DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 37

To be attached to and form a part of your Delta Dental PPO Provider Arrangement.

Your group has purchased this Rider to change your Delta Dental PPO Provider Arrangement contract as follows:

The coverage that is currently available to dependents under your family contract now includes spousal equivalents and their eligible dependent children.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



Fay Donohue
President and CEO, DSM

Incorporated under the laws of the
Commonwealth of Massachusetts
as a Non-Profit Organization

DDP-PPA R37 (11/19/03)

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 47

To be attached to and form a part of your Delta Dental PPO Provider Arrangement

Your group has purchased this Rider to change your Delta Dental PPO Provider Arrangement contract as follows:

Periodic Oral Exams and Cleanings are covered twice per calendar year.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



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President and CEO, DSM

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DDP-PPA R47 01/21/04

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 90

To be attached to and form a part of your Delta Dental PPO Provider Arrangement

Your group has purchased this Rider to change your Delta Dental PPO Provider Arrangement contract as follows:

Full Mouth X-rays are covered once every 36 months.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



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DDP-PPA 90 (11/24/03)

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 124

To be attached to and form a part of your Delta Dental PPO Provider Arrangement

Your group has purchased this Rider to change your Delta Dental PPO Provider Arrangement contract as follows:

Bitewing x-rays are covered two times per calendar year.

NOTE: Underlined terms are defined in your contract.

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DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 134

To be attached to and form a part of your Delta Dental PPO Provider Arrangement

Your group has purchased this Rider to change your Delta Dental PPO Provider Arrangement contract as follows:

Fluoride treatment for members under age 19 are paid two (2) times per calendar year.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
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DDP-PPA R134 12/04/2003

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 173

To be attached to and form a part of your Delta Dental PPO Provider Arrangement.

Your group has purchased this Rider to change your Delta Dental PPO Provider Arrangement contract as follows:

Definitions: Delta Dental PPO Non Panel Dentists:

A dentist who has not signed an agreement with Delta Dental to accept Delta Dental PPO Panel Dentist allowances for services rendered for subscribers in the Delta Dental PPO plan. A Delta Dental PPO Non Panel Dentist who is under agreement as a Delta Dental participating dentist agrees to accept the contracted allowances for services rendered and not to balance bill subscribers.

A dentist who is not under any agreement and is not participating with Delta Dental will receive a reduced payment from Delta Dental and can balance bill for the difference between Delta Dental's payment and his or her actual charge.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



Fay Donohue
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DDP-PPA R173 (11/24/03)

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 226

To be attached to and form a part of your Delta Dental PPO Provider Arrangement.

Sealants on unrestored, permanent molars are a covered Type I benefit once per tooth every 4 years for covered individuals through age 15. Sealants are also a covered Type I benefit to age 19 for covered individuals who have had a recent cavity and their dentist determines that they may be at risk for future decay.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



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President and CEO, DSM

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DDP-PPA R226 01/01/2009 (Revised 06/23/2005)

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
AMENDMENT 242

To be attached to and form a part of your Delta Dental PPO Provider Arrangement

An endosteal implant (a device surgically inserted into the bone to provide support for a single restoration) is covered as a Type III benefit when used in lieu of a three unit bridge and the adjacent abutment teeth are not to be restored. Implants not meeting this definition are not covered by this amendment. Implant benefits are subject to all the terms and conditions of the contract.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



Fay Donohue
President and CEO, DSM

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DPP-PPA R242 09/09/05 (Revised 01/19/07)

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
AMENDMENT 284

To be attached to and form a part of your Delta Dental PPO Provider Arrangement Plan

Periodontal maintenance, as defined by the American Dental Association Current Dental Terminology, following active periodontal therapy is covered once every three months as a Type I benefit. Dental prophylaxis is part of the contract limitation for periodontal maintenance.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



Fay Donohue
President and CEO, DSM

Incorporated under the laws of the
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as a Non-Profit Organization

DPP R284 01/16/2007

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
AMENDMENT 293

To be attached to and form a part of your Delta Dental PPO Certificate

Your Delta Dental PPO contract has been modified as follows:

Part I

Family Contract: a *contract* that includes you, your spouse and your dependent children up to age 26. **Adopted children** and children under your own or your spouse's legal guardianship are also covered. In addition, **a physically or mentally handicapped child** who is incapable of earning his or her own living and over 26 years may be eligible to continue coverage under a family membership if *Delta Dental* is notified within 72 days of the child's twenty-sixth birthday and by completing a disabled dependent application.

Part IV

13B: Your dependent child under your *family contract* becomes 26 years of age.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS

Fay Donohue
President and CEO, DSM

Incorporated under the laws of the
Commonwealth of Massachusetts
as a Non-Profit Organization

DPP R293 05/31/2007 (revised 08/05/2010)

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
BENEFITS PAYABLE RIDER 645

To be attached to and form a part of your Delta Dental PPO Provider Arrangement 2

Your group has purchased this Rider. Benefits for the covered services described in your Delta Dental PPO Contract are reimbursed as follows:

DEDUCTIBLES

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each calendar year. This means you must pay the first $50 of benefits provided in each calendar year.

	In-Network Benefits		**Out-of-Network Benefits**	
Diagnostic and Preventive Services (Type 1 Benefits)				
	Dental Service pays 100% of charges up to the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers.	You pay nothing.	Dental Service pays 100% of the usual, customary and reasonable fee.	You pay 0% of the usual, customary and reasonable fee.
Restorative and other Basic Services (Type 2 Benefits)				
	Dental Service pays charges up to 80% of the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers.	You pay up to 20% of the schedule amount.	Dental Service pays 80% of the usual, customary and reasonable fee.	You pay 20% of the usual, customary and reasonable fee.
Prosthodontic and Other Services (Type 3 Benefits)				
	Dental Service pays charges up to 50% of the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers.	You pay up to 50% of the schedule amount.	Dental Service pays 50% of the usual, customary and reasonable fee.	You pay 50% of the usual, customary and reasonable fee.
Orthodontic Coverage				
	Dental Service pays charges up to 50% of the usual, customary and reasonable fee.	You pay up to 50% of the usual, customary and reasonable fee.	Dental Service pays charges up to 50% of the usual, customary and reasonable fee.	You pay up to 50% of the usual, customary and reasonable fee.

Your total benefits are limited to a maximum of $1,750 for each member for each calendar year. The orthodontic benefits are limited to a lifetime maximum of $1,750 and are provided only for members who are under 19 years of age.

