

**APPENDIX A
Benefit Groups Defined**

	<u>Months/Term of Year</u>	<u>Full-time Equivalency</u>
Group A	12 months	100%
Group B	9, 10, 11 months (academic year)	100%
Group C	12 months	75-99%
Group D	9, 10, 11 months (academic year)	75-99%



APPENDIX B

University of Vermont

This chart represents the level of coverage for services performed by dentists who participate in the Northeast Delta Dental network. You are free to visit any dentist, participating or non-participating. Visit our website at www.nedelta.com for an updated list of participating dentists. Certain benefit limitations may apply. Please see the reverse side of this page for information about how to use your program.

Outline of Covered Services		High Option	Base Plan
Coverage A	<ul style="list-style-type: none"> • DIAGNOSTIC: Evaluations - 2 per Calendar Year X-Rays - complete series or panoramic film once in a 3-year period, bitewing x-rays once each Calendar Year. • CONSULTATIONS • PREVENTIVE: † Cleanings - 2 per Calendar Year. † Fluoride treatment once per Calendar Year to age 19. Space maintainers to age 16. Sealant application to permanent molars, once in a lifetime per tooth, for children to age 15 • † PERIODONTAL CLEANING (Maintenance procedures) • EMERGENCY PALLIATIVE TREATMENT • APPLIANCES TO CONTROL HARMFUL HABITS † Note: Unless medically necessary, Cleanings are limited to 2 and Fluoride treatments to 1 per Calendar Year. 	100%	100%
Coverage B	<ul style="list-style-type: none"> • X-Rays of individual teeth • RESTORATIVE: Amalgam fillings, Composite fillings (anterior teeth only) • ORAL SURGERY: Surgical and routine extractions and certain other surgical procedures. • ENDODONTICS: Root canal therapy • PERIODONTICS: Treatment of gum disease • CROWNS • ONLAYS • DIAGNOSTIC CASTS • REPAIRS TO DENTURES, CROWNS & BRIDGES 	80%	80%
Coverage C	<ul style="list-style-type: none"> • PROSTHODONTICS: Removable and fixed partial dentures (bridge); complete dentures Rebase and reline Complete and partial denture adjustments Tissue Conditioning Implants 	60% *	50%
Coverage D	<ul style="list-style-type: none"> • ORTHODONTICS: Correction of crooked teeth for adults and children 	50%	50%
Calendar Year Maximum for services covered under A, B and C (excluding orthodontics)		\$1,500 *	\$750
Lifetime Orthodontics Maximum (per person)		\$1,000 *	\$500
Calendar Year Deductible for both plans: \$25 per person/ \$75 per family		Does <u>Not</u> Apply to Coverage A.* Applies only to Coverages B, C and D	Applies to Coverages A, B, C and D

*** INCREASED BENEFIT ON HIGH OPTION PLAN.**

- Please Note:
- Employees must stay in elected plan for a minimum of one year.
 - Services that are covered under your Medical plan are not covered benefits under your Northeast Delta Dental plan.
 - The benefit year is January 1 through December 31 each year. If the University of Vermont subscriber changes benefit effective July 1, benefits paid and deductibles applied during the first half of the year will be carried to the second half.

This chart is provided only as a summary for your convenience; in the event of a conflict or discrepancy between the chart and the group contract, the group contract will prevail. Please refer to your Northeast Delta Dental Plan Description booklet for complete benefit information.

Customer Service
1-800-832-5700

"Extraordinary Service is Our Guarantee"

(Please see reverse)

Participating Dentists' Network

You'll get the best value from your program when you receive your dental care from one of Northeast Delta Dental's participating dentists:

▲ **No balance billing:** Because participating dentists accept their filed fees 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 Northeast Delta Dental Premier network, call your dentist or visit our Web site at www.nedelta.com. You can also call our Customer Service department at 1-800-832-5700 or 603-223-1234.

Claim Process for 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 program's coverage. You are responsible to pay any remaining balance directly to the dentist.

Non-Participating Dentists

Within the Northeast Delta Dental operating area: Delta Dental provides coverage regardless of the patients' choice of dentists, participating or not. When visiting a nonparticipating dentist, payment for services rendered will be based on the lesser of the dentist's actual submitted charge or the Plan'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.

Outside the Northeast Delta Dental operating area: When visiting a nonparticipating dentist, 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 zip code 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.

Predetermination of Benefits

Northeast Delta Dental strongly encourages predetermination of cases involving costly or extensive treatment plans. Although it is 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 program has additional group dental coverage, the Coordination of Benefits provision described in your Dental Plan Description booklet will determine the sequence and extent of payment. If you have any questions, please contact our Customer Service department at 1-800-832-5700 or, 603-223-1234.

Identification Card

Two identification cards from Northeast 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 program.

