465 Medford St., Boston, MA 02129 617-886-1234

Subscriber's Certificate for Total Choice PPO Individual Dental Insurance Policy

*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 Right to Examine This Policy: Your satisfaction is our number-one priority. You have the right to examine this policy for 10 business days from the date of delivery. Should this policy not meet your needs, please return to us, within 10 business days, the original policy with a letter telling us of your intent to cancel. You will receive a full refund of all premiums paid towards the cancelled policy, and your policy will be void from its effective date. We will subtract from the refund any payments made for claims under this *Contract*. If we have paid more for claims under this C*ontract* than you have paid to us in subscription charges, we have the right to collect the excess from you.

This policy does not include coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act. It will only be offered when the carrier is reasonably assured that an applicant is covered by a plan with the required level of coverage of pediatric dental services.

Pre-existing conditions: Expenses incurred in connection with any dental procedure started prior to coverage are excluded. Benefits are not available for the replacement of teeth missing prior to the member's effective date of coverage.

This policy is guaranteed renewable for life: This policy will be up for renewal 12 months from your effective date, as long as the product offering has not been discontinued in the market. We reserve the right to change premium rates upon renewal of the policy. We agree to keep your coverage in force as long as you continue to pay the premiums on time and as long as you retain your residency in Massachusetts.

Entire Contract; Changes: This policy, including endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval is endorsed or attached here. No agent has authority to change this policy or to waive any of its provisions.

Steven J Pollock

Steve Pollock
President & CEO

*DSM Massachusetts Insurance Company, Inc. is doing business as *Delta Dental* of Massachusetts.

Table of Contents

Part I:
Delta Dental of Massachusetts
Outline of Coverage
Total Choice PPO

A. Description of Benefits, Coinsurance Amounts and Frequency Limitations:

The extent of your benefits is explained in the *Schedule of Benefits* incorporated as part of this *Contract*. This coverage includes the following types of services:

Type 1 services include 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. Type 1 services are covered at 100% when rendered by a *Participating Dentist*. Type 1 services are covered at 80% when rendered by a *Non-Participating Dentist.* There is no deductible on Type 1 services.

1. Comprehensive oral examination (including the initial dental history and charting of teeth); once every 60 months per member.
2. Periodic oral evaluation; twice every 12 months.
3. Intra oral X-ray image of the entire mouth (Full Mouth Series or Panoramic image) once every 60 months.
4. Intra oral bitewing x-rays images (x-rays of the crowns of the teeth); twice every 12 months when oral conditions indicate need.
5. Single tooth x-ray images; as needed (5 images per date of service).
6. Routine cleaning, scaling and polishing of teeth; twice every 12 months.
7. Fluoride treatment for *Covered Individuals* under 15 years of age; twice every 12 months.
8. Space maintainers required due to the premature loss of teeth; only for *Covered Individuals* under 14 years (once per tooth) and not for the replacement of primary or permanent anterior teeth.
9. Limited oral evaluation problem focused exams; 2 visits per 12 months.
10. Sealants for unrestored permanent molars; once per tooth for members through age 15.

Type II services include the following dental services to: (i) restore decayed or *Fractured* teeth when teeth have a good prognosis; (ii) remove diseased or damaged natural teeth when teeth do not have a good prognosis; (iii) treat oral disease when teeth have a good prognosis; (iv) repair dentures or bridges; (v) rebase or reline dentures; and (vi) repair or recement bridges, crowns and onlays. Type II services are covered at 80% when rendered by a *Participating Dentist*. Type II services are covered at 60% when rendered by a *Non-Participating Dentist*. There is a $50 individual deductible on Type II and Type III services. There is a $150 Family deductible on Type II and Type III services.

1. Fillings consisting of silver amalgam and (in the case of front teeth) synthetic (white) 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 (and all inlays) on posterior teeth will be treated as an *Alternate Benefit* and paid as an amalgam. 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. Inlays- Metallic, porcelain and composite resin inlays will be treated as an *Alternate Benefit* and an amalgam allowance will be reimbursed. No benefits are provided for replacing an inlay for 60 months after the date that the prior inlay was fabricated.
3. Protective restorations, once per tooth.
4. Stainless steel crowns on deciduous (baby) teeth; once every 24 months per tooth.
5. Simple and surgical tooth extractions, once per tooth.
6. General anesthesia when necessary and appropriate for the covered removal of impacted teeth, up to one hour only when provided by a licensed, practicing dentist.
7. Palliative dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm. 3 visits per 12 months.
8. Repair of dentures, once per denture per 12 months; Repair of fixed bridges, once per bridge per 12 months. Recementing of fixed bridges, once in a lifetime.
9. Rebase or reline dentures; once per denture every 36 months.
10. Tissue conditioning; two treatments per denture every 36 months.
11. Repair crowns and onlays once per tooth per 12 months. Recementing of a crown is limited to once every 12 months per tooth.
12. Adding teeth to existing partial or full dentures. Once per tooth, per denture.
13. Periodontic Services on natural teeth only:
    - Non-surgical procedures include scaling and root planing, once per quadrant every 24 months.
    - Surgical procedures, including gingivectomy, osseous surgery, soft tissue grafts and crown lengthening. One surgical procedure is covered once per quadrant, every 36 months.
    - Bone grafts and guided tissue regeneration to aid in surgical procedures is limited to 2 teeth, per 36 months, per quadrant.
14. Endodontic Services:
    - Root Canal Therapy, once per permanent tooth per lifetime.
    - Vital pulpotomy, limited to once per each deciduous tooth.
    - Retreatment root canal therapy on permanent teeth, once in a lifetime per tooth after 24 months of initial root canal therapy.
    - Apicoectomy once per permeant tooth, per lifetime.
15. Periodontal Cleanings following active periodontal therapy; once every 3 months, not to be combined with regular cleanings.

Type III services include the following dental services and supplies: to replace missing natural teeth with artificial ones and to restore severely decayed or *Fractured* teeth. Services covered on permanent teeth only. Teeth must have a good prognosis to qualify for benefits. Type III services are covered at 50% when rendered by a *Participating Dentist*. Type III services are covered at 30% when rendered by a *Non-Participating Dentist*. There is a $50 individual deductible on Type II and Type III services. There is a $150 Family deductible on Type II and Type III services.