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

For services performed by Massachusetts Delta Dental PPO panel providers, the In-Network benefit allowance is based on the Delta Dental PPO table of allowance or the dentist's submitted fee if lower. Delta Dental pays the dentist directly for covered services. The dentist will bill covered members for balances resulting from plan specific deductibles and co-payments.

OUT-OF-NETWORK SERVICES:

For services performed by Massachusetts Delta Dental PPO non-panel dentists, the Out-of-Network benefit co-payments for each type of service is the same as the in-network panel dentist co-payments. This co-payment will be applied against the negotiated fees for dentists who are under a contractual agreement with Delta Dental or the dentist's submitted fee if lower. The dentist also agrees not to balance bill subscribers.

In those circumstances where the dentist is not under any agreement with Delta Dental, Delta Dental pays the covered member directly for covered services, and the member is responsible for paying the dentist. The dentist will bill the covered member for the difference between the Delta Dental payment and his / her submitted charge and balances resulting from plan specific deductibles and co-payment.

OUT-OF-STATE DENTIST SERVICES

We will provide benefits for the covered services described in your contract when any dentist outside of Massachusetts furnishes them.

For service performed by out of state Delta Dental PPO panel providers, the In-Network benefit allowance is based on the Delta Dental PPO table of allowance or the dentist's submitted fee if lower. Delta Dental pays the dentist directly for covered services. The dentist will bill covered members for balances resulting from plan specific deductibles and co-payments.

For services performed by a Delta Dental non-panel dentist, the out-of-network benefit co-payment for each type of service is the same as the in-network panel dentist co-payment. This co-payment will be applied against the negotiated fees for dentists who are participating with Delta Dental as a Delta Dental participating provider or the dentist's submitted fee if lower. The dentist will bill covered members for balances resulting from plan specific deductibles and co-payments and agrees not to balance bill subscribers.

In those circumstances where the dentist is not participating as a Delta Dental participating provider with Delta Dental, benefits for covered services furnished by out-of state dentists are based on the dentist's fee or the customary fee for that geographic area, whichever is less. Delta Dental pays the covered member directly for covered services, and the member is responsible for paying the dentist. The dentist will bill the covered member for the difference between the Delta Dental payment and his / her submitted charge and balances resulting from plan specific deductibles and co-payments.

All Claims for benefits under this agreement must be submitted within one (1) year of the date the Covered Member received the service.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS



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DDP-PPA 2 BPR 645 12/21/2012

Subscriber's Certificate

Delta Dental PPO

*Delta Dental** certifies that you have the right to benefits for services according to the terms of your *contract*. This certificate is part of your *contract*.

Your *Delta Dental subscriber* identification card will be mailed to you separately. It identifies you to a dentist as a *Delta Dental subscriber* who has the right to the benefits in your *contract*. You should present your identification card to the dentist before you receive services so that we may properly administer your benefits.

ATTEST: Dental Service of Massachusetts, Inc.



Fay Donohue
President & CEO



Myra Green
Corporate Clerk

Incorporated under the laws of the Commonwealth of Massachusetts as a not-for-profit organization.

*Dental Service of Massachusetts, Inc. is doing business as Delta Dental.
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SP030 Delta Dental PPO National II – revised October 2011

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Introduction

This certificate is part of the *contract* between you and *Delta Dental*. We urge you to read it carefully.

Please note that words in *italics* are listed in Part I, Definitions.

This certificate includes three types of services:

> Type 1 includes services to prevent or detect tooth decay and other forms of oral disease.
>
> Type 2 includes services to: (i) restore decayed or *fractured* teeth; (ii) remove diseased or damaged natural teeth; (iii) treat oral disease; (iv) repair dentures or bridges; (v) rebase or reline dentures; and (vi) recement bridges, crowns and onlays.
>
> Type 3 includes services and supplies to: (i) replace missing natural teeth with artificial ones and (ii) restore severely decayed or *fractured* teeth.

Your group may also have purchased Supplemental Coverage, which provides limited benefits to help pay for services to prevent and correct misalignment of the teeth (orthodontics). These additional benefits are described in Riders that are also considered part of your *contract*. If your group has purchased these benefits, make sure you have a copy of the proper Rider. Your *plan sponsor* can supply you with them.

The dental services described in this *contract* are covered immediately as of your *effective date*, unless your benefits are subject to a waiting period. You are entitled to these benefits on a non-discriminatory basis, including those benefits that are mandated by state and federal law.

Additionally, there are some limitations or restrictions on your membership, which are found in Parts III and IV.

The index at the end of this certificate lists where you can find the benefits and limitations contained in your *contract*.

If you have any questions, contact your *plan sponsor* or *Delta Dental's* Customer Service department. *Delta Dental* telephone numbers are listed at the end of this certificate.

Member Rights and Responsibilities

As a *Delta Dental* member, you have the right to:

- file *grievances* about *Delta Dental* or the *Delta Dental PPO Panel Dentists*.
- be provided with appropriate information about *Delta Dental* and its benefits, dentists, and policies
- be informed of your diagnosis, treatment and prognosis by your dentist
- give informed consent before beginning any dental treatment, and be made aware of consequences of refusing treatment
- obtain a copy of your dental record, in accordance with the law
- be treated with respect and recognition of your dignity and need for privacy
- at your request, interpreter and translation services related to administrative procedures are available to you or a covered family member.

خدمات ترجمة فورية/ترجمة

في حالة طلبكم نقوم بتوفير مترجمين وخدمات ترجمة تتعلق بالإجراءات الإدارية.

អ្នកបកប្រែ ឬកិច្ចការបកប្រែ
បើអ្នកស្នើឲ្យមានអ្នកបកប្រែ និងកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងទៅនឹង
វិធីចាត់ចែងការ យើងមានផ្តល់ជូន ។

翻譯服務

如果您提出請求，我們可以為您提供協助辦理行政手續的翻譯服務。

Services de traduction et d'interprétariat.
Les services de traduction et d'interprétariat en connexion avec les procédures administratives sont disponibles sur demande

Υπηρεσίες Διερμηνέα/Μεταφραστή
Μετά από αίτησή σας, υπηρεσίες διερμηνέα και μεταφραστή σχετικά με διοικητικές διαδικασίες είναι στη διάθεσή σας.

Sèvis Entèprèt ak TradiksyonSi w mande sèvis entèprèt ak tradiksyon pou prosede administratif, nap mete yo a dispozisyon ou.

