DELTA DENTAL®

465 Medford Street
Boston, MA 02129
617•886•1000

Subscriber's Policy - DeltaCare

We certify that you have the right to benefits for services according to the terms of your *contract*. This policy 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.

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 written letter informing 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 policy. If we have paid more for claims under this policy than you have paid us in subscription charges, we have the right to collect the excess from you.

This Policy is renewable. This policy will be up for renewal 12 months from your effective date. 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 grounds do not exist which permit us to cancel this policy in accordance with Part V, Section 7 of this policy.

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 be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

The Massachusetts Division of Insurance determined the service area for this *contract* is Bristol, Essex, Middlesex, Norfolk, Plymouth and Suffolk counties. If a member resides outside of those counties, the member may experience somewhat longer travel times/distances in order to receive covered services from a DeltaCare dentist.

ATTEST: DSM Massachusetts Insurance Company, Inc.

Steven Pollock
President & CEO

David Abelman
Corporate Clerk

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

Table of Contents

INTRODUCTION ....[2]

MEMBER RIGHTS AND RESPONSIBILITIES..[3]

OUTLINE OF COVERAGE……………………………………………………………………….....[4]

PART I DEFINITIONS..[5]

PART II PLAN DESCRIPTION ....[9]

PART III BENEFITS ....[11]

PART IV EXCLUSIONS ....[14]

PART V OTHER CONTRACT PROVISIONS..[16]

PART VI INDEX ....[24]

Introduction

This policy is part of your *contract*. We urge you to read it carefully.

Please note that the words in *Italics* are listed in Part I, “Definitions”.

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 Part IV of this policy.

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

If you have any questions, contact our DeltaCare Customer Service department. Our telephone numbers are listed at the end of this policy.

Member Rights and Responsibilities

<u>You have the following rights as a *Delta Dental* member.</u>

- You have the right to file grievances about *Delta Dental* or the participating dentists. In the case of an adverse determination, we may include alternative treatment options that are covered and are appropriate and consistent with general principles of professional dental practice.
- You have the right to be provided with appropriate information about *Delta Dental* and its benefits, dentists, and policies.
- You have the right to be informed of your diagnosis, treatment and prognosis by your dentist.
- You have the right to give informed consent before beginning any dental treatment. You also have the right to be made aware of consequences of refusing treatment.
- You have the right to obtain a copy of your dental record, in accordance with the law.
- You have the right to be treated with respect and recognition of your dignity and need for privacy.

Interpretation/Translation Services.

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
វិធីចាត់ចែងការ យើងមានផ្តល់ជូន ។

ដែលជាប់ទាក់ទងទៅនឹង

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 Tradiksyon Si w mande sèvis entèprèt ak tradiksyon pou prosede administratif, nap mete yo a dispozisyon ou.

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

ບໍລິການນາຍພາສາ/ແປເອກະສານ
ຖ້າທ່ານຮ້ອງຂໍ,ຈະມີບໍລິການນາຍພາສາແລະແປເອກະສານໃຫ້ກັບທ່ານ 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 following duties as a *Delta Dental* member.</u>

- You must ask questions in order to understand your dental condition and treatment.
- You must follow instructions for recommended treatment given by your dentist.
- You must provide information to your dentist that is necessary to render care to you.

DSM Massachusetts Insurance Company, Inc.
Outline of Coverage - DeltaCare

Policy number:

1. Description of 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 extent of your benefits is explained in the Benefits Payable Rider 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 any maximum or you receive a treatment which will cause you to exceed any 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.

This policy includes three types of services:

i. Type I includes services to prevent or detect tooth decay and other forms of oral disease.
ii. Type II 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.
iii. Type III includes services and supplies to: (i) replace missing natural teeth with artificial ones and (ii) restore severely decayed or *fractured* teeth.

2. The Benefits Payable Rider incorporated as part of this contract sets forth any (i) deductibles, (ii) coinsurance, (iii) waiting periods, (iv) benefit maximums, and (v) frequency limitations for coverage.

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

4. Dependents will no longer be eligible for coverage under the subscriber's policy once they reach their 26th birthday.

5. This policy is subject to premium increases upon 30 days' written notice.

6. Pre-Existing Conditions. We exclude dental expenses incurred in connection with any dental procedure started prior to coverage. We do not cover replacement of teeth missing prior to the member's effective date of coverage.