1. Dentures and Bridges
   - Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each 60 months, covered for members 16 and over.
   - Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were installed at least 60 months before replacement. Covered for members 16 and over.
   - Temporary partial dentures as follows:
     - To replace any of the six upper or lower front teeth, but only if the temporary partial dentures 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 on permanent teeth only on members 12 years and older only as follows, but only when the teeth cannot be restored with the fillings described under Restorative Services and Other Basic Services due to severe decay or *Fractures*:
   - Initial placement of crowns and onlays.
   - Replacement of crowns and onlays; once every 60 months per tooth.
   - Covered for members 12 years and older.
3. Post and core or crown buildup on permanent teeth only on members 12 years and older when needed to retain a crown on a tooth with excessive breakdown due to caries and/or fractures, once per tooth every 60 months.
4. Endosteal implant (a device surgically inserted into the bone to provide support for a single restoration) on members 16 and older when used in lieu of a three unit bridge; Implants are only covered when they serve to replace a single missing tooth, once every 5 years. In order to be covered, teeth abutting the implant on each side must:
   - Be free of decay or fracture,
   - Have root anatomy that is adequate and sound with no visible damage or evidence of any infection or significant bone loss,
   - Be periodontally stable with probings less than 5 mm,
   - Be in appropriate occlusion, and
   - NOT be expected to require major (e.g. a crown) restorations.

B. There is no annual maximum for this plan.

C. ***Waiting Periods:*** There are no *Waiting Periods* under this plan.

D. Pre-existing conditions: For work in progress before the effective date of this policy – dental expenses incurred in connection with any dental procedure started prior to coverage are excluded. No benefits are available for the replacement of teeth missing prior to the member's effective date of coverage.

E. This policy is renewable upon becoming eligible for Medicare.

F. Dependents will no longer be eligible for coverage under the subscriber's policy once they reach age 26.

G. This policy is subject to premium increases at the time of renewal. We will provide you 30-day's notice of any rate increase. This policy will be in force for 12 months from the effective date.

H. You have the right to examine this policy for 10 days from the date of delivery. Should this policy not meet your needs please return to us, within 10 days, the original policy with a written letter telling us of your intent to cancel. You will receive a full refund of all premiums paid toward the cancelled policy and your policy will be void from the original effective date. We will subtract from the refund any payments made for *Claims* under this *Contract*. If we have paid more for *Claims* under this C*ontract* than you have paid us in subscription charges, we have the right to collect the excess from you.

Read your policy carefully. This disclosure statement is a very brief summary of your policy. The policy itself sets forth the rights and obligations of both you and the insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

COMPLAINTS: If you have a complaint, call us or your agent. If you are not satisfied, you may call the Massachusetts Division of Insurance.

Part II: Member Rights & Responsibilities

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

- File *grievances* about *Delta Dental* or the *participating dentist*s. In the case of an adverse determination, *Delta Dental* may include alternative treatment options that are covered, appropriate, and consistent with general principles of professional dental practice.
- 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.

You have the responsibility to:

- 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.

You have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-876-3981 TTY 1-800-555-5555**.**

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ំពី បេ, អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នា
បៅកនុងភាសា រស់អ្នក បោយមិនអ្ស់ប្ាក់ ។ ប្បេើមបីនិយាយជាមួយអ្នករកដប្រ សូម 1-844-876-3981 TTY 1-800-555-5555 ។

Chinese:
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話
在此插入數字1-844-876-3981 TTY 1-800-555-5555。

Vietnamese: quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-876-3981 TTY 1-800-555-5555.

Arabic: صوصخب ةلئسأ هدعاست صخش ىدل وأ كيدل نكا نإ 1-844-876-3981 ب لصتا مجرتم عم ثدحتلا .ةقلك ةيا نود نم كنغلب
ةيورورضلا

Korean: 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-844-876-3981 TTY 1-800-555-5555 로 전화하십시오.

French: vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-876-3981 TTY 1-800-555-5555.

Russian: то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-876-3981 TTY 1-800-555-5555.

Spanish: tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-876-3981 TTY 1-800-555-5555.

German: haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-876-3981 TTY 1-800-555-5555 an.

Tagalog: may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-876-3981 TTY 1-800-555-5555.

Gujarati: વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો િ ત કરિ મ ટે,આ 1-844-876-3981 TTY 1-800-555-5555 પર કોલ કરો.

Hindi: के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी ि्भाषषए से बात करने के लिए , 1-844-876-3981 TTY 1-800-555-5555 पर कॉि करें।

Italian: hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-876-3981 TTY 1-800-555-5555.

Japanese:
についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-876-3981 TTY 1-800-555-5555 までお電話ください。

Portuguese: você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-876-3981 TTY 1-800-555-5555.

French Creole: se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-876-3981 TTY 1-800-555-5555.

Polish: masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-876-3981 TTY 1-800-555-5555.

Amharic: ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-876-3981 TTY 1-800-555-5555 ይደውሉ።

Greek: Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-844-876-3981 TTY 1-800-555-5555.

Lao: ຖ້າທ່ານ, ຫ ູ ືຄົນຫ ່ທ່ານກ ໍາລັງຊ ່ວຍເຫ ູ ືອ, ມ ຄ ໍາຖ ໍາມກ ່ຽວກ ັບ, ທ ່ານມ ສ ິດຫ ່ ຈ ະໄດ ້ ຮ ັບການຊ ່ ວຍເຫ ູ ືອ ແລະ ຂ ໍ ້ ມ ູ ນຂ ່ າວສ ານຫ ່ ເປ ັ ນພ າສ າຂ ອ ງທ ່ ານ ບ ໍ ່ ມ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ. ການໂອ ້ ລ ົ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ຫ ້ ໂ ທ ຫ າ 1-844-876-3981 TTY 1-800-555-5555.

Part III: Notices

NONDISCRIMINATION NOTICE

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, gender identity, sexual orientation, disability, or sex. *Delta Dental* does not exclude people or treat them differently because of race, color, national origin, age, gender identity, sexual orientation, disability, or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, visit: http://www.deltadentalma.com or call the number at the end of this Subscriber Certificate.