Servizi di interpretariato e traduzioneA richiesta, sono disponibili servizi di interpretariato e traduzione relazionati con pratiche amministrative.

ບໍລິການນາຍພາສາ/ແປເອກະສານ
ຖ້າທ່ານຮ້ອງຂໍ, ຈະມີບໍລິການນາຍພາສາແລະແປເອກະສານ ໃຫ້ກັບທ່ານ ສຳລັບເລື້ອງທີ່ກ່ຽວຂ້ອງກັບຂັ້ນຕອນການບໍລິຫານ.

Serviços de tradutor(a)/intérprete Se assim o solicitar, estão disponíveis serviços de tradução e interpretação para os procedimentos administrativos.

Услуги устного/письменного перевода
По Вашему требованию будут предоставлены услуги устного и письменного перевода, связанные с административными процедурами.

Servicios de interpretación/traducción Si usted lo solicita, se encuentran a su disposición servicios de interpretación y traducción para asistirle en procedimientos administrativos.

<u>You have the responsibility to:</u>

- ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by your dentist
- provide information to your dentist that is necessary to render care to you
- be familiar with *Delta Dental* benefits, policies and procedures, by reading *Delta Dental* written materials, or calling Customer Service.

Part I: Definitions

Adverse determination: means a decision by *Delta Dental* to deny, reduce, or modify the availability of any dental care services, because your condition failed to meet the requirements for coverage based on necessity, appropriateness of care, level of care, or effectiveness.

Calendar-year Deductible this *deductible* must be satisfied each calendar year.

Carry-forward Deductible: any portion of the *deductible* amount that is satisfied during the last three months of the calendar year is carried forward and applied to the following year's *deductible*.

Complaint: means any *inquiry* made by you or on your behalf to *Delta Dental* that is not explained or resolved to your satisfaction within ten (10) business days of the *inquiry*; or involves an *adverse determination*.

Contract: this Subscriber's Certificate, Benefit Payable Rider, Enrollment Form, any applicable Riders, Endorsements and Supplemental Agreements.

Covered Individual: a person who receives dental benefits from *Delta Dental*. Usually includes *subscribers* and their dependents.

Date of Service: the actual date that the service was completed. With multi-stage procedures, the *date of service* is the final completion date (the insertion date of a denture, for example).

Deductible: the portion of the covered dental expenses which the *subscriber* must pay before the plan's payment begins.

Delta Dental: Dental Service of Massachusetts, Inc. is doing business as either *Delta Dental* of Massachusetts or *Delta Dental*.

Delta Dental PPO Non-panel Dentist: a dentist who has not signed an agreement with *Delta Dental* to accept *Delta Dental PPO Panel Dentist* allowances for services rendered on *covered individuals* in the *Delta Dental PPO* plan.

Delta Dental PPO Panel Dentist: a dentist who has signed an agreement with *Delta Dental* to accept reimbursement based on an established *Delta Dental PPO Panel Dentist* allowances for services rendered on *covered individuals* enrolled in the *Delta Dental PPO* plan.

Disenrollment: *Covered individuals* who are disenrolled because they have moved out of our service area, or whose continuations of coverage periods have expired. Former dependents

who no longer qualify as dependents, or *covered individuals* who lose coverage under an employer sponsored plan because they have ceased employment, or because their employer group has canceled coverage under the plan, reduced number of hours worked, become disabled, retired or died.

Effective Date: the date, as shown on our records, on which your coverage begins under this *contract* or an amendment to it.

Emergency medical condition: a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B).

Family Contract: a *contract* that includes you, your spouse and your dependent children up to age 26. **Adopted children** and children under your own or your spouse's legal guardianship are also covered. In addition, **a physically or mentally handicapped child** who is incapable of earning his or her own living and is over 26 years may be eligible to continue coverage under a family membership if *Delta Dental* is notified within 72 days of the child's twenty-sixth birthday, and by completing a disabled dependent application.

Fracture: the breaking off of rigid tooth structure not including crazing due to thermal changes or chipping due to attrition.

Grievance: refers to any oral or written *complaint* submitted to *Delta Dental* by you or on your behalf concerning any aspect or action of *Delta Dental*. This is including, but not limited to, review of *adverse determinations* regarding the scope of your coverage, denial of services, quality of care and administrative operations.

Individual Contract: a *contract* that includes only the *subscriber*.

Inquiry: means any question or concern communicated by you or on your behalf to *Delta Dental*, which has not been the subject of an *adverse determination*.

Maximum Fee Allowance: The payment amount that *Delta Dental* sets for the *Delta Dental PPO Non-panel Dentist and Non-Participating Dentist* for services that may be provided under this *contract*. Benefits are payable in accordance with the Outline of Reimbursement as filed and approved by the Division of Insurance for Massachusetts dentists for this *contract* and the terms and conditions of the applicable Benefits Payable Rider attached to this certificate and in effect at the time services are rendered.

Non-Participating Dentist: a dentist registered under Massachusetts G.L.c. 112, ss. 45, 48 or any fully registered or licensed dentist in any other jurisdiction who has not entered into an

agreement with *Delta Dental* to furnish services to its *covered individuals* under its traditional fee-for-service benefit plans.

Open Enrollment: a period during which an organization allows persons not previously enrolled in the dental plan to apply for plan membership.

Participating Dentist: a dentist registered under Massachusetts G.L.c. 112, ss. 45, 48 and who has entered into an agreement with *Delta Dental* to furnish services to its *covered individuals* under its traditional fee-for-service benefit plans.

Plan Sponsor: the person or organization that is your representative if you are a *subscriber* of a group plan. In the case of an employment group subject to the Employee Retirement Income Security Act of 1974, as amended, the *plan sponsor* is the *plan sponsor* designated under that act. The *plan sponsor* is your agent and is not the agent of *Delta Dental*. The *plan sponsor* sends to us the subscription charge due from you and receives all notices from us for you. We will send your *plan sponsor* any subscription refund due to you. It is the *plan sponsor's* responsibility to notify you of changes to your benefits or your charges.

Subscriber: an employee or member, certified by the *plan sponsor*, who is eligible to receive dental benefits from *Delta Dental*.

Part II: Benefits

You have the right to benefits for the following services on a non-discriminatory basis, EXCEPT as limited or excluded elsewhere in this *contract*.

The benefits are limited to a maximum dollar payment for each *covered individual* for each calendar year. The extent of your benefits is explained in the Benefits Payable Rider your group has purchased which is incorporated as part of this *contract*.

