Subscriber's Certificate

Delta Dental EPO

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

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

ATTEST: DSM Massachusetts Insurance Company, Inc.

Steven Pollock
President & CEO

James Hawkins
Corporate Clerk

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

Table of Contents

Introduction

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

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

This certificate includes four types of services:

> Type 1 includes services to prevent or detect tooth decay and other forms of oral disease.
>
> Type 2 includes services to: (i) restore decayed or *fractured* teeth; (ii) remove diseased or damaged natural teeth; (iii) repair dentures or bridges; (iv) rebase or reline dentures; and (v) recement bridges, crowns and onlays.
>
> Type 3 includes services and supplies to: (i) replace missing natural teeth with artificial ones; and (ii) restore severely decayed or *fractured* teeth.
>
> Medically necessary Orthodonture only for *covered individuals* under age 19.

A more detailed description of the covered services and the extent of coverage for those services are provided in Part II: Benefits and in your Benefits Payable Rider. Type 3 services may not be available for *covered individuals* age 19 and older depending on the plan under which you are covered. Please make sure to read your Benefits Payable Rider carefully.

If you receive services covered by this certificate from a *Delta Dental EPO Panel Dentist*, the dentist must accept payment from *Delta Dental* as payment in full for the covered services except under the circumstances provided in Part IV of this certificate. If you receive covered services from a dentist who is not a *Delta Dental EPO Panel Dentist*, the dentist may charge you the difference between the dentist's fee and the amount paid by *Delta Dental*.

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. Your coverage is not subject to a pre-existing condition limitation.

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

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

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

Member Rights and Responsibilities

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

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

خدمات ترجمة فورية/ترجمة

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

អ្នកបកប្រែ ឬកិច្ចការបកប្រែ
បើអ្នកស្នើឲ្យមានអ្នកបកប្រែ និងកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងទៅនឹង
វិធីចាត់ចែងការ យើងមានផ្តល់ជូន ។

翻譯服務

如果您提出請求 ，我們可以為您提供協助辦理行政手續的翻譯服務 。

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

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

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

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

ບໍລິການນາຍພາສາ/ແປເອກະສານ
ຖ້າທ່ານຮ້ອງຂໍ, 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 responsibility to:</u>

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

Part I: Definitions

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

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

Connector: means The Commonwealth Health Insurance Connector Authority.

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

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

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

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

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

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

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

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

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

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

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

Exclusive Provider Organization(EPO): An organization that requires that members visit panel dentists only; care from non-panel dentists is not covered except in some cases for an emergency. This Subscriber Certificate provides benefits on an EPO basis unless an out-of-network benefit option is purchased, in which case the available out of network benefits will be described in Part IV, Paragraph 5 of this Subscriber Certificate and in the Benefits Payable Rider accompanying this Subscriber Certificate.

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

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

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

Individual Contract: a *contract* that includes only the *subscriber,* or only a minor dependent in the case of child only coverage.

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

Maximum Fee Allowance: The payment amount that *Delta Dental* sets for the *Delta Dental EPO Non-panel Dentist and Non-Participating Dentist* for services that may be provided under this *contract*. Benefits are payable in accordance with the Outline of Reimbursement as

filed and approved by the Division of Insurance for Massachusetts dentists for this *contract* and the terms and conditions of the applicable Benefits Payable Rider attached to this certificate and in effect at the time services are rendered.

Medically Necessary Orthodonture*:* Patient must be under the age of nineteen (19) and must have severe and handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto qualifier. The HLD score used to determine whether a *covered individual* qualifies for coverage is based on *Delta Dental's* calculation and not the score of the treating dentist. Prior authorization is required to qualify for coverage. Authorization will only be given to new cases and not takeover cases.

Non-Participating Dentist: a dentist registered under Massachusetts G.L.c. 112, §§ 45, 48 or any fully registered or licensed dentist in any other jurisdiction who has not entered into an agreement with *Delta Dental* to furnish services to its *covered individuals* under its exclusive provider organization arrangement.

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

Out of Pocket Maximum: This is the maximum you will pay in deductibles, copays and coinsurance for allowable expenses in any Plan Year.

Participating Dentist: a dentist registered under Massachusetts G.L.c. 112, §§ 45, 48 and who has entered into an agreement with *Delta Dental* to furnish services to its *covered individuals* under its exclusive provider organization arrangement.

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

Plan Year: a consecutive 12-month period during which the plan provides benefits under this *contract*. A Plan Year may be a calendar year or otherwise.

Subscriber: an employee or member, certified by the *plan sponsor*, who is eligible to receive dental benefits from *Delta Dental*. A parent of guardian enrolling a minor dependent assumes all of the subscriber responsibilities on behalf of the minor dependent.

You: a covered member.

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: 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 your group has purchased which is incorporated as part of this *contract*. The Benefits Payable Rider also sets forth frequency limitations for coverage.

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.

You have the right to see providers outside of the Commonwealth of Massachusetts who are participating providers in the Delta Dental PPO provider panel, subject to the terms and conditions of this *contract* and the Benefits Payable Rider. You can obtain information regarding participating out-of-state providers by visiting *Delta Dental's* web site, www.deltadentalma.com, or calling Customer Service.