If you believe that *Delta Dental* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ugonna Onyekwu
Civil Rights Coordinator
Compliance Department
465 Medford Street
Boston, MA 02129
Fax: 617-886-1390
Phone: 617-886-1683
Email: FairTreatment@greatdentalplans.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can file a complaint electronically through

the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have the right of access and correction with respect to all information collected about you. The obligations imposed by M.G.L. Ch. 175I § 4 (c)-(e) upon an insurance institution or insurance representative may be satisfied by another insurance institution or insurance representative authorized to act on its behalf. Information collection and disclosure authorized pursuant M.G.L. Ch. 175I § 4 (c)-(e) is limited to the practices described in the notice issued or available pursuant to this section.

If you wish to have a more detailed explanation of our information practices, please contact *Delta Dental*, 465 Medford Street, Boston, MA 02129.

Part IV: Definitions

Adverse Determination: A *Delta Dental* decision (a) to deny, reduce, or terminate a plan benefit or (b) to reduce payment in part or deny payment altogether for a plan benefit.

Allowable Charge: the dollar amount upon which *Delta Dental* bases its payment and the dollar amount *Participating Dentists* consider to be payment in full. The *Allowable Charge* is typically a discounted rate rather than the actual charge, and is never more than the amount charged by the dentist. For services rendered by *Non-Participating Dentist*, the *Allowable Charge* is a percentage of a usual, customary and reasonable charge, as determined by *Delta Dental*.

Alternate Benefit: in cases where alternative, less costly methods of treatment exist, benefits are provided for the least costly professionally accepted treatment. If the treatment rendered is not the one listed as a covered service under this *Contract*, the difference between *Delta Dental's Allowable Charge* and the cost for the actual treatment rendered is your responsibility.

Annual Maximum Benefit: the maximum dollar amount we will pay toward the cost of covered services rendered during each calendar year. You are responsible for costs for services over the *Annual Maximum Benefit.*

Appeal: is a request for *Delta Dental* to reconsider an *Adverse Determination* or an upheld denial.

Claim: is any request for a plan benefit or benefits made in accordance with the *Contract*. *Delta Dental* will not treat a communication regarding benefits as a *Claim* unless the communication is submitted in accordance with this *Contract*. *Delta Dental* will treat any request for plan benefits that is not made in accordance with this Contract as an incorrectly filed *Claim*. *Delta Dental* will treat the resubmission of a *Claim* as the same original *Claim*, not a new or separate *Claim*.

Coinsurance: the amount that you are obliged to pay for covered services after you satisfy any applicable *Deductible*. *Coinsurance* is typically a percentage of the charge or *Allowable Charge* for a service rendered and appears on your *Schedule of Benefits*.

Contract: this Subscriber Certificate, together with the attached *Schedule of Benefits*, your Enrollment Form and Application, and any applicable Riders, Endorsements, Amendments, or Supplemental Agreements.

Covered Individual or Member: a person who is eligible to receive dental benefits from *Delta Dental*. Usually includes *Subscribers* and their enrolled dependents.

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

Deductible: The amount that the *Subscriber* must pay toward covered services before the plan will begin paying any benefits. Your *Deductible* amount can be found on your *Schedule of Benefits*.

Delta Dental: DSM Massachusetts Insurance Company, Inc., doing business as Delta Dental of Massachusetts.

Effective Date: The date, as shown on our records, when 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 or your spousal equivalent, and/or your dependent children up to the maximum dependent age listed in your *Schedule of Benefits*. Adopted children and children under your own or your spouse's or spousal equivalent'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 the maximum dependent age listed in your *Schedule of Benefits* years may be eligible to continue coverage under a family membership if *Delta Dental* is notified within 72 days of when the child exceeds the maximum dependent age, 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: any oral or written complaint a *Member* submits to *Delta Dental* concerning any aspect of the *Member's* coverage or any action of *Delta Dental* concerning the *Member*, except that a *Grievance* does not include a *Claim* or an *Appeal*.

Inquiry: is any communication by or on behalf of a Member to Delta Dental of Massachusetts that has not been the subject of an *Adverse Determination* and that requests redress of an action, omission or policy of the carrier.

Non-Participating Dentist: With regard to dental services provided in Massachusetts pursuant to this *Contract*, a doctor of dentistry who is duly licensed and qualified under applicable laws to provide such services and who, at the time such services were rendered, was not subject to an agreement with *Delta Dental* to furnish such services pursuant to *Delta Dental's* Total Choice PPO plan.

Participating Dentist: With regard to dental services provided in Massachusetts pursuant to this *Contract*, a doctor of dentistry who is duly licensed and qualified under applicable laws to

provide such services and who, at the time such services were rendered, had entered into and was subject to an agreement with *Delta Dental* to furnish such services pursuant to *Delta Dental's* Total Choice PPO plan.

Plan Year: a consecutive 12- month period during which the plan provides benefits under this *Contract*. A *Plan Year* may or may not correspond with the calendar year. Your *Plan Year* will appear in your *Schedule of Benefits*.

Schedule of Benefits: the part of your *Contract* which outlines the specific coverage in effect as well as the amount, if any, that you may be responsible for paying towards your dental care. Your *Schedule of Benefits* is attached to this Subscriber Certificate.

Subscriber: An individual whose name this policy is under.

Waiting Period: the period of time that must pass after your *Effective Date* before a *Covered Individual* is eligible for benefits under this *Contract.* If applicable, the *Waiting Period* is listed in your *Schedule of Benefits*.

Part III: Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of this *Contract*, including your *Schedule of Benefits*. We will not provide benefits for any dental service that is not necessary and appropriate to diagnose or to treat your dental condition.

A. To be necessary and appropriate, a service must be consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of (1) those teeth that are decayed or *Fractured* or (2) those teeth where supporting structure is weakened by disease (including periodontal, endodontic and related diseases). Dental care must be furnished 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 Subscriber Certificate:

   We determine what services are covered under this *Contract*. Coverage decisions are made 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.

