to request a copy.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Important Questions	Answers	Why this matters:
Does this plan use a network of providers?	Yes. For a list of preferred providers, see <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> or call 1-888-333-4742.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes, some exceptions apply.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



- Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>	<b>Limitations &amp; Exceptions</b>
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 Copayment per visit	Not covered	None
	Specialist visit	\$15 Copayment per visit	Not covered	None
	Other practitioner office visit	\$15 Copayment per visit	Not covered	Cost sharing may vary for certain practitioners.
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then no charge	Not covered	PET scans, MRA and Nuclear medicine services are covered in full
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at <a href="http://www.harvardpilgrim.org/2016Premium4T">www.harvardpilgrim.org/2016Premium4T</a> .	Most generic drugs	30-Day Supply Retail Pharmacy	Tier 1: No charge	None
		90-Day Supply Retail Pharmacy	Tier 1: No charge	
Preferred brand drugs	30-Day Supply Retail Pharmacy	90-Day Supply Mail Order Pharmacy	Tier 1: No charge	Some generic drugs are in this tier.
		30-Day Supply Retail Pharmacy	Tier 2: \$10 Copayment	
		90-Day Supply Retail Pharmacy	Tier 2: \$30 Copayment	
		90-Day Supply Mail Order Pharmacy	Tier 2: \$10 Copayment	
Preferred brand drugs	30-Day Supply Retail Pharmacy	90-Day Supply Retail Pharmacy	Tier 3: \$20 Copayment	Some generic drugs are in this tier.
		90-Day Supply Retail Pharmacy	Tier 3: \$60 Copayment	
		90-Day Supply Mail Order Pharmacy	Tier 3: \$40 Copayment	

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
	Non-preferred brand drugs	30-Day Supply Retail Pharmacy Tier 4: \$30 Copayment 90-Day Supply Retail Pharmacy Tier 4: \$90 Copayment 90-Day Supply Mail Order Pharmacy Tier 4: \$60 Copayment		Same as above.
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 4		Must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	Deductible, then no charge	Not covered	None
	Physician/surgeon fees	Deductible, then no charge	Not covered	None
If you need immediate medical attention	Emergency Room Services	\$150 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	Same As Participating Provider	None
	Emergency Medical Transportation	Deductible, then no charge	Same As Participating Provider	None
If you have a hospital stay	Urgent Care	Convenience care clinic \$15 Copayment per visit Urgent care clinic \$15 Copayment per visit Hospital Urgent care clinic: \$75 Copayment per visit	Convenience care clinic Not Covered Urgent care clinic Not Covered Hospital Urgent care clinic: Same As Participating Provider	None
	Facility fee (e.g, hospital room)	Deductible, then no charge	Not covered	None
	Physician/surgeon fee	Deductible, then no charge	Not covered	None

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>	<b>Limitations &amp; Exceptions</b>
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<b>Group Therapy: \$5</b> Copayment per visit <b>Individual Therapy: \$15</b> Copayment per visit	Not covered	None
	Mental/Behavioral health inpatient services	No charge	Not covered	None
	Substance use disorder outpatient services	<b>Group Therapy: \$5</b> Copayment per visit <b>Individual Therapy: \$15</b> Copayment per visit	Not covered	None
If you are pregnant	Substance use disorder inpatient services	No charge	Not covered	None
	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	Deductible, then no charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services (Inpatient)	Deductible, then no charge	Not covered	– Limited to 100 days per calendar year Day limits combined with Skilled nursing care.
	Habilitation services (Outpatient)	\$15 Copayment per visit	Not covered	– Physical Therapy – limited to 25 visits per calendar year – Occupational Therapy – limited to 25 visits per calendar year Physical and Occupational visit limits are combined per calendar year – Speech Therapy – limited to 25 visits per calendar year
	Skilled nursing care	Deductible, then no charge	Not covered	– Limited to 100 days per calendar year Day limits combined with Rehabilitation services.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance	Not covered	None
	Hospice services	No charge	Not covered	If inpatient services are required, please see "If you have a hospital stay".
If your child needs dental or eye care	Eye exam	\$15 Copayment per visit	Not covered	- Limited to 1 exam per calendar year You may have other coverage under a Vision Rider.
	Glasses	Not covered	Not covered	You may have other coverage under a Vision Rider.
	Dental check-up	Not covered	Not covered	You may have other coverage under a Dental Rider.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs  
**Excluded Services & Other Covered Services:**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Infertility Treatment
- Long-Term (Custodial) Care
- Most Cosmetic Surgery
- Most Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Services that are not Medically Necessary
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Routine eye care (Adult)

Questions: Call 1-888-333-4742 or visit us at [www.harvardpilgrim.org](http://www.harvardpilgrim.org). If you are not clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.harvardpilgrim.org/fhcr](http://www.harvardpilgrim.org/fhcr) or call 1-888-333-4742 to request a copy.