Dental Plan Description Booklet

You will receive a Dental Plan Description booklet shortly after your enrollment. This booklet describes the benefits of your program and tells you how to use your plan. Please read it carefully to understand the benefits and provisions of your Northeast Delta Dental program.

Who is Eligible?

All eligible employees and their dependents, defined as:

Spouse

Unmarried, dependent children to age 19;

Unmarried, full-time dependent students to age 25; and,

Incapacitated dependent children, regardless of age.

If enrolling one eligible dependent, all eligible dependents must be enrolled unless they are covered elsewhere.

Guarantee Of Service ExcellenceSM Program

Northeast Delta Dental is committed to providing extraordinary service to all of its customers. We believe that when our people are inspired to pursue excellence in order to achieve a higher level of customer satisfaction, all of those who share in Northeast Delta Dental will benefit. To emphasize our commitment, we guarantee seven major areas of service to our clients and reinforce them by our comprehensive group refund policy.

Claims Inquiry

If you have further questions, please contact Northeast Delta Dental's Customer Service department at 1-800-832-5700 or 603-223-1234. This information should be used only as a guideline for your dental benefits program. For detailed information on your group's terms, conditions, limitations, exclusions, and guarantees, please refer to your Dental Plan Description booklet or consult your employer.



APPENDIX C

Premium Chart

Base Salary as of Jan. 1st of Current Year	Employee % of Cost
Less than \$15,000	4%
\$15,001 to \$20,000	6%
\$20,001 to \$30,000	8%
\$30,001 to \$40,000	10%
\$40,001 to \$50,000	12%
\$50,001 to \$60,000	14%
\$60,001 to \$70,000	16%
\$70,001 to \$80,000	18%
\$80,001 to \$90,000	20%
\$90,001 to \$100,000	22%
\$100,001 to \$110,000	24%
\$110,001 to \$120,000	26%
\$120,001 to \$130,000	27%
\$130,001 to \$140,000	28%
\$140,001 to \$150,000	29%
Over \$150,001	30%

APPENDIX D

Type of Service	Blue Cross and Blue Shield of Vermont - UA				MVP Health Plan UA MVP HMO Co-Pay 15
	Vermont Health Partnership		Vermont Freedom Plan (only if living outside VT & W. NH)		
Hospital	In BcBs Network (Preferred Benefits)	Out-of-BcBs Network (Standard Benefits)	In BcBs Network Participating Provider	Out Of BcBs Network Non-Participating Provider	Benefits Provided with PCP Referral
Inpatient	Plan Pays 100% after \$250 co-pay \$750 Family Max	Plan Pays 70% after \$500 deductible has been met.	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	Plan Pays 100% after \$240 co-pay
Outpatient Surgery	Plan Pays 100% after \$100 co-pay	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	Plan Pays 100% after 20% or \$100 co-pay
Outpatient Services	Plan Pays 100%	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	Plan Pays 100% after 20% or \$100 co-pay
Ambulance	Plan Pays 100% after \$50 co-pay	Same As Above	Same As Above	Same As Above	Plan Pays 100%
Emergency Room	Plan Pays 100% after \$50 co-pay	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	In-Area \$50 co-pay Out-of-area Plan pays 100%
Physician & Misc Medical Services					
In-Office Surgery	\$10 co-pay PCP, \$20 co-pay Specialist	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	\$15 co-pay
Lab & X-ray Charges	Plan Pays 100%	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	Plan Pays 100%
Office Visits	\$10 co-pay PCP, \$20 co-pay Specialist	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	\$15 co-pay
Major Oral Surgery	Plan Pays 100% after \$100 co-pay	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	Not Covered Coverage through Delta Dental
Chiropractor	\$20 Specialist co-pay	Not Covered	Plan Pays 90% after \$100 deductible	Not Covered	\$15 co-pay
Vaccinations and Immunizations	\$10 co-pay PCP, \$20 co-pay Specialist	Same As Above	Plan Pays 90% after \$100 deductible	Plan Pays 70% after \$200 deductible	\$15 co-pay
Routine Eye Exams (Network Provider)	\$20 co-pay Every year	Not Covered	Not Covered	Not Covered	You pay \$15 co-pay Every 2 years
Mental Health & Substance Abuse	Access through UVM EAP or Magellan Behavioral Health	Out-of-Network (Standard Benefits)	In BcBs Network	Out Of BcBs Network	Access through MVP Mental Health Referral Unit
Residential Treatment	Plan Pays 100% after \$250 co-pay \$750 Family Max	Plan Pays 50% of R&C after \$200 deductible; \$3,000 annual; \$10,000 life Max.	Plan Pays 90% after \$100 deductible	Not Covered	Plan Pays 100%
Office Visits	\$20 Specialist co-pay	Same As Above	Plan Pays 90% after \$100 deductible	Not Covered	You pay \$15 per visit
Intensive Out Pt Treatment	Plan Pays 100%	Same As Above	Plan Pays 90% after \$100 deductible	Not Covered	Plan Pays 100%