2. WE DO NOT PROVIDE BENEFITS FOR:

The *Schedule of Benefits* provides a summary of dental services or items for which coverage is excluded under this Subscriber Certificate.

Please note that we will not provide coverage:

- if you have reached your *Annual Maximum Benefit*;
- if your balance is due to your *Deductible*;
- if the services were provided by a dentist who is not duly licensed in the state in which he or she practices; or
- if the services were rendered after your coverage termination date

Part IV: Other Contract Provisions

1. BENEFIT PAYMENTS FOR SERVICES RENDERED BY A *PARTICIPATING DENTIST*

   IN-NETWORK SERVICES:

   For services performed by a *Participating Dentist*, the In-Network payment is based on the *Allowable Charge* or the dentist's submitted fee, if lower. *Delta Dental* pays the *Participating Dentist* directly for covered services. The dentist will bill covered *Members* for balances resulting from plan specific *Deductibles* and any *Coinsurance*.

   If you have received a covered service when you have already exhausted your *Annual Maximum Benefit* or you received a covered service which will cause you to exceed your *Annual Maximum Benefit* you will only be responsible for charges up to *Delta Dental's* negotiated rate, provided that the service that you received is not excluded from coverage under the terms of this *Contract*.

2. WHEN YOUR IN-NETWORK DENTIST *MAY* CHARGE YOU MORE

   When your *Participating Dentist*, provides covered services based on the *Delta Dental Allowable Charge*, he or she must accept the *Allowable Charge* as payment in full. But in the following cases you may be responsible for the difference between the *Allowable Charge* and the dentist's actual charge for covered services:

   A. If you receive a treatment that is excluded under your plan, you may be billed at the dentist's normal rate rather than the negotiated rate.

   B. If your dentist renders services or uses materials that are more expensive than those customarily furnished by most dentists, benefits may be provided towards the service with the lower fee. This is sometimes referred to as an *Alternate Benefit*. In this case, you may be responsible for the difference between the *Allowable Charge* for the service with the lower fee and *Allowable Charge* for service with the higher fee. Please see your *Schedule of Benefits* for additional information.

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

3. PRE-TREATMENT ESTIMATES

   If your dentist determines that the services to be rendered to you will exceed $300, we suggest that your dentist file a copy of the treatment plan with *Delta Dental* BEFORE these services are rendered in order to determine if any coverage may be provided by *Delta Dental*. 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.

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. Please note that a pre-treatment estimate is not a guarantee of payment and not required to obtain care.

4. BENEFIT PAYMENTS FOR SERVICES RENDERED BY *NON-PARTICIPATING DENTISTS*

   A. OUT-OF-NETWORK SERVICES:

   For services performed by *a Non-Participating Dentist*, the out-of-network benefit *Coinsurance* for each type of service may be up to 20 percentage points higher than the in-network dentist *Coinsurance*. Payments made to the *Non-Participating Dentist* shall be a percentage of the dentist's fee, up to a usual and customary charge, and not a percentage of the amount paid to *Participating Dentists*. The *Coinsurance* will be applied against the fee allowed by *Delta Dental* or the dentist's submitted fee, if lower. Please see your Schedule of Benefits for you *Coinsurance* amount.

   For services performed by a *Non-Participating Dentist*, *Delta Dental* pays the *Subscriber* directly for covered services, and the *Member* is responsible for paying the dentist. The dentist will bill the covered *Subscriber* for the difference between the *Delta Dental* payment and his / her submitted charge and balances resulting from plan specific *Deductibles* and *Coinsurance.*

   B. EMERGENCY CARE

   When a *Covered Individual* requires emergency care as the result of an *Emergency Medical Condition* and cannot reasonably reach a Total Choice PPO dentist, payment for such care will be paid at the same level as if the *Covered Individual* had been treated by a Total Choice PPO dentist, once you notify *Delta Dental* that you sought such emergency care.

   Nothing in this section will prohibit a covered member from seeking emergency care whenever the member is confronted with an emergency medical condition that in the judgment of a prudent layperson would require pre-hospital emergency medical services. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent.

   Coverage will not be denied for dental expenses incurred as a result of such emergency condition.

5. TIME LIMIT

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

If benefits are denied because a *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 paid by *Delta Dental*. You will still be responsible for your relevant *Coinsurance* or *Deductibles*, if any.

This provision applies only if you properly identify yourself as a *Covered Individual* by presenting your *Subscriber* identification card. If you do not properly identify yourself as a *Covered Individual*, you may be responsible for the cost of any services rendered.

6. 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.

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

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

Participating Dentists have agreed to give us all information necessary to determine your benefits under this *Contract*. *Participating Dentists* have agreed not to charge for this service.

If you receive services from a *Non-Participating Dentist*, you must obtain all dental records or other related information we need in order to determine if those services are covered under this *Contract*. *Delta Dental* will not pay you or 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, even if they would otherwise be covered under this *Contract*. All services provided by a *Non-Participating* are your responsibility and benefit determinations will be made based on the benefits available to you and information provided to us by the dentist.

8. PREMIUM PAYMENT

A. Payments: The amount of money that you pay to us for your benefits under this *Contract* is called your subscription charge or premium payment. You are responsible to pay the total subscription charges by the due date on each **monthly** invoice.

B. Grace Period: A grace period of 31 days will be given for the payment of each subscription due after the first premium, during which grace period the policy shall

continue in force. If subscription charges have not been paid within 31 days after the payment due date, we may end this agreement upon written notice to you, as of the date to which subscription charges have been paid.

C. Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium shall reinstate the policy without requiring an application for reinstatement. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, we will reinstate the policy upon our approval of such application or, without such approval, on the 45th day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provision endorsed here or attached here in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid but not to any period more than 60 days before the date of reinstatement.

D. Changes: We may change your subscription charge. Each time we change the subscription charge, we will send you a notice at least 30 days before the effective date of change.

9. WE MAY CHANGE YOUR CONTRACT

We may change a part of your *Contract*. If we do, we will send you a notice each time. The notice will describe the change being made. You can also call our Customer Service department to get information on your plan change. Telephone numbers are listed at the end of this certificate.