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-333-4742**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov)

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

HPHC Member Appeals-Member Services Department	Department of Labor's Employee Benefits Security Administration	New Hampshire Insurance Department
Harvard Pilgrim Health Care of New England, Inc.	1-866-444-3272	21 South Fruit Street, Suite 14
1600 Crown Colony Drive Quincy, MA 02169	<a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>	Concord, NH 03301
Telephone: 1-888-333-4742		1-800-852-3416
Fax: 1-617-509-3085		<a href="http://www.nh.gov/insurance">www.nh.gov/insurance</a>
		<a href="mailto:consumerservices@ins.nh.gov">consumerservices@ins.nh.gov</a>

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

## Language Access Services:

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助，请拨打这个号码 1-888-333-4742。

De assistência em Português, por favor ligue 1-888-333-4742.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

<b>Having a baby</b> (normal delivery)	
■ Amount owed to providers: \$7,540	
■ Plan pays: \$6,390	
■ Patient pays: \$1,150	

<b>Sample care costs:</b>	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

<b>Patient pays:</b>	
Deductibles	\$1,000
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,150</b>

<b>Managing type 2 diabetes</b> (routine maintenance of a well-controlled condition)	
■ Amount owed to providers: \$5,400	
■ Plan pays: \$4,470	
■ Patient pays: \$930	

<b>Sample care costs:</b>	
Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

<b>Patient pays:</b>	
Deductibles	\$0
Co-pays	\$850
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$930</b>

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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Questions and answers about the Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

#### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

#### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

#### Does the Coverage Example predict my own care needs?

X **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

#### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

#### Does the Coverage Example predict my future expenses?

X **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.



## Outline of Benefits

This summary describes the level of coverage under your employer's Local Government Center HealthTrust (LGC HealthTrust) Dental Plan for services performed by dentists who participate in the Delta Dental Premier network. Employees and their eligible dependents are free to visit any dentist, participating or nonparticipating. Visit Delta Dental's Web site at [www.nedelta.com](http://www.nedelta.com) for an updated list of participating dentists. Your LGC HealthTrust Dental Plan includes all of the following coverage categories. This information is provided for summary purposes only; certain benefit limitations may apply. Please refer to your Dental Plan Description for complete benefit information. In the event of a conflict or discrepancy between this summary and either the Plan Document or the Dental Plan Description, the Plan Document or the Dental Plan Description will prevail.

### Dental Plan Option 17

Coverage A Diagnostic/Preventive	Coverage B Basic	Coverage C Major	Coverage D Orthodontics
<b>Deductible: None</b>	<b>Deductible: \$25 Per Person, Per Year (\$75 Per Family)</b>		<b>Deductible: None</b>
<b>Covered at * 100%</b>	<b>Covered at * 50%</b>	<b>Covered at * 50%</b>	<b>Covered at * 50%</b>
<p><b>Diagnostic:</b> Evaluations - twice in a calendar year</p> <p>X-rays - complete series or panoramic film once in a 3-year period; bitewing x-rays - once in a calendar year; x-rays of individual teeth as necessary</p> <p>Oral cancer screening/brush biopsy - once in a calendar year, no age limit</p> <p><b>Preventive:</b> Cleanings (routine and/or periodontal) - four per calendar year</p> <p>Fluoride - twice in a calendar year through age 18</p> <p>Space maintainers - through age 15</p> <p>Sealant application to permanent molars - once in a 3-year period per tooth, for children through age 18</p>	<p><b>Restorative:</b> Amalgam (silver) fillings and/or Composite (white) fillings (anterior and posterior teeth)</p> <p><b>Oral Surgery:</b> Surgical and routine extractions</p> <p><b>Endodontics:</b> Root canal therapy</p> <p><b>Periodontics:</b> Periodontal cleaning (maintenance procedures - routine and/or periodontal) - four per calendar year</p> <p>Treatment of gum disease</p> <p>Clinical crown lengthening</p> <p><b>Denture Repair:</b> Repair of a removable denture to its original condition</p> <p><b>Emergency Palliative Treatment</b></p>	<p><b>Prosthodontics:</b> Removable and fixed partial dentures (bridge); complete dentures</p> <p>Rebase and reline (dentures)</p> <p>Crowns</p> <p>Onlays</p> <p>Implants</p>	<p><b>Orthodontics:</b> Correction of crooked teeth for dependent children through the end of the month in which the child turns 19</p>
<b>Calendar Year Maximum: \$750 per person (Coverages A, B and C combined) beginning each January 1<sup>st</sup></b>			<b>Orthodontic Lifetime Maximum: \$1,000 Per Person</b>