If you received treatment that is not covered under your plan, you may be billed at the dentist's normal fee rather than *Delta Dental's* negotiated fee. Also if you receive a treatment when you have already exhausted your maximum or you receive a treatment which will cause you to exceed your maximum, you may be billed at the dentist's normal fee rather than *Delta Dental's* negotiated fee. To avoid any unexpected out of pocket expenses, it is recommended that you visit *Delta Dental's* web site, www.deltadentalma.com, or call Customer Service to determine your remaining benefit.

Make sure you have a copy of this Rider. Your *plan sponsor* can give you a copy of it.

A. Diagnostic and Preventive Services (also referred to as Type 1)

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most *covered individuals* receive during a routine preventive dental visit.

1. Comprehensive Oral Examination (including the initial dental history and charting of teeth); once every 60 months.
2. Periodic oral evaluation; once every six months.
3. X-rays of the entire mouth; once every 60 months.
4. Bitewing x-rays (x-rays of the crowns of the teeth); once every six months when oral conditions indicate need.
5. Single tooth x-rays; as needed.
6. Routine cleaning, scaling and polishing of teeth; once every six months.
7. Periodontal Cleanings; once every 3 months, not to be combined with regular cleanings.
8. Fluoride treatment for *covered individuals* under 19 years of age; once every six months.
9. Space maintainers required due to the premature loss of teeth; only for *covered individuals* under 14 years and not for the replacement of primary or permanent anterior teeth.
10. Emergency oral evaluation problem focused exams.

11. Sealants for unrestored permanent molars; once per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who have had a recent cavity and are at risk for decay.
12. Chlorhexidine Mouthrinse; when administered and dispensed in the dentist's office following scaling and root planing.
13. Fluoride Toothpaste; when administered and dispensed in the dentist's office following periodontal surgery.

B. Restorative Services and Other Basic Services (also referred to as "Type 2")

Benefits are available for the following dental services to: (i) restore decayed or *fractured* teeth; (ii) remove diseased or damaged natural teeth; (iii) treat oral disease; (iv) repair dentures or bridges; (v) rebase or reline dentures; and (vi) repair or recement bridges, crowns and onlays.

1. Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each 24 month period. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentists charge. No benefits are provided for replacing a filling within 24 months of the date that the prior filling was furnished.

2. Sedative fillings; once per tooth.

3. Stainless steel crowns on deciduous (baby) teeth; once every 24 months per tooth.

4. Certain surgical services to treat oral disease or injury. This includes simple tooth extractions and extractions of impacted teeth

5. Periodontic services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery).

6. Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth on covered members.

7. General anesthesia when necessary and appropriate for covered surgical services covered only when provided by a licensed, practicing dentist.

8. Emergency dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm.

9. Repair of dentures or fixed bridges; once every 12 months. Recementing of fixed bridges; once in a lifetime

10. Rebase or reline dentures; once every 36 months.

11. Tissue conditioning; two treatments every 36 months.

12. Repair or recement crowns and onlays. Recementing is limited to once every 12 months per tooth.

13. Adding teeth to existing partial or full dentures.

C. Prosthodontic and Other Services (also referred to as "Type 3")

Benefits are available for the following dental services and supplies: to replace missing natural teeth with artificial ones and to restore severely decayed or *fractured* teeth.

1. Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each 60 months.

- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were installed at least 60 months before replacement.

- Temporary partial dentures as follows:

  - To replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.

  - For the replacement of permanent teeth for *covered individuals* who are under 16 years.

2. Crowns and Onlays

Crowns and onlays as follows, but only when the teeth cannot be restored with the fillings described as a Basic Benefit in Section 1.B.1 due to severe decay or *fractures*:

- Initial placement of crowns and onlays.

- Replacement of crowns and onlays; once every 60 months per tooth.

3. Implants

An endonsteal implant (a device surgically inserted into the bone to provide support for a single restoration) when used in lieu of a three unit bridge and the adjacent abutment teeth are not to be restored.

Part III: Limitations and Exclusions

1. WE LIMIT BENEFITS FOR SOME SURGICAL SERVICES

   No benefits are provided for the following services when the *covered individual's* condition requires that he or she be admitted as an inpatient in a hospital or surgical day care center. However, we will consider review of the following in-hospital surgical procedures for coverage if they are not benefits under your medical carrier's *contract*:

   - surgical removal of unerupted teeth or impacted teeth when imbedded in bone
   - extraction of seven or more permanent teeth
   - the excision of a benign or cancerous growth other than a radicular cyst
   - radicular cysts involving the roots of three or more teeth
   - gingivectomies involving two or more gum quadrants
   - gingival flap
   - mucogingival surgery
   - osseous surgery
   - osseous graft
   - soft tissue graft

   We will not consider coverage:

- if your non-payment was due to reaching your maximum
- if your non-payment was due to meeting your *deductible*

2. WE PROVIDE BENEFITS ONLY FOR NECESSARY AND APPROPRIATE SERVICES

   - We will not provide benefits for a dental service that is not covered under the terms of your *contract* as listed in your benefits. In addition, we will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition as determined by *Delta Dental*.

   A. To be necessary and appropriate, a service must be:

      - consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist

   B. Who determines what is necessary and appropriate under the terms of the *contract*:

That decision is made by *Delta Dental* based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the *contract* even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

3. WE DO NOT PROVIDE BENEFITS FOR:

- A service or procedure that is not generally accepted as determined by *Delta Dental*.
- A service or procedure that is not described as a benefit in this *contract*.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have this *contract*.
- An illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if you did not have this *contract*. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare. We will not provide benefits if you could have received government benefits by applying for them within the appropriate agency's time limitation.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Consultations.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or *fracture*, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
- Implants when not in lieu of a three unit bridge and transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.

- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing overdentures.
- Services related to congenital anomalies. However, this exclusion does not apply to orthodontic services that may be covered by your group's orthodontic rider.
- Tooth desensitization
- Occlusal adjustment

Part IV: Other *Contract* Provisions

1. DUAL CHOICE OPTIONS

   If *Delta Dental* PPO is offered as part of a Dual Choice Option, enrollment changes are only accepted at the annual *open enrollment* period. A *subscriber* is not eligible to change plans except at that time.

2. BENEFIT PAYMENTS FOR SERVICES BY A *PANEL DENTIST*

   The amount of co-insurance and *deductibles*, if any, that you may be required to pay your *Delta Dental PPO Panel Dentist* is explained in the Benefits Payable Rider your group has purchased. Payments are made directly to a *Delta Dental PPO Panel Dentist* from *Delta Dental*.