The notice will tell you the effective date of the change. The change will apply to all benefits for services you receive on or after the effective date. There is one exception: If you started receiving services for a procedure requiring two or more visits (a multi-stage procedure) before the effective date of the change, we will not apply the change to services related to that procedure.

10. WHEN YOUR COVERAGE BEGINS

You will be responsible for maintaining with *Delta Dental* a current and updated listing of covered dependents and will be responsible for maintaining with us an accurate and current listing.

You 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. 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 IV of this certificate and in your Schedule of Benefits.

You, your spouse, or spousal equivalent, and your dependent children under 26 years of age, as well as their children under 26 years of age, are eligible for coverage. Adopted children and children under your own or your spouse's or spousal equivalent'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.

11. WHEN YOUR COVERAGE ENDS

A. *Covered Individual* will not be eligible for coverage when any of the following occurs:

1. The *Subscriber* is no longer enrolled in the plan.
2. Your dependent child under your *Family Contract* reaches his or her 26th birthday.
3. If your dependent child is either mentally or physically handicapped upon reaching 26 years and is not capable of earning his or her own living, your child can continue coverage under your *Family Contract* through special arrangements. You must apply for this coverage within 72 days of your child's 26th birthday. Also, 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*.
4. Whenever your dependent child's coverage under your *Family Contract* ends, the coverage for any offspring of that dependent child also ends.
5. 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. Delta Dental may request a copy of your divorce decree in order to aid with activities related to coordination of benefits. This provision shall apply to any policy issued or renewed within or without the commonwealth and which covers residents of the commonwealth.
6. The subscriber is no longer a Massachusetts resident.

12. TERMINATION OF A CONTRACT

A. You may cancel your *Contract* for any reason. To do so, you must give us notice in writing at least 30 days prior to the termination date. If your subscriber charge is paid for period beyond your cancellation date, we will refund the subscription charge for that period to you 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*.

B. We may cancel your *Contract*.
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. You will owe us the subscription charge due for the period between the due date and the cancellation date.

A written notice will be sent to your last known home address. The notice will include the date your dental plan was terminated that the termination was because of non-payment of subscription charges, and that we will honor dental services that are covered under your dental plan for you and your dependents prior to the effective date of the notice.

We 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

We may also, upon due notice to you, 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 you 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 *Contract* if your subscription charges are overdue according to the provisions of 940 CMR 9.00. Cancellation will be effective on a date we choose, but not earlier than the subscription charge due date. You will owe us the subscription charge due for the period between the due date and the cancellation date.
c) We may cancel your *Contract* if you have been guilty of uncooperative or unethical dealings with us, or for any other cause that the Commissioner of Insurance approves.
d) Time Limit on Certain Defenses: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability as defined in the policy commencing after the expiration of such 2-year period; OR Incontestable: After this policy has been in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical

condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

e) 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.

f) We may cancel your *Contract* if you are no longer a resident of Massachusetts.

13. BENEFITS AFTER CANCELLATION

If you cancel your *Contract* no benefits will be provided for services that you receive after your cancellation date.

If your *Contract* is cancelled for reasons other than for a fraud or misrepresentation, we will continue to provide certain benefits for specific covered multi-stage procedures, provided that the first treatment visit for that procedure was rendered prior to your termination date. Multi-stage procedures are those that require two or more visits to complete and include crowns, bridges, dentures and root canals. Coverage will be available up to the limitations listed in your *Contract* provided the treatment is completed within 30 days of the termination date. If you have purchased benefits for orthodontic services, the policy of continuing benefits will not apply to these orthodontic services.

14. NOTICES

To you: When we send a notice to you we will send it by first class mail. Once we mail the notice or bill we are not responsible for its delivery. This applies to your bill for subscription charges. This also applies to a notice of a change in the subscription charge or a change in the *Contract*. If your name or mailing address changes, you should notify us at once.

To us: Send letters or *Inquiries* to *Delta Dental* of Massachusetts, 465 Medford Street, Boston, Massachusetts 02129. Always include your name and your *Subscriber* identification number.

15. 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 Commissioner of Insurance.

16. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after your *Effective Date* of coverage. If before a *Member'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.

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 Subscriber identification number and any necessary information needed to file your *Claim*. If you do not properly identify yourself as a *Covered Individual* within 12 months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

Nothing in this Subscriber Certificate will prohibit a *Covered Individual* from seeking emergency care whenever the individual is confronted with an *Emergency Medical Condition*. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent.

17. 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.

18. COORDINATION OF BENEFITS (COB)

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 coordinate benefits in according to any applicable state coordination of benefits law (including the provisions of the Massachusetts Division of Insurance's regulations regarding COB, the "COB Regulations") and this Subscriber's Certificate. A copy of the COB Regulations is available from *Delta Dental* upon request.

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.

When *Delta Dental* is the secondary plan, we will provide benefits toward the remaining balance for covered services. These benefits are determined by the terms of your *Contract* and this Subscriber's Certificate, subject to the COB Regulations.

IMPORTANT: No statement in this section should be interpreted to mean that we will provide any more benefits than those described in the *Schedule of Benefits* and 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 Subscriber Certificate.

19. RIGHT TO RECOVER OVERPAYMENTS

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

IMPORTANT: No statement in this section shall mean that we will provide more benefits than those described in your *Contract.* If you have questions about coordination of benefits or your *Contract*, please contact our Customer Service department. Telephone numbers are listed at the end of the Subscriber's Certificate.

20. LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of such loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

21. QUALITY ASSURANCE

As a *Delta Dental Covered Individual* you have the freedom to seek services from *Delta Dental* dentists or specialists or from the dentist of your choice**.** *Participating Dentists* meet network and credentialing standards and submit *Claims f*or covered services directly to *Delta Dental*.

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

Quality Control: *Delta Dental's* quality assurance system includes:

- Utilization reviews to ensure appropriate care
- Compliance audits
- Credentialing
- Customer and member surveys
- Grievance tracking
- Research studies identifying alternative treatment for curing disease

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.