7. Pre-existing conditions: For work in progress prior to 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.

8. This policy is not subject to any waiting periods.

9. This policy does not cover benefits for mental illness or pregnancy.

10. Free Look Provision. 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 written letter informing 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 policy. If we have paid more for claims under this policy than you have paid us in subscription charges, we have the right to collect the excess from you.

11. 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.

12. COMPLAINTS: If you have a complaint, call us at 800-872-0500 or your agent. If you are not satisfied, you may call the Massachusetts Division of Insurance.

13. Exclusions and limitations are set forth in Part IV of this policy.

Part I: Definitions

Adverse determination. A decision by us 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.

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

Contract. This policy, the application, any applicable Riders, Endorsements and Supplemental Agreements.

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

Primary Care Dentist. A dentist who has entered into an agreement with *Delta Dental* to furnish services to DeltaCare *members*. Each *member* selects a *primary care dentist* upon enrollment in DeltaCare.

Effective Date. The date, as shown on our records, 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 26 years of age. 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 we are notified within 72 days of the child's twenty-sixth birthday.

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

Grievance. An oral or written complaint submitted to us by you or on your behalf concerning any aspect or action of us. 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. A question or concern communicated by you or on your behalf to us, which has not been the subject of an *adverse determination*.

Maximum Fee Allowance. The payment amount that we set for the non-participating dentist services that may be provided under this *contract*. Benefits are payable in accordance with the Outline of Reimbursement for this contract for Massachusetts dentists and the terms and conditions of the applicable Benefits Payable Rider attached to this policy and in effect at the time services are rendered.

Member. A person entitled to benefits under this policy. This usually includes *subscribers* and their dependents.

Quality Assurance Management. A program that provides specific policies and procedures to ensure that minimum standards are met and proper evaluations are conducted in order to provide insureds with quality care.

Specialist. A dentist who is either board eligible or board certified to perform specialty care. The DeltaCare *specialist* works with your *Primary care dentist* to coordinate treatment for specialty services that are needed.

Subscriber. An individual whose name this policy is under.

Utilization Review or UR. A formal process designed to monitor the use of, or evaluate the medical necessity, appropriateness or efficiency of healthcare services.

Waiting Period. The period of time that must pass with respect to the individual before the individual is eligible to be covered for benefits under this *contract.*

Part II : Plan Description

1. Patients who use a *Primary care dentist* do not need to file claim forms.

2. At the beginning of coverage, each *subscriber* and his or her dependent(s) must select a *Primary care dentist* from a list provided by us. If no dentist is selected, one will be assigned to you by us. To receive benefits *members* must receive all their dental care from the selected *Primary care dentist* or from a *specialist* to which they are referred by the *Primary care dentist*. Requests for changes of primary care dentist can be made over the phone by contacting the DeltaCare Unit using the phone number listed on the back side of your ID card. Changes will take effect on the first day of the month following the request.

   We will provide you at least 30 days' notice before disenrollment of your *Primary care dentist* from our network. If you are currently undergoing a dental procedure, you should return to the disenrolled dentist to complete your treatment. To ensure continuous access to dental care, we will automatically assign you to a new *Primary care dentist*. This information will be contained in your notification letter. You may continue with the assigned provider or you may contact our Customer Service department to select another *Primary care dentist*.

3. The *Primary care dentist* will coordinate dental care needed by the patient as defined in the benefits section.

4. If treatment warrants the use of a *specialist*, your *Primary care dentist* may refer you to a *specialist* to provide treatment. The *member* is responsible for paying any co-payments for specialty care directly to the *specialist*. Benefits for specialty care services including periodontal and endodontic services and oral surgery are limited to a $1,000 calendar year maximum.