Benefit percentages shown are based upon the actual charge submitted to a maximum of the participating dentist's approved fees, or Delta Dental's allowance for non-participating dentists

## Delta Dental Premier Dentist Network

You'll get the best value from your Plan when you receive your dental care from a Delta Dental Premier participating dentist:

- ▲ **No balance billing:** Because participating dentists accept Delta Dental's approved amount for service, you will normally pay less when you visit a participating dentist.
- ▲ **No claim forms:** Participating dentists will prepare and submit claim forms for you.
- ▲ **Direct payment:** Northeast Delta Dental pays the dentist directly, so you don't have to pay the covered amount up-front and wait for a reimbursement check.

To find out if your dentist is part of the Delta Dental Premier network, call your dentist or visit Delta Dental's Web site at [www.nedelta.com](http://www.nedelta.com). Click on Locate a Dentist, then Local or National Dentist Directory. You can also call Delta Dental's Customer Service Department at 800.832.5700 or 603.223.1234.

## Claim Submission Process

### Participating Dentists

- ▲ Present your ID card to the dentist at the time of your visit.
- ▲ The dentist will submit your claim to Northeast Delta Dental.
- ▲ Northeast Delta Dental will send you a Notification of Benefits detailing what has been processed under your Plan's coverage. You are responsible to pay any remaining balance directly to the dentist.

### Nonparticipating Dentists

Your Plan provides coverage regardless of the patients' choice of dentists, participating or not. When visiting a nonparticipating dentist within the Northeast Delta Dental operating area of Maine, New Hampshire and Vermont, payment for services rendered will be based on the lesser of the dentist's actual submitted charge or Delta Dental's allowance for nonparticipating dentists. The patient may be required to submit the claim directly and pay for the services at the time they are provided. The Notification of Benefits and the claim payment will go to the subscriber; the patient will be responsible for any remaining balance. (In Maine, the claim payment will go to the subscriber unless a valid assignment of benefits has been received).

When visiting a nonparticipating dentist outside the Northeast Delta Dental operating area, payment for services rendered will be based on the lesser of the dentist's actual submitted charge or an amount equal to a selected percentile of a nationally-recognized database for the area in which the services were provided. The patient may be required to submit the claim directly and pay for the services at the time they are provided; the patient will be responsible for any remaining balance. The Notification of Benefits will go to the subscriber. The claim payment will go to the dentist unless the claim is marked "paid," otherwise it will be sent to the subscriber. (In Maine, the claim payment will go to the subscriber unless a valid assignment of benefits has been received).



**Local Government Center**

PO Box 617  
Concord, NH 03302-0617  
603.224.7447  
800.527.5001  
[www.nhlgc.org](http://www.nhlgc.org)

## Predetermination of Benefits

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.

## Coordination of Benefits

When a covered individual under this Plan has additional group dental coverage, the Coordination of Benefits provision described in your Dental Plan Description will determine the sequence and extent of payment. If you have any questions, please contact Delta Dental's Customer Service department at 800.832.5700 or 603.223.1234.

## Identification Card

Two identification cards from Delta Dental will be produced and distributed shortly after your enrollment. Both cards are issued in the subscriber's name, but can be used by everyone covered under the Plan.

## Dental Plan Description

You will receive a Dental Plan Description shortly after your enrollment. The Dental Plan Description describes the benefits of your Plan and tells you how to use your Plan. Please read it carefully to understand the benefits and provisions of your LGC HealthTrust Dental Plan.

## Who is Eligible

All eligible employees and their dependents, defined as:

- Spouse/civil union partner;
- Unmarried, dependent children from age 2 to age 26;
- Incapacitated dependent children, regardless of age.

Please refer to the Dental Plan Description for additional information regarding dependent eligibility.

## Eligibility or Benefits Questions

If you have questions regarding eligibility or benefits, please contact your employer or Local Government Center at 800.527.5001.

## Claims Questions

If you have further questions, please contact Northeast Delta Dental's Customer Service department at 800.832.5700 or 603.223.1234.

This summary should be used only as a guideline for your dental plan coverage. For detailed information on your Plan's terms, conditions, limitations, exclusions and guarantees, please refer to your Dental Plan Description or consult your employer.



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