21. 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* can be done either retrospectively or at the time a *Claim* for services has been submitted for reimbursement or payment. In order for a submitted *Claim* to be covered, the procedure must be included as one of the covered services in your *Contract*. If a procedure is not a covered service then the *Claim* for that service will be denied in accordance with the terms of your *Contract* and the group *Contract*, if applicable. Coverage of certain procedures may also be limited by frequency, age, *Effective Dates* of coverage, etc. Please refer to this Subscriber Certificate and your *Schedule of Benefits* for more information on your coverage.

All *Claims* are processed within 30 working days of obtaining all necessary information. For all *Claims* submissions your dentist will receive an explanation of benefits that details how each submitted procedure was reimbursed and/or the reason for denial. For all *Claims* where there is a member financial responsibility, the *Subscriber* will also 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 Benefit 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*, to 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

Website: www.deltadentalma.com

22. *GRIEVANCE* PROCESS

Delta Dental will accept *Grievances* by telephone, by mail, or by electronic means. Upon receipt of an oral *Grievance*, *Delta Dental* will open a case for the member who submitted it and request that the member submit a written version of such *Grievance* within 10 business days. If you do not submit the written *Grievance* within 10 business days, *Delta Dental* will close the *Grievance* without further action.

Delta Dental will assign a *Grievance* to a Complaints & Grievances Specialist who will ensure that a person who is (or persons who are) knowledgeable about the matters at issue in the *Grievance* review the matter. The Complaints & Grievances Specialist will provide the member with a written resolution of a *Grievance* within 30 business days of receipt. The written resolution will identify the specific information considered and an explanation of the basis for the decision.

Delta Dental will establish a system for maintaining records of *Grievances* and responses to G*rievances* and will maintain the records for a period of seven years.

23. APPEAL OF AN *ADVERSE BENEFIT DETERMINATION*

How to file an *Appeal*:

You have a right to appeal an *Adverse Benefit Determination* under this *Contract*. Except for urgent care *Claims*, discussed below, you may appeal an *Adverse Benefit Determination* by submitting a written request for *Appeal* to *Delta Dental.*

In writing:

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

By telephone:

1-800-872-0500

Delta Dental receives an *Appeal* on the earlier of (a) the date *Delta Dental* begins to process the *Appeal* or (b) three business days after the date on which the *Appeal* is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope addressed to the above name and address. The postmark on any such envelope will be proof of the date of mailing.

Submission of Comments and Other Information:

You have the right to submit documents, written comments, or other information in support of an *Appeal*.

***Appeal* Deadline:**

You must file an Appeal of an *Adverse Benefit Determination* or Upheld Denial within 180 days following your receipt of the notice of original *Adverse Benefit Determination* or notice of Upheld Denial, as applicable. Failure to comply with this deadline may cause you to forfeit any right to any further review of an *Adverse Benefit Determination* or Upheld Denial under this *Contract* or in a court of law.

Number of *Appeals*:

The number of *Appeals* you are permitted to make depends on whether the *Adverse Benefit Determination* is based on a contractual limitation or a scientific or clinical determination.

In the event that an *Adverse Benefit Determination* is made on the basis of a contractual limitation, you may appeal such an *Adverse Benefit Determination* once.

In the event that an *Adverse Benefit Determination* is made on the basis of a scientific or clinical determination, you may *Appeal* such *Adverse Benefit Determination*. If, upon review, *Delta Dental* denies your *Appeal* (an "Upheld Denial"), then you may *Appeal* the Upheld Denial, which results you having a total of two *Appeals* following the initial *Adverse Benefit Determination.*

24. CONFORMITY WITH STATE STATUTES

Any provision of this *contract* which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

25. OFFICE OF PATIENT PROTECTION

You can contact the Office of Patient Protection in Massachusetts at 50 Milk Street, 8th Floor, Boston, MA 02109 or via phone at 800-436-7757.

Part V: Filing a Claim

1. EXPLANATION OF BENEFITS

Each time we process a *Claim* for you under this *Contract*, a written notice may be sent to your dentist called an Explanation of Benefits (EOB) which will explain your benefits for that *Claim*. If you owe money to your dentist for services rendered, an Explanation of Benefits will be forwarded to the *Subscriber* that describes your responsibility.

2. WHO FILES A CLAIM

Participating Dentists:

Participating Dentists will file *Claims* directly to us for the services covered by this *Contract*. We will make benefit payments to them.

Non-participating Dentists:

If you use a *Non-participating Dentist*, the dentist may file a *Claim* directly with us for the services covered under this *Contract* or you may be asked to file a *Claim*. *Delta Dental* will send payment for *Claims* directly to the *Subscriber*. It is your responsibility to pay your dentist. You will also be responsible for paying the dentist the difference between the *Non-participating Dentist's* charge and *Delta Dental's Allowable Charge* in addition to any applicable *Deductible* and *Coinsurance*.

3. TIME LIMIT OF FILING CLAIMS

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

If benefits are denied because a *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 patient liability, if any. This applies only if you properly inform your *Participating Dentist* that you are a *Covered Individual* by presenting your *subscriber* identification card.

4. WHEN YOU FILE A CLAIM

When you file a *Claim* for the services of a *Non-participating Dentist,* the following rules apply:

You must give us written notice of *Claim* within one year of the occurrence or commencement of any service covered by the policy. Notice given by or on behalf of the insured or the beneficiary to the insurer at *Delta Dental's* main office or to any authorized

agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Obtain an Attending Dentist's Statement *Claim* form from *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*; or (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 our Customer Service department. *Delta Dental* telephone numbers are listed at the end of this certificate.

Claim forms: The insured can obtain a claim form from our website, www.deltadentalma.com, or by requesting a claim form from our Customer Service department. If such forms are not furnished within 15 days after the request the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possibly and in no event except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of *Claims*: All benefits under this policy for any loss will be paid immediately upon receipt of due written proof of such loss. However, no benefits will be paid until the Claim Form required by the policy has been submitted to *Delta Dental*.

Payment of *Claims*: Dental benefits provided under this policy will be paid by Delta Dental directly to *Participating Dentists. Claim* payments for services performed by *Non-participating* dentists will be made directly to you, or to your estate should any benefits be unpaid at death.