5. Each *member* selects or is assigned a *Primary care dentist* who is participating in the DeltaCare network. For services performed by primary care and specialty DeltaCare dentists, the in-network benefit allowance is based on the DeltaCare schedule of patient co-payments. The primary care dentist has agreed to accept *Delta Dental*'s monthly per member per month payment plus applicable patient co-payments as full payment. The DeltaCare *specialist* has agreed to accept the DeltaCare specialty fee schedule plus applicable patient co-payments as payment in full for covered services. Neither *Primary care dentists* nor DeltaCare *specialists* may bill the patient for amounts other than those listed on the schedule of patient co-payments, except in the case of *specialist's* charges in excess of any annual maximum. Specialty services are subject to an annual maximum as specified in your Benefits Payable Rider. You are responsible for payment of *specialist's* actual charge for covered services in excess of the annual maximum.

6. No benefit is payable for services performed by a dentist other than a *Primary care dentist* or a *specialist* as set forth in this *contract*, except in the case of emergency care described in Item 7.

7. When a *member* has the sudden onset of a dental condition that requires immediate treatment to relieve pain, the member must call his or her *Primary care dentist.* The *member's* care must be provided or referred by the *Primary care dentist*. If the *member* is out of the area and is unable to see his or her *Primary care dentist*, then only minor dental procedures for pain relief (such as pulpectomy or temporary filling) are covered. Submit a claim for reimbursement to *Delta Dental* of Massachusetts; Attention: DeltaCare, 465 Medford Street, Boston, MA 02129.

   Nothing in this section will prohibit a *member* from seeking emergency care whenever the *member* 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. Coverage will not be denied for dental expenses incurred as a result of such emergency condition.

8. Your *Primary care dentist* may authorize a standing referral for specialty dental care provided by a DeltaCare *specialist* if all of the following circumstances are satisfied.

   a. If the *Primary care dentist* determines that such referrals are appropriate.

   b. If the DeltaCare *specialist* agrees to a treatment plan for you and provides your *Primary care dentist* with all necessary clinical and administrative information on a regular basis.

   c. If the dental care services to be provided are consistent with the terms of your *contract*.

   Nothing in this section shall be construed to permit a DeltaCare *specialist* who is subject to a referral to authorize any further referral of you to any other dentist without our approval.

Part III: Benefits

You have the right to benefits for the following services. Your right to benefits is subject to limits and exclusions elsewhere in this *contract.* Co-payments, which are the responsibility of the *member*, may apply for certain procedures. For the list of valid services and corresponding co-payments, please refer to your schedule of co-payments. Your schedule of co-payments is incorporated as part of this policy. Benefits for specialty care services including periodontal and endodontic services and oral surgery are limited to $1,000 per calendar year.

A. Diagnostic and Preventive Services.

Benefits are available for the following dental services to diagnose or prevent tooth decay and other forms of oral disease. These dental services are what most *members* 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; twice per calendar year.

3. Full mouth intraoral radiograph examination or panoramic examination according to the frequency recommended by the Food and Drug Administration's "Guidelines for Prescribing Dental Radiographs" but not to exceed once every 24 months.

4. Posterior bitewing examination according to the frequency recommended by the Food and Drug Administration's "Guidelines for Prescribing Dental Radiographs" but are limited to not more than one series of four films in any six-month period.

5. Single tooth x-rays; as needed.

6. Routine cleaning, scaling and polishing of teeth based upon the individual needs assessment of the patient but not to exceed two treatments in any 12 consecutive months.

7. Topical fluoride treatment based upon individual risk assessment of the patient but not to exceed two treatments for *members* under 19 years in any 12 consecutive months.

8. Space maintainers required due to the premature loss of teeth; only for *members* under age 14 and not for the replacement of primary or permanent anterior teeth.

9. Emergency oral evaluation problem-focused exams.

10. Sealants based upon individual risk assessment needs of the patient but are for unrestored permanent molars only, once per tooth for members through age 15.

B. Restorative Services and Other Basic Services.

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 every 24-month period. However, synthetic (white) fillings are limited to single surface restoration 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 dentist's charge. No co-payment is required for the replacement of 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 symptomatic 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: (i) treatment of the nerve of a tooth; (ii) removal of dental pulp; and (iii) pulpal therapy. Vital pulpotomy is limited to deciduous teeth on covered members.

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

8. Repair of dentures or fixed bridges once each 12 months, and recementing of fixed bridges once per lifetime.

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

10. Tissue conditioning; two treatments every 36 months.

11. Repair or recement crowns and onlays limited to once per tooth.

C. Prosthodontic and Other 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.

1. **Dentures and Bridges.**

   Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every 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.