3. WHEN YOUR PANEL DENTIST *MAY* CHARGE YOU MORE

   When your *Delta Dental PPO Panel Dentist* provides covered services based on the *Delta Dental* PPO allowance in each state, he or she must accept the allowance as payment in full. But in the following cases you will be responsible for the difference between the *Delta Dental* payment and the dentist's actual charge for covered services:

   A. If you have received a treatment when you have already exhausted your maximum or you received a treatment, which will cause you to exceed your maximum benefit allowed for services, you may be billed at the dentist's normal rate rather than *Delta Dental's* negotiated rate. For example, the maximum dollar amount for a *covered individual* in a calendar year. To avoid any unexpected out of pocket expenses, you can visit *Delta Dental's* web site, www.deltadentalma.com, or call Customer Service to determine your remaining benefits.

   B. If you receive a treatment that is not covered under your plan, you may be billed at the dentist's normal rate rather than the negotiated rate.

   C. If you and your dentist decide to use services that are more expensive than those customarily furnished by most dentists, benefits will be provided towards the service with the lower fee.

   D. If you receive payment from another person or his or her insurance company for injuries he or she caused.

   E. If, for some reason, you receive services from more than one dentist for the same dental procedure or receive services that are furnished in a series during a planned

course of treatment. In such a case the total amount of your benefit will not be more than the amount that would have been provided if only one dentist had furnished all the services.

4. PRE-TREATMENT ESTIMATES

If your dentist expects that dental treatment will involve a series of covered services (over $300), he or she should file a copy of the treatment plan with *Delta Dental* BEFORE these services are rendered to a *covered individual*. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service.

Upon receipt of the treatment plan we will notify you and your dentist about the maximum extent of your benefits for the services reported.

NOTE: Pre-treatment estimates are calculated based on current available benefits and the patient's eligibility. Estimates are subject to modification and eligibility that apply at the time services are completed and a claim is submitted for payment.

If your dentist does not file a treatment plan for a pre-treatment estimate, we will decide the extent of your benefits based on a review of those services using standards that are generally considered as accepted dental practices.

5. BENEFIT PAYMENTS FOR SERVICES BY *NON-PANEL DENTISTS*

A. Massachusetts *Delta Dental PPO Non-panel Dentists*

For services performed by a Massachusetts non-panel *participating dentist*, the out-of-network coinsurance may be 20% lower than the in-network panel dentist coinsurance. The coinsurance will be applied against the lesser of the dentists negotiated fee allowance or the dentist's submitted charge.

A non-panel *participating dentist* will receive a reduced payment and can balance bill the difference between *Delta Dental's* payment and their actual submitted charge.

For services performed by a Massachusetts *non-participating dentist*, the out-of-network coinsurance may be 20% lower than the in-network panel dentist coinsurance. The coinsurance will be applied against the lesser of the *maximum fee allowance* or the dentist's submitted charge. The *non-participating dentist* will receive a reduced payment and can balance bill the difference between *Delta Dental's* payment and their actual submitted charge.

Any dentist, participating, non-panel or non-participating, may bill *covered individuals* for the difference between the *Delta Dental* payment and any amounts

resulting from plan specific *deductibles*, coinsurance, or amounts in excess of the plan maximums.

B. Out-of-State *Delta Dental PPO Non-panel Dentists*

For services performed by a non-panel *participating dentist*, the out-of-network coinsurance may be 20% lower than the in-network panel dentist coinsurance. The coinsurance will be applied against the lesser of the dentists negotiated fee allowance or the dentist's submitted charge.

For services performed by a *non-participating dentist*, the out-of-network coinsurance may be 20% lower than the in-network panel dentist coinsurance. The coinsurance will be applied against the lesser of the *maximum fee allowance* or the dentist's submitted charge. The *non-participating dentist* will receive a reduced payment and can balance bill the difference between *Delta Dental's maximum fee allowance* and their actual submitted charge. The member will be responsible for paying the dentist.

Any dentist, participating, non-panel or non-participating, may bill *covered individuals* for the difference between the *Delta Dental* payment and any amounts that may result from plan specific *deductibles*, coinsurance, or amounts in excess of the plan maximums.

C. Emergency Care

When a *covered individual* receives emergency care and cannot reasonably reach a *Delta Dental PPO Panel Dentist*, payment for such care will be paidat the same level as if the *covered individual* had been treated by a *Delta Dental PPO Panel Dentist* once you notify *Delta Dental* of your need to seek such care.

6. COVERING WORK IN PROGRESS

If you have had continuous coverage with another dental carrier and two or more visits have occurred prior to your group's *effective date* with *Delta Dental*, that multi-visit procedure must be considered for payment by the previous dental carrier. If only one visit of a multi-visit procedure occurred prior to your group's *effective date* with *Delta Dental*, *Delta Dental* will be responsible for paying that claim.

7. TIME LIMIT

All claims for benefits under this *contract* for services by any dentist must be submitted within **one year** of the date that you complete the service.

If benefits are denied because a *Delta Dental PPO Panel Dentist* or *Delta Dental Participating Dentist* fails to submit a claim on time, you will not be responsible for paying the dentist for the portion of the dentist's charge that would have been a benefit under your plan. You will be responsible for your relevant coinsurance or *deductibles*, if any. This applies only if you properly inform your *Delta Dental PPO Panel Dentist* or *participating dentist* that you are a *covered individual* by presenting your *subscriber* identification card.

8. SUBROGATION

You may have a legal right to recover some costs of your dental care from someone else because another person has caused your illness or injury. When you have this right, you must let us use it if we decide to recover any payments we have made for the illness or injury. However, if you use this right to recover money from someone else, you must repay us for the payments we have made. Our right to repayment comes first. It can be reduced only by our share of your reasonable cost of collecting your claim against the other person, or if the payment received is described as payment for other than dental expenses. You must give us information and assistance and sign necessary documents to help us receive our repayment. You must not do anything that might limit our repayment.

9. WE MUST HAVE ACCESS TO YOUR DENTAL AND/OR OTHER RECORDS

You agree that when you claim benefits under this *contract*, you give us the right to obtain all dental records and/or other related information that we need from any source. This information will be kept confidential.