If you have any questions, contact our Customer Service department. *Delta Dental* telephone numbers are listed at the end of this certificate.

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

Delta Dental of Massachusetts
465 Medford Street, Boston, MA 02129

SCHEDULE OF BENEFITS
Total Choice PPO

COVERAGE

In-Network Benefits		Out-of-Network Benefits
Diagnostic and Preventive Services- Type I Services		
Delta Dental pays 100% of covered charges up to the *Allowable Charge* for services by a *Participating Dentist.* Your *Coinsurance* for these services is 0%.		*Delta Dental* pays 80% of covered charges up to the *Allowable Charge* for services by a *Non-participating Dentist.* Your *Coinsurance* for these services is 20%.
Restorative and other Basic Services-Type II Services		
Delta Dental pays 80% of covered charges up to the *Allowable Charge* for services by a *Participating Dentist.* Your *Coinsurance* for these services is 20%.		*Delta Dental* pays 60% of covered charges up to the *Allowable Charge* for services by a *Non-participating Dentist.* Your *Coinsurance* for these services is 40%.
Prosthodontic and Other Services-Type III Services		
Delta Dental pays 50% of covered charges up to the *Allowable Charge* for services by *Participating Dentist.* Your *Coinsurance* for these services is 50%.		*Delta Dental* pays 30% of covered charges up to the *Allowable Charge* for services by a *Non-participating Dentist.* Your *Coinsurance* for these services is 70%.
Orthodontic Services		
Not Covered		Not Covered

Note: Certain *Annual Maximum Benefits*, *Waiting Periods*, and *Deductibles* may apply to your coverage. Please see your *Annual Maximum Benefit* and *Deductible* on page 6 of this *Schedule of Benefits* for more information. Please see page 4 of this Schedule of Benefits for more information.

Waiting Periods

There are no *Waiting Periods* under this plan.

Plan Year

Your *Plan Year* begins on your *Effective Date* and ends 12 months thereafter.

Maximum Dependent Age

Under your *Family Contract*, your dependent children are covered to age 26.

Diagnostic and Preventive Services- Type I Services

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 per member.
2. Periodic oral evaluation; twice every 12 months.
3. Intra oral X-ray image of the entire mouth (Full Mouth Series or Panoramic image) once every 60 months.
4. Intra oral bitewing x-rays images (x-rays of the crowns of the teeth); twice every 12 months when oral conditions indicate need.
5. Single tooth x-ray images; as needed (5 images per date of service).
6. Routine cleaning, scaling and polishing of teeth; twice every 12 months.
7. Fluoride treatment for *Covered Individuals* under 15 years of age; twice every 12 months.
8. Space maintainers required due to the premature loss of teeth; only for *Covered Individuals* under 14 years (once per tooth) and not for the replacement of primary or permanent anterior teeth.
9. Limited oral evaluation problem focused exams. 2 visits per 12 months.
10. Sealants for unrestored permanent molars; once per tooth for members through age 15.

Restorative Services and Other Basic Services-Type II Services

Benefits are available for the following dental services to: (i) restore decayed or *Fractured* teeth when teeth have a good prognosis; (ii) remove diseased or damaged natural teeth when teeth do not have a good prognosis (iii) treat oral disease when teeth have a good prognosis; (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 (white) 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 (and all inlays) on posterior teeth will be treated as an *Alternate Benefit* and paid as an amalgam. 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. Inlays- Metallic, porcelain and composite resin inlays will be treated as an *Alternate Benefit* and an amalgam allowance will be reimbursed. No benefits are provided for replacing an inlay for 60 months after the date that the prior inlay was fabricated.
3. Protective restorations, once per tooth.
4. Stainless steel crowns on deciduous (baby) teeth; once every 24 months per tooth.
5. Simple and surgical tooth extractions, once per tooth.
6. General anesthesia when necessary and appropriate for the covered removal of impacted teeth, up to one hour only when provided by a licensed, practicing dentist.

7. Palliative dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm. 3 visits per 12 months.
8. Repair of dentures, once per denture per 12 months; Repair of fixed bridges, once per bridge per 12 months. Recementing of fixed bridges, once in a lifetime.
9. Rebase or reline dentures; once per denture every 36 months.
10. Tissue conditioning; two treatments per denture every 36 months.
11. Repair crowns and onlays once per tooth per 12 months. Recementing of a crown is limited to once every 12 months per tooth.
12. Adding teeth to existing partial or full dentures. Once per tooth, per denture.
13. Periodontic Services on natural teeth only:
    - Non-surgical procedures include scaling and root planing, once per quadrant every 24 months.
    - Surgical procedures, including gingivectomy, osseous surgery, soft tissue grafts and crown lengthening. One surgical procedure is covered once per quadrant, every 36 months.
    - Bone grafts and guided tissue regeneration to aid in surgical procedures is limited to 2 teeth, per 36 months, per quadrant.
14. Endodontic Services:
    - Root Canal Therapy, once per permanent tooth per lifetime.
    - Vital pulpotomy, limited to once per each deciduous tooth.
    - Retreatment root canal therapy on permanent teeth, once in a lifetime per tooth after 24 months of initial root canal therapy.
    - Apicoectomy once per permeant tooth, per lifetime.
15. Periodontal Cleanings following active periodontal therapy; once every 3 months, not to be combined with regular cleanings.

Prosthodontic and Other Services-Type III Services

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. Services covered on permanent teeth only. Teeth must have a good prognosis to qualify for benefit.

1. Dentures and Bridges
    - Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each 60 months, covered for members 16 and over.
    - Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were installed at least 60 months before replacement. Covered for members 16 and over.
    - Temporary partial dentures as follows:
        - To replace any of the six upper or lower front teeth, but only if the temporary partial dentures 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 on permanent teeth only on members 12 years and older only as follows, but only when the teeth cannot be restored with the fillings described under Restorative Services and Other Basic Services due to severe decay or *Fractures*:
    - Initial placement of crowns and onlays.
    - Replacement of crowns and onlays; once every 60 months per tooth.
    - Covered for members 12 years and older.