   Adding teeth to existing partial dentures or to a bridge.

   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 *members* 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 in Section B.1. due to severe decay or *fractures*:

   a. Initial placement of crowns and onlays.

   b. Replacement of crowns and onlays which present with evidence of active recurrent decay at the margins or radiographically present under the restoration; once every 60 months per tooth.

Part IV Exclusions

Exclusions.

We do not provide benefits for:

1. Any service that is not specifically listed as a covered expense.

2. Cosmetic dental care.

3. Dental conditions arising out of and due to *subscriber*'s employment or for which Worker's Compensation is payable. Services which are provided to the *subscriber* by state government or agency thereof, or are provided without cost to the *subscriber* by any municipality, county or other subdivision.

4. Treatment required by reason of war.

5. Dental services performed in a hospital and related hospital fees.

6. Treatment of fractures and dislocations.

7. Replacement of fixed and removable prosthetics (crowns, bridges, full or partial dentures and other appliances) due to loss, theft or damage.

8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

9. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist.

10. Dental expenses incurred in connection with any dental procedure started prior to *subscriber*'s eligibility with the DeltaCare program. Example: teeth prepared for crowns or root canals in progress.

11. Treatment of congenital malformations.

12. Treatment of cysts and malignancies.

13. Dispensing of drugs.

14. Cases which, in the professional judgment of the attending dentists, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

15. Prophylactic removal of impactions (asymptomatic nonpethological) or extraction solely for purpose of orthodontia.

16. “Specialist consultations” for non-covered benefits.

17. Implant placement or removal, appliances placed on or services associated with implants.

18. Occlusal Guards.

19. Accidental Injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

20. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly generally accepted method of treatment.

21. A service rendered by someone other than a licensed dentist or a hygienist that is employed by a licensed dentist.

22. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits.

23. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full mouth reconstruction and are not a benefit of the DeltaCare program.

24. Tooth desensitization.

25. Any service not specifically listed as a covered expense.

27. Orthodontic services.

Part V Other Contract Provisions

1. 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.

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

   Primary care dentists have agreed to give us all information necessary to determine your benefits under this *contract*. Massachusetts State law requires Massachusetts *non-participating dentists* to provide this information also. *Primary care dentists* have agreed not to charge for this service.

   We will treat any medical information we receive about you as confidential.

3. SUBSCRIPTION CHARGE.

   A. Payments. The amount of money that you pay to *Delta Dental* for your benefits under this *contract* is called your subscription charge. You are responsible to pay to *Delta Dental* the total subscription charges by the due date indicated on each *Delta Dental* invoice.

   B. Grace Period. A grace period of 31 days will be granted for the payment of each subscription falling 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 date on which payment is due, *Delta Dental*, upon written notice to you, may terminate this *contract* 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, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has

previously notified the insured in writing of its 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 there under as they had under the policy immediately before the due date of the defaulted premium, subject to any provision endorsed hereon or attached hereto 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 sixty days prior to 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 prior to the effective date of change.

4. WE MAY CHANGE YOUR CONTRACT.

We shall deliver to you prior notice of material modifications in covered services under this dental plan at least 60 days before the effective date of the modifications.

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 policy.

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.

5. WHEN YOUR COVERAGE BEGINS.

The dental services described in this policy 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.

You, your spouse and your dependent 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.

6. WHEN YOUR COVERAGE ENDS.

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

A. The *subscriber* is no longer enrolled in the plan.

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

C. However, if your 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 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*.

D. 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 or divorce 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.

E. If you relocate outside of the service area.

7. TERMINATION OF A CONTRACT.

A. You may cancel your *contract*. You must give us notice in writing at least 30 days prior to the 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. *Delta Dental* may cancel your *contract*.

We may cancel your *contract,* upon due notice to you, 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 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 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.

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. Time Limit on Certain Defenses: After two 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 two-year period. 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.

8. BENEFITS AFTER CANCELLATION.

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

9. NOTICES.

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 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 *Delta Dental* at once.