Delta Dental PPO Panel Dentists and *Delta Dental Participating Dentists* have agreed to give us all information necessary to determine your benefits under this *contract*. Massachusetts state law- M.G.L.c. 176E §7-requires Massachusetts *non-participating dentists* to provide this information also. *Delta Dental PPO Panel Dentists* and *Delta Dental Participating Dentists* have agreed not to charge for this service.

If you receive services from a *Delta Dental PPO Non-panel Dentist* or a *Non-Participating Dentist* who practices and treats you outside Massachusetts, you must help us obtain all dental records or other related information we need. *Delta Dental* will not pay the dentist for providing this information. If the dentist does not provide the required information, we may not provide benefits for his or her services.

10. SUBSCRIPTION CHARGE

A. Payments: The amount of money that your *Plan Sponsor* pays to *Delta Dental* for your benefits under this *contract* is called your subscription charge. Your *Plan Sponsor* is responsible to pay to *Delta Dental* the total subscription charges by the due date indicated on each monthly invoice. If subscription charges have not been paid within 30 days after the date on which payment is due, *Delta Dental*, upon written notice to the *Plan Sponsor*, may terminate this Agreement as of the date to which subscription charges have been paid. *Delta Dental* is not responsible if your *Plan Sponsor* fails to pay us. This is true even if your *Plan Sponsor* has charged you for all or part of the subscription charge.

B. Your *Plan Sponsor* will be solely responsible for collecting any portion of the subscription charges, which it assesses, to you.

C. Changes: *Delta Dental* may change your subscription charge. Each time we change the subscription charge *Delta Dental* will send your *Plan Sponsor* a notice at least 15 days before the change takes effect. It is your *Plan Sponsor's* responsibility to notify you of those changes in subscription charges

11. WE MAY CHANGE YOUR *CONTRACT*

Delta Dental shall issue and deliver to your *Plan Sponsor* prior notice of material modifications in covered services under this dental plan at least 60 days before the *effective date* of the modifications. Your *Plan Sponsor* will notify you of this change. *Delta Dental* is not responsible if the *Plan Sponsor* does not notify you that your *contract* will be changed. .

In addition to the notice describing the change being made, you can also call our Customer Service department to get information on your plan change. The telephone numbers are listed at the end of this certificate.

The notice will also tell you the *effective date* of the change. Where applicable the notice will contain any expiration dates. The change will apply to all benefits for services you receive on or after the *effective date*. However, if before the *effective date* of the change you started receiving services for a procedure requiring two or more visits, we will not apply the change to services related to that procedure. If your *Plan Sponsor* has purchased benefits for orthodontic services, this limitation will not apply to these benefits.

12. WHEN YOUR COVERAGE BEGINS

Your *Plan Sponsor* will maintain with *Delta Dental* a current and updated listing of covered *subscribers* and covered dependents and will be responsible for maintaining with us an accurate and current listing.

Your *Plan Sponsor* will inform us when you or your dependents are eligible as a *covered individual* or family member under this certificate of coverage. This eligibility is based upon *Delta Dental's* underwriting guidelines and your *Plan Sponsor*. The dental services

described in this certificate are covered immediately as of your *effective date*, unless your benefits are subject to a waiting period or there exist some limitations or exclusions on your membership which are found in Part III of this certificate.

You, your spouse and your unmarried dependent children under 26 years of age, as well as their unmarried children under 26 years of age, are eligible for coverage. **Adopted children** and children under your own or your spouse's legal guardianship are also eligible for coverage. A **physically or mentally handicapped child,** who is incapable of earning his or her own living and over 26 years, may be eligible to continue coverage under a *family contract* if *Delta Dental* is notified within 72 days of the child's twenty sixth birthday, and by completing a disabled dependent application.

13. WHEN YOUR COVERAGE ENDS

There are no conversion privileges under the *contract*. However, a *covered individual* may have the right to continue dental coverage for a period of time under state law and under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You and certain family members may be entitled to continue participating in this plan for a limited period even under conditions (such as your death or termination of employment) that would otherwise make you ineligible for coverage, so long as you pay the appropriate subscription in full. Contact your *plan sponsor* for more detailed information regarding continuation of coverage.

You may be eligible for continued coverage if your termination is due to a plant closing or partial plant closing as defined by state law. Contact your *plan sponsor* for more detailed information.

A *covered individual* will not be eligible for coverage when any of the following occurs:

A. The *subscriber* is no longer enrolled in the group. We will cover you under this *contract* until your *plan sponsor* notifies us.

B. Your dependent child under your *family contract* becomes 26 years of age..

   However, if your unmarried dependent child is either mentally or physically handicapped upon reaching 26 years and is incapable of earning his or her own living, special arrangements can be made for your child to continue coverage under your *family contract*. You must apply for this continued coverage through your *plan sponsor* within 72 days of your child's twenty-sixth birthday. In addition, you must supply us with any medical or other information that we may need to determine if your child is eligible to continue coverage under your *family contract*.

C. If you become divorced or legally separated, your spouse's coverage under an existing family membership will continue so long as you remain a *subscriber* of the plan, unless a court judgment provides otherwise. This coverage will continue until either you or your spouse remarries, or until the date of coverage termination stated in the

judgment of divorce or separation, whichever is earlier. If you remarry and your divorce judgment so provides, your former spouse will have the right, for an additional subscription, to continue to receive such benefits as are available to you by means of the issuance of an individual plan.

14. TERMINATION OF A *CONTRACT*

A. You or your *Plan Sponsor* may cancel your *contract*.

1. Your *Plan Sponsor* may cancel your *contract* for any reason. To do so, your *Plan Sponsor* must give us notice in writing at least 30 days prior to the termination date.

You may also cancel your *contract* through your *Plan Sponsor*. To do so, your *Plan Sponsor* must give us notice in writing within 72 days of cancellation. If your subscription charge is paid for a period beyond your cancellation date, we will refund the subscription charge for that period to your *Plan Sponsor* provided no claim payments have been made for services rendered after your termination date.

If you cancel your *contract*, you must wait at least one year after your cancellation before you can enroll again as a *subscriber*. You can only enroll on your group's anniversary date or when a special *open enrollment* occurs.

B. *Delta Dental* may cancel your *contract*.

1. We may cancel your group's *contract* under the terms of our agreement with your group. If your group's *contract* is canceled or not renewed, your coverage will automatically be terminated as of the same date.

If your group dental plan was terminated for non-payment of fees, charges, rates or premiums a written notice will be sent to your last known home address. The notice will include, the date your group dental plan was terminated, the termination was due to non-payment of fees, charges, or premium, and *Delta Dental* will honor dental services that are covered under your dental plan for you and your dependents prior to the *effective date* of the notification.