3. Post and core or crown buildup on permanent teeth only on members 12 years and older when needed to retain a crown on a tooth with excessive breakdown due to caries and/or fractures, once per tooth every 60 months.
4. Endosteal implant (a device surgically inserted into the bone to provide support for a single restoration) on members 16 and older when used in lieu of a three unit bridge; Implants are only covered when they serve to replace a single missing tooth. once every 5 years. In order to be covered, teeth abutting the implant on each side must:
    - Be free of decay or fracture,
    - Have root anatomy that is adequate and sound with no visible damage or evidence of any infection or significant bone loss
    - Be periodontally stable with probings less than 5 mm,
    - Be in appropriate occlusion, and
    - NOT be expected to require major (e.g. a crown) restorations.

EXCLUSIONS

1. A service, supply, procedure or appliance that is not described as a covered service in your contract.
2. A service or procedure that is not generally accepted as determined by *Delta Dental*. (example: LANAP-Laser Assisted New Attachment Protocol)
3. Any procedure rendered in order to save a tooth when it has been determined by *Delta Dental* that there is poor statistical probability that the tooth will survive for 60 months. Poor statistical probability is defined as less than a 70% chance from a restorative, endodontic or periodontal perspective that the tooth will survive. (example: surgical periodontal regenerative procedures to stabilize a tooth loosened due to extensive periodontal disease)
4. Incomplete procedures.
5. Any service or supply furnished along with, in preparation for, or as a result of a non-covered service.
6. Services that are rendered due to the requirements of a third party, such as an employer or school.
7. Travel time and related expenses.
8. An illness or injury that we determine arose out of and in the course of your employment.
9. 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*.
10. 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.
11. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
12. A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
13. Costs associated with cancellation fees for appointments with your dentist that you fail to keep.
14. 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.

15. A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
16. Services for which the member, absent this coverage, would incur no charge, including but not limited to any service rendered free of charge by a provider to a member of his/her immediate family, or to an immediate family member of the provider's spouse.
17. Consultations.
18. A service to treat disorders of the joints of the jaw (temporomandibular joints).
19. A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
20. Restorations for reasons other than decay or *Fracture*, such as erosion, abrasion, or attrition.
21. Services that are meant primarily to change or to improve your appearance.
22. Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
23. Athletic guards, mouth guards and any repairs or adjustments of any guards.
24. Implants when not in lieu of a three unit bridge and transplants.
25. Implant abutments when the surgical implant was not covered.
26. Implant maintenance.
27. Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomys, root amps, ridge augementations and dental implant placements.
28. Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
29. Surgical or non-surgical procedures around dental implants (including, but not limited to, antimicrobial agents and soft tissue grafts).
30. Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
31. Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
32. Lab exams.
33. Photographs.
34. Laminate veneers.
35. Duplicate dentures and bridges.
36. Temporary complete dentures and temporary fixed bridges or crowns.
37. Stainless steel crowns on permanent teeth.
38. Cast restorations, copings and attachments for installing overdentures, including associated endodontic procedures such as root canals.
39. Precision attachments, semiprecision attachments or copings.
40. Diagnostic photographs, cephalometiric films, Surgical access of an unerupted tooth, and placement of devices for an eruption of an impacted tooth (unless your coverage includes orthodontic services).
41. The replacement of teeth beyond the normal complement of teeth.
42. Gingivectomy to aid to the placement of a restoration.
43. Pulp caps.
44. Services related to congenital anomalies. However, this exclusion does not apply to some covered orthodontic services, if available.
45. Tooth desensitization.
46. Occlusal adjustments.
47. Tooth bleaching procedures.
48. Computerized tomography (CT) scans, cone beam images, surgical stents, surgical guides for implants.
49. Transitional implants and interim abutments.
50. Sinus lifts.
51. Gingival irrigation.

52. Nitrous Oxide.
53. Localized delivery of antimicrobial agents.
54. Surgical access of an unerupted tooth and placement of device to facilitate eruption of impacted tooth, unless otherwise specified under Orthodontic Benefits.
55. Charges associated with office visits rendered after regular office hours.
56. Silver Fluoride.
57. Occlusal orthotic device, retainer and night-guard adjustments.
58. Cleaning and inspection of removable appliances.
59. Dental case management procedures.
60. Teledentistry.

DEDUCTIBLES

Restorative and other Basic Services, and Prosthodontic and Other Services described above are subject to a $50 *Deductible* for each *Covered Individual* every calendar year. In the case of a *Family Contract*, the total *Deductible* payment for all *Covered Individuals* shall not exceed $150 for Restorative and other Basic Services, and Prosthodontic and Other Services in a calendar year. This means the *Covered Individual(s)* must pay the first $50 of benefits provided every calendar year, not to exceed $150 per calendar year for families with 3 or more *Covered Individuals*.

ANNUAL MAXIMUM BENEFIT

This plan does not have an *Annual Maximum Benefit*.

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

For services performed by a *Participating Dentist*, the In-Network *Allowable Charge* is based on the Total Choice PPO table of allowance or the dentist's submitted fee, if lower. *Delta Dental* pays the *Participating Dentist* directly for covered services. The dentist will bill covered members for balances resulting from plan specific *Deductibles* and *Coinsurance*.

OUT-OF-NETWORK SERVICES:

For services performed by *a Non-Participating Dentist*, the out-of-network benefit *Coinsurance* for each type of service will be up to 20 percentage points higher than the in-network dentist *Coinsurance*. The *Allowable Charge* for *Non-Participating Dentist* shall be a percentage of the dentist's fee, up to a usual and customary charge, and not a percentage of the amount paid to *Participating Dentists*. The *Coinsurance* will be applied against the fee allowed by *Delta Dental* or the dentist's submitted fee, if lower.

For services performed by a *Non-Participating Dentist*, *Delta Dental* pays the covered member directly for covered services, and the member is responsible for paying the provider. The provider will bill the covered member for the difference between the *Delta Dental Allowable Charge* and his / her submitted charge and balances resulting from plan specific *Deductibles* and *Coinsurance*.

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

NOTE: italicized words are defined in your Subscriber Certificate.

President & CEO

* DSM Massachusetts Insurance Company, Inc. is doing business as *Delta Dental* of Massachusetts.