Send letters to *Delta Dental*, 465 Medford Street, Boston, Massachusetts 02129. Attention DeltaCare. Always include your name and *DeltaCare subscriber* identification number found on the DeltaCare *subscriber* identification card.

10. 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.

11. 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.

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 *member* and supply him or her with your DeltaCare *subscriber* identification number and any necessary information.

12. 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 (including the provisions of the Massachusetts Division of Insurance's regulations regarding COB, the "COB Regulations") and this policy. 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 policy, subject to the COB Regulations.

13. RIGHT TO RECOVER OVERPAYMENTS.

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

IMPORTANT: No statement in this section should be interpreted to mean that we will provide any more benefits than those already 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 policy.

14. QUALITY ASSURANCE.

As a DeltaCare member you have the option to select a participating DeltaCare provider as your primary care dentist and seek services from this participating provider. Should you require specialty services your primary care dentist will refer you to DeltaCare specialists for treatment. For further details about your coverage please refer to the benefit descriptions and exclusions sections of this policy.

Delta Dental has established a Quality Management Program ("Program"). The Program includes specific policies and procedures to ensure that minimum standards are met. The policies and procedures also ensure proper evaluations are conducted in order to provide quality care.

The 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.
- UR program.
- Accessibility of services.
- Member and provider satisfaction.

The Program has been developed in conjunction with individual practitioners and individual practitioners participate actively within the Program to ensure the Program's overall effectiveness.

15. UTILIZATION REVIEW.

This is the formal process designed to monitor the use of, or evaluate the appropriateness or efficiency of health care services. A UR program has been established to ensure that any guidelines and criteria used to evaluate the appropriateness of a health care service are clearly documented. The UR program also ensures procedures for applying such criteria are 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. The program is reviewed at least annually to ensure that criteria are applied consistently.

Any UR conducted under your dental *contract* is done retrospectively 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 policy. If a procedure is not a covered procedure then the claim for that procedure will be denied in accordance with the terms of your policy. Frequency, age, *effective dates* of coverage, etc. may also limit coverage of certain procedures, which are all contractually stated within your policy.

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 UR 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 partial denied based on medical appropriateness, this is considered an adverse determination. These decisions are reviewed by qualified and appropriately licensed dental 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 UR decisions with *Delta Dental*, you can submit your *inquiry* to us:

In writing: Attention: Customer Service
Delta Dental of Massachusetts
P.O. Box 9595
Boston, MA 02114-9595

By telephone: 1-800-872-0500
By fax: 1-617-886-1420
web site: www.deltadentalma.com

16. GRIEVANCE PROCESS.

You have the right to make inquiries and/or file a complaint with *Delta Dental* of Massachusetts. If you are not satisfied, you may call the Massachusetts Division of Insurance.

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

In writing:	Attention: Grievances Delta Dental of Massachusetts P.O. Box 9595 Boston, MA 02114-9595
By telephone:	1-800-872-0500
By fax:	1-617-886-1420
Website:	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.

We will send a written acknowledgement of our receipt of your *grievance* to you or your authorized representative, if any, within ten (10) 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 clinical justification that is consistent with generally accepted principles of professional dental practice. Our written response will (a) identify the specific information upon which the *adverse determination* was based and (b) 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.

17. LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty 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 three years after the time written proof of loss is required to be furnished.

18. NOTICE OF CLAIM

Written notice of claim must be given to *Delta Dental* within twenty days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to *Delta Dental* at *Delta Dental's* main office or to any authorized agent of *Delta Dental*, with information sufficient to identify the insured, shall be deemed notice to *Delta Dental.*

19. CLAIMS 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.

20. PROOF OF LOSS

Written proof of loss must be furnished to 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 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.

21. 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*.

22. PAYMENT OF CLAIMS

Payment for dental benefits provided under this policy will be paid by *Delta Dental* directly to *DeltaCare* dentists.

23. PHYSICAL EXAMINATIONS

Delta Dental at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

24. CHANGE IN BENEFICIARY

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

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 carefully read through your *contract*.

B.

Benefits. 6, 7, 10, 11, 12, 15, 22, 23]

C.

Contract. [5, 6, 17]
Member. [5, 8]

D.