Delta Dental will make a reasonable effort to notify you. The notice will be sent by either first class or certified mail, postage pre-paid to your last-known home address

If you or your employer replaced your dental plan with another insured or self-insured dental plan, the provisions of this notice will not apply.

We may, upon due notice to your *Plan Sponsor*, cancel your *contract* under any of the following circumstances:

a. We may cancel your *contract* if you make any fraudulent claim or misrepresentation to us or to any dentist, such as an incorrect or incomplete statement on your application card which led us to believe you were eligible for this coverage when in fact you were not. In such a case, cancellation will be as of your *effective date*. We will refund your *Plan Sponsor* the subscription charge you have paid us. We will subtract from the refund any payments made for claims under this *contract*. If we have paid more for claims under this *contract* than you have paid us in subscription charges, we have the right to collect the excess from you.

b. We may cancel your coverage if you have not paid your subscription charges. Cancellation will be effective on a date we choose, but not earlier than the subscription charge due date. If you are a *subscriber* of a group plan, the *Plan Sponsor* will owe us the subscription charge due for the period between the due date and the cancellation date. You agree that we may use your rights against the *Plan Sponsor* to collect those subscription charges.

c. We may cancel your *contract* if you commit any acts of physical or verbal abuse which readily pose a threat to a dentist or other of our members which are unrelated to your mental or physical condition.

d. We may cancel your *contract* if you relocate outside our service area

e. We may cancel your *contract* for non-renewal or cancellation of the group *contract* through which you receive coverage.

For information regarding benefits after cancellation see Part IV, Section 15 of this certificate.

C. Cancellation due to loss of eligibility

Your *contract* will be canceled when you are no longer eligible in the group through which the *contract* was issued. If your *contract* is canceled because you are no longer eligible, we will continue to provide benefits only if you started receiving services for a procedure before the cancellation date and that procedure requires two or more visits and the treatment is completed within 30 days of the termination date. In such a case, the benefits described in this *contract* are available after your cancellation date for services related to that procedure. If your group has purchased benefits for orthodontic services, the policy of continuing benefits will not apply to these orthodontic services.

15. BENEFITS AFTER CANCELLATION

If you or your *plan sponsor* cancels your *contract* no benefits will be provided for services that you receive after your cancellation date.

If we cancel your *contract* for any reason other than for a fraudulent claim or misrepresentation, we will continue to provide benefits only if before the cancellation date you started receiving services for a procedure that requires two or more visits and the treatment is completed within 30 days of the termination date. In such a case, the benefits described in this *contract* are available after your cancellation date for services related to that procedure. If your group has purchased benefits for orthodontic services, the policy of continuing benefits will not apply to these orthodontic services.

16. NOTICES

A. To you: When we send a notice to your *plan sponsor* we will send it by first class mail. Once we mail the notice or bill we are not responsible for its delivery. It will be your *plan sponsor's* responsibility to notify you. This applies to your bill for subscription charges as well as to a notice of a change in the subscription charge or a change in the *contract*. If your name or mailing address should change, you should notify your *plan sponsor* at once. Be sure to give your *plan sponsor* your old name and address as well as your new name and address.

B. To us: Send letters to *Delta Dental*, 465 Medford Street, Boston, Massachusetts 02129. Always include your name and *Delta Dental* PPO *subscriber* identification number.

17. ENROLLMENT AND *CONTRACT* CHANGES

All enrollment applications and any additions or changes to a *contract* are allowed ONLY when they conform to our Underwriting Guidelines on file with the Massachusetts Division of Insurance. If your group is enrolled in a dual choice option, you are only eligible to change your enrollment status during the annual *open enrollment* period.

18. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after the *effective date* of this *contract*. If before a *subscriber's effective date* he or she started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure. If your group has purchased benefits for orthodontic services, this limitation will not apply to those benefits. Your *plan sponsor* can supply you with the proper orthodontic endorsement describing your benefits.

In order for you to receive any of the benefits for which you may have a right, you must inform your dentist that you are a *covered individual* and supply him or her with your *Delta Dental* PPO *subscriber* identification number and any necessary information needed to file your claim. If you fail to inform your dentist within 12 months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

Nothing in this certificate of coverage will prohibit a *covered individual* from seeking emergency care whenever the individual is confronted with an *emergency medical*

condition, which in the judgment of a prudent layperson would require pre-hospital emergency services. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent.

19. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

We will not interfere with the relationship between dentists and patients. You are free to select any dentist. It is your responsibility to find a dentist. We are not responsible if a dentist refuses to furnish services to you.

We are not liable for injuries or damages resulting from the acts or omissions of a dentist.

20. COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies if you or any of your dependents have another plan that provides coverage for services that are benefits under your *contract*. *Delta Dental* will administer the COB according to the applicable state Coordination of Benefits law and this Subscriber's Certificate.

The plan that provides benefits first under the COB rules is known as the primary plan. The primary plan is responsible for providing benefits in accordance with its terms and conditions of coverage without regard to coverage under any other plan. The plan that provides benefits next is the secondary plan. It provides benefits toward any remaining balance for covered services in accordance with its terms and conditions of coverage, including its COB provision.

Delta Dental, as the secondary plan, will provide benefits toward any remaining patient balance for covered services in accordance with your *contract*, provided that the amount paid by *Delta Dental* as the secondary plan, when added to the amount paid by the primary plan, will not exceed the lesser of the provider's submitted charge or the amount allowed under your *Delta Dental contract*.

IMPORTANT: No statement in this section should be interpreted to mean that we will provide any more benefits than those described in the Benefits Section of this *contract*. If you have any questions about COB and your *contract*, please contact our Customer Service department. The telephone numbers are listed at the end of this certificate.

21. RIGHT TO RECOVER OVERPAYMENTS

If we pay more than we should have under COB, then you must refund any overpayment to *Delta Dental*.

22. QUALITY ASSURANCE

As a *Delta Dental covered individual* you have the freedom to seek services from *Delta Dental* panel dentists or specialists or from the dentist of your choice**.** For further details about your coverage please refer to the benefit descriptions, exclusions and other *contract* provisions sections of this certificate of coverage.

Delta Dental has established a Quality Management Program for our *Delta Dental* panel dentists to state specific policies and procedures to ensure that minimum standards are met and that proper evaluations are conducted in order to provide insured with quality care.