Type of Service	Blue Cross and Blue Shield of Vermont - UA			MVP Health Plan UA MVP HMO Co-Pay 15
	Vermont Health Partnership		Vermont Freedom Plan (only if living outside VT & W. NH)	
Major Medical Expenses				
RX Drugs Retail 30 day supply	\$100/\$300 deductible \$5 generic \$20 preferred \$40 non-preferred Prescribed Contraceptives	\$100/\$300 deductible \$5 generic \$20 preferred \$40 non-preferred Prescribed Contraceptives	\$100/\$300 deductible \$5 generic \$20 preferred \$40 non-preferred Prescribed Contraceptives	\$100 deductible \$5 generic \$20 preferred \$40 non-preferred Prescribed Contraceptives
RX Drugs Mail Order 90 day supply	\$100/\$300 deductible \$10 generic \$40 preferred \$80 non-preferred Prescribed Contraceptives	\$100/\$300 deductible \$10 generic \$40 preferred \$80 non-preferred Prescribed Contraceptives	\$100/\$300 deductible \$10 generic \$40 preferred \$80 non-preferred Prescribed Contraceptives	\$100 deductible \$10 generic \$40 preferred \$80 non-preferred Prescribed Contraceptives
RX Limit	Single \$1,300	RX out-of-pocket Limit Two-person \$2,600 Family \$3,800		
Durable Medical Equipment & Medical Supplies	\$100 Deductible	\$100 deductible	\$200 deductible	\$ 0 deductible
	Plan pays 80% after deductible; out-of-pocket limit \$15,000; after you meet your out-of-pocket limit, you pay nothing.	Plan pays 80% after deductible; out-of-pocket limit \$15,000; after you meet your out-of-pocket limit, you pay nothing.	Plan pays 70% after deductible; out-of-pocket limit \$15,000; after you meet your out-of-pocket limit, you pay nothing.	Plan pays 80% - \$250,000 Lifetime Maximum

Additional Information Concerning the Blue Cross & Blue Shield Plan:

VHP members no longer need referrals for services by specialty providers. Visit fees for specialty providers are higher than visits for your Primary Care Physicians. VHP incorporates a Prior Approval Program for certain procedures.

VHP Procedures that Require Prior Approval

1. Plastic or cosmetic surgery (for example, abdominoplasty, lipectomy, blepharoplasty, breast reconstruction, otoplasty, panniculectomy, rhinoplasty or septorhinoplasty)
2. Dental surgery (oral surgery, trauma, orthognathic surgery)
3. Chiropractic care after initial 12 visits in a calendar year
4. Radiology special procedures (MRI, MRA, MRS, PET scans)
5. UPPP/somnoplasty
6. Continuous Passive Motion (CPM) equipment
7. Durable Medical Equipment with a purchase price over \$1,000.
8. Orthotics/prosthetics
9. Polysomnography (sleep studies)
10. Chondrocyte transplants
11. Home infusion therapy
12. Private duty nursing
13. Transplants
14. TENS units/neuromuscular stimulators
15. Rehabilitation (cardiac/pulmonary/inpatient rehabilitation facility)
16. Services by an out-of-network provider

The network for Vermont Health Partnership includes the State of Vermont plus eastern New York and western New Hampshire.

Maior Medical Expenses

Vermont Health Partnership and Vermont Freedom Plan out-of-network coverages are based on BCBS' determination of usual, customary and reasonable charges for covered services.

In-patient hospitalization and hospital-based surgery must receive Pre-admission Review or Admission Review for all hospital admissions. If you do not call for Managed Benefits review, you may get \$1,000 less in-patient benefits. This penalty is charged for each occurrence, and it applies, in addition, to Plan deductibles, including the standard benefits [out-of-network] deductibles in the Vermont Health Partnership Plan.

With Regard to the Vermont Health Partnership Plan, Standard Benefits are subject to a \$500 per person and \$1,000 per family annual deductible. There is also a \$40 penalty per occurrence, in addition to the Standard Benefit to any hospital emergency room.

The annual OOP for VFP Plan is \$1,000 per covered person, \$3,000 per family. In addition to the OOP, the insured must also pay all co-payments, deductibles, and non-compliance penalties.

The OOP maximum does not apply to Mental Health & Substance Abuse treatment.

Lifetime benefits are limited to \$1,000,000 per person under the VFP Plan.

Lifetime benefits are generally limited to \$1,000,000 under the VHP Plan, however, there is no limit on Preferred services provided by network providers.

This information is in summary form, therefore, many details are not included. For a detailed description of benefits, you must read the appropriate Subscriber Certificate. In the event of a conflict between this summary and the Subscriber Certificate, the Subscriber Certificate will prevail.