Definitions. [2, 5]
Delta Dental Plan. [0, 2, 3, 4, 5, 6, 7, 8, 12, 18, 21, 23, 24, 25]
Primary care dentist. [5, 8]
Diagnostic and Preventive Services. [10]

E.

Effective Date. [5]
Exclusions. [14, 15]

F.

Family Contract. [6]

G.

Grievance Process. [25]

I

Individual Contract. [6]
Introduction. [2]

O.

Other Contract Provisions. [17]

P.

Plan Description. [7]

Q.

Quality Assurance. [6, 23]

S.

Specialist. [6, 15]
Subscriber. [0, 5, 6]

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

Customer Service:
617•886•1300
800•872-0500

Corporate Office:
617•886•1000

DSM MASSACHUSETTS INSURANCE COMPANY, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
DELTACARE I - BENEFITS PAYABLE RIDER 1

To be attached to and form a part of your Delta Dental Subscriber Policy.

Benefits for the covered services described in your DeltaCare contract are reimbursed as follows subject to the noted coinsurance, benefit maximums, and deductibles noted on this and the accompanying pages:

In-Network Benefits		**Out-of-Network Benefits**
Diagnostic and Preventive Services (Type 1 Benefits)		
Delta Dental pays a fixed per member per month amount to the DeltaCare Option Panel Provider.	You pay based on the schedule of patient co-payments.	Not Covered
Restorative and other Basic Services (Type 2 Benefits)		
Delta Dental pays a fixed per member per month amount to the DeltaCare Option Panel Provider.	You pay based on the schedule of patient co-payments.	Not Covered
Prosthodontic and Other Services (Type 3 Benefits)		
Delta Dental pays a fixed per member per month amount to the DeltaCare Option Panel Provider.	You pay based on the schedule of patient co-payments.	Not Covered

Your total benefits are not subject to a calendar year maximum except for specialty care which is subject to a $1,000 calendar year maximum. Please note that these benefits are not subject to any waiting periods.

DSM.MA.DELTACARE.IND.BPR.1-01.15

IMPORTANT:

DEDUCTIBLES

IN-NETWORK BENEFITS:

There is no deductible for services provided by your DeltaCare Primary Care Dentist or a specialist you are referred to by your primary care dentist.

OUT-OF-NETWORK BENEFITS:

No benefits are provided for services performed by non-panel dentists, except for emergency services covered under the terms of your Policy

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

Each covered individual selects or is assigned a DeltaCare Primary Care Dentist who is participating in the DeltaCare network. For services performed by primary care and specialty DeltaCare providers, the in-network benefit allowance is based on the DeltaCare schedule of patient co-payments. The primary care dentist has agreed to accept Delta Dental's monthly per member per month payment plus applicable patient co-payments as full payment. The DeltaCare specialist has agreed to accept the DeltaCare specialty fee schedule amounts as payment in full for covered services. For covered services network dentists may not bill the patient for amounts other than those listed on the schedule of patient co-payments.

OUT-OF-NETWORK SERVICES:

No benefits are provided for services performed by non-panel dentists, except for emergency services covered under the terms of your Policy

DISENROLLMENT:

Delta Dental, excluding all administrative disenrollments, covered individuals who moved out of the service area, covered individuals whose continuation of coverage expired, former dependents who do not qualify as dependents, covered individuals who lose coverage under an employer sponsored plan because they have ceased employment, or because their employer group canceled coverage under the plan, reduced number of hours worked, or became disabled, retired, or died equaled less than .001% for the previous calendar year.

OUT-OF-NETWORK EMERGENCY CARE

When a Covered Individual has the sudden onset of a dental condition that requires immediate treatment to relieve pain, the member must call his or her DeltaCare Primary Care Dentist and have their care provided or referred by the DeltaCare Primary Care Dentist. If the Covered Individual is out of the area and is unable to see his or her DeltaCare Primary Care Dentist, then only emergency medical conditions are covered. Submit a claim for reimbursement to:

Delta Dental of Massachusetts
Attention: DeltaCare Unit
P.O. Box 9595
Boston, MA 02114

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

NOTE: Underlined terms are defined in your Policy.

DSM MASSACHUSETTS INSURANCE COMPANY, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS

Steven Pollock
President and CEO, DSM