The Quality Management Program addresses the following standards

- Provider and member services
- Provider credentialing
- The patient record/file
- Sterilization and infection control
- Medical emergency preparedness
- Environmental and radiology safety
- Professional standards/onsite reviews
- Utilization review program
- Accessibility of services
- Member and provider satisfaction

The quality management program has been developed in conjunction with individual practitioners who participate actively within the program to ensure the program's overall effectiveness

23. UTILIZATION REVIEW

This is the formal process designed to monitor the use of, or evaluate the medical appropriateness or efficiency of health care services. A utilization review program has been established to ensure that any guidelines and criteria used to evaluate the medical appropriateness of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients and characteristics of the local delivery system. The program was developed in conjunction with actively practicing dentists in all specialty areas of expertise and is reviewed at least annually to ensure that criteria are applied consistently.

Any utilization review conducted under your dental *contract* is done retrospectively or at the time a claim for services has been submitted for reimbursement. In order for a submitted claim to be covered, the procedure must be included as one of the "Covered Procedures" in your certificate. If a procedure is not a covered procedure then the claim for that procedure will be denied in accordance with the terms of your certificate and the group policy. Coverage of certain procedures may also be limited by frequency, age, *effective dates* of coverage, etc which are all *contract*ually stated within your certificate.

There are also a number of listed procedures which are only considered a covered expense if a patient presents with a specified health history and/or has been diagnosed with a specified condition. During the claims review of these specific procedures, there may be a determination by a licensed dental practitioner that the procedure that was performed was not determined to be medically appropriate in accordance with the criteria that has been established in accordance with our utilization review program. In these situations, the claim for that procedure may be denied or partially reimbursed in accordance with the benefit for an alternate procedure.

All claims are processed within 30 working days of obtaining all necessary information. Our standard turn-around times are generally 10 working days for claim review. For all claims submissions you and your dentist will receive an explanation of benefits which details how each submitted procedure was reimbursed and/or the reason for denial.

When a claim has been denied or partially denied based on medical appropriateness, this is considered an *adverse determination*. These decisions are reviewed by qualified and appropriately licensed health professionals and only after receiving any relevant clinical information necessary to make the decision.

If you wish to make an *inquiry*, determine the status or outcome of a decision with *Delta Dental*, you can submit your *inquiry* to us:

In writing:

Attention: Customer Service
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129

By telephone:1-800-872-0500

web site:www.deltadentalma.com

24. *GRIEVANCE* PROCESS:

You have the right to make inquiries and/or file a *complaint* with *Delta Dental* of Massachusetts.

If you wish to make an *inquiry*, file a *complaint*, or determine the status or outcome of utilization review decisions with *Delta Dental*, you can submit your *inquiry* or *complaint* to us:

In writing:

Attention: Grievances

Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129

By telephone:1-800-872-0500
web site:www.deltadentalma.com

Internal Levels of Review:

Internal *Inquiry* Process: *Delta Dental* will attempt to answer your questions and/or resolve concerns for all issues with the exception of reviews of an *adverse determination* (if you request a review for an *adverse determination*, this will be handled through the internal *grievance* process discussed below).

Internal *Grievance* Process:

You may file a *grievance* by phone, in person, by mail, or by electronic means. If an oral *grievance* has been presented, we will request your *grievance* in writing and be sent to us within ten (10) business days, unless this time frame has been waived or extended by mutual written agreement between both you and *Delta Dental*.

We will send a written acknowledgement of our receipt of your *grievance* to you or your authorized representative, if any, within fifteen (15) business days of receipt. We will provide you or your authorized representative, if any, a written resolution of a *grievance* within thirty (30) business days of receipt of the written *grievance*.

Written Decision:

In the event that your *grievance* involves an *adverse determination*, our written response shall include a substantive clinical justification that is consistent with generally accepted principles of professional dental practice and will:

1. Identify the specific information upon which the *adverse determination* was based.
2. Reference and include applicable clinical practice guidelines and review criteria.

Reconsideration:

We will always provide you with the opportunity to have a final decision reconsidered where relevant information is received too late to review within the thirty (30) business day time limit or is not received but is expected to become available within a reasonable period.

We will review reconsideration and provide our written response to you as soon as possible following receipt of the additional information. We agree to provide a response no later than thirty (30) business days following your request for reconsideration.

Part V: Filing a Claim

EXPLANATION OF BENEFITS

Each time we process a claim for you under this *contract*, a written notice may be sent to you called an Explanation of Benefits (EOB) which will explain your benefits for that claim. This notice will tell you how we paid the claim or the reasons it was denied.

WHO FILES A CLAIM

Delta Dental PPO Panel Dentists:

Delta Dental PPO Panel Dentists will file claims directly to us for the Services covered by this *contract*. We will make benefit payments to them

Delta Dental PPO Non-panel Dentists:

If you use a *Delta Dental PPO Non-panel Dentist*, the dentist will file claims directly to us for the services covered under this *contract*. *Delta Dental* will send payment for claims directly to the dentist. You will be responsible for paying the dentist the difference between the dentist's charge and *Delta Dental's* payment.

If you use *a Delta Dental PPO Non-panel Dentist* who is also a *non-participating dentist* in *Delta Dental's* traditional programs, you may be asked to file a claim. Claims payments will be made directly to you. It is your responsibility to pay your dentist. You are also responsible for paying the dentist the difference between his full charge and *Delta Dental's* payment.

WHEN YOU FILE A CLAIM

When you file a claim for the services of a *Delta Dental PPO Non-panel Dentist* who does not participate in any of *Delta Dental's* traditional plans, the following rules apply. Obtain an Attending Dentist's Statement claim form from your *plan sponsor* or *Delta Dental*, complete it, and send it to *Delta Dental*. After we receive your completed forms we will (a) send you a check for your claim to the extent of your benefits under this *contract*; (b) send you a notice in writing of why we are not paying your claim; or (c) send you a notice in writing of what additional information or records we need to decide if we should pay your claim. It is up to you to pay your dentist. If you have any questions, contact your *plan sponsor* or our Customer Service department. *Delta Dental* telephone numbers are listed at the end of this certificate.

Part VI: Index

This index lists the major benefits and limitations of your *contract*. Of course, it does not list everything that is covered in your *contract*. To understand fully all benefits and limitations you must read carefully through your *contract*.

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465 Medford Street
Boston, MA 02129
www.deltadentalma.com

Customer Service:
617•886•1234
800•872•0500

Corporate Office:
617•886•1000
800•451•1249