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

COVERED SERVICES FOR MEMBERS AGE 19 OR OLDER

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

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

1. Comprehensive Oral Examination (including the initial dental history and charting of teeth); once every 60 months per dentist.

2. Periodic oral evaluation; 2 every 12 months.

3. X-rays of the entire mouth; once every 60 months.

4. Bitewing x-rays (x-rays of the crowns of the teeth); 2 every 12 months when oral conditions indicate need.

5. Single tooth x-rays; as needed.

6. Routine cleaning, scaling and polishing of teeth; 2 every 12 months.

7. Periodontal Cleanings following active periodontal treatment; once every 3 months, not to be combined with regular cleanings.

8. Emergency oral evaluation problem focused (limited) exams. 2 in 12 months.

9. Chlorhexidine Mouthrinse; when administered and dispensed in the dentist's office following scaling and root planing.

10. Fluoride Toothpaste; when administered and dispensed in the dentist's office following periodontal surgery.

B. Restorative Services and Other Basic Services (also referred to as "Type 2") Benefits are available for the following dental services to: (i) restore decayed or *fractured* teeth (teeth must have a good prognosis to qualify for benefit); (ii) remove diseased or damaged natural teeth; (iii) treat oral disease (teeth must have a good prognosis to qualify for benefit); (iv) repair dentures or bridges; (v) rebase or reline dentures; and (vi) repair or recement bridges, crowns and onlays.

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

2. Protective Restorations; once per tooth.

3. General anesthesia when necessary and appropriate for covered impacted wisdom teeth only when provided by a licensed, practicing dentist (up to one hour).

4. Palliative dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm. 3 in 12 months.

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

6. Rebase or reline dentures; once per denture every 36 months.

7. Tissue conditioning; two treatments per denture every 36 months.

8. Repair crowns and onlays; once per tooth per 12 months. Recementing of a crown is limited to once every 12 months per tooth.

9. Adding teeth to existing partial or full dentures; once per tooth per denture

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

11. 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); one periodontal surgery per quadrant every 36 months. Scaling and root planing once per quadrant per 24 months.

12. Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth on covered members. Apicoectomy once per tooth. Retreatment of previous root canal therapy is a benefit once per tooth after 24 months of original root canal.

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

The Type 3 services described below may not be provided for *covered individuals* age 19 and older depending on the plan under which you are covered. Please consult your Benefits Payable Rider to determine whether individuals age 19 and older are covered for Type 3 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 (teeth must have a good prognosis to qualify for benefit).

Crowns and Onlays

Crowns and onlays:

- Initial placement of crowns and onlays.

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

Dentures and Bridges

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

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

- Temporary partial dentures as follows to replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.

COVERED SERVICES FOR MEMBERS UNDER AGE 19

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

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

1. Comprehensive Oral Examination (including the initial dental history and charting of teeth); one per lifetime per provider.

2. Periodic oral evaluation; two every 12 months.

3. X-rays (FMX and panoramic radiographs) of the entire mouth; once every 36 months.

4. Bitewing x-rays (x-rays of the crowns of the teeth); two every 12 months when oral conditions indicate need.

5. Single tooth x-rays; maximum of four per visit and no more than 12 per 12 months.

6. Routine cleaning, scaling and polishing of teeth; two every 12 months.

7. Periodontal Cleanings; once every 3 months following active periodontal treatment, not to be combined with regular cleanings.

8. Fluoride treatment for *covered individuals* under 19 years of age; one treatment per 90 days.

9. Space maintainers are covered due to the premature loss of teeth when tooth has not begun to erupt or when migration of adjacent tooth has occurred; not for the replacement of primary or permanent anterior teeth.

10. Emergency oral evaluation problem focused (limited) exams. 2 in 12 months; not covered with palliative treatment or detailed comprehensive exam on same date of service.

11. Sealants for unrestored permanent molars; once per tooth per 36 months.

B. Restorative Services and Other Basic Services (also referred to as "Type 2") Benefits are available for the following dental services to: (i) restore decayed or *fractured* teeth (teeth must have a good prognosis to qualify for benefit); (ii) remove diseased or damaged natural teeth; (iii) treat oral disease (teeth must have a good prognosis to qualify for benefit); (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 synthetic tooth color fillings, but limited to one filling for each tooth surface for each 12 month period. However,

synthetic (white) fillings are limited to restorations for posterior permanent teeth. Multi-surface synthetic restorations on posterior primary (deciduous) teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentists charge. No benefits are provided for replacing a filling within 24 months of the date that the prior filling was furnished.

2. Protective restorations; once per tooth.

3. Stainless steel crowns on deciduous (baby) teeth; once every 24 months per tooth (no more than four per date of service).

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

5. Palliative dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm. Not covered with other exam codes on the same date of service

6. Repair of dentures or fixed bridges; not a covered benefit within 6 months of insertion. Recementing of fixed bridges; not a covered benefit within 6 months of insertion

7. Rebase or reline dentures; once per denture per 24 months after 6 months of initial denture insertion.

8. Repair or recement crowns; recement of a crown after 6 months of initial crown insertion.

9. Adding teeth to existing partial or full dentures; after 6 months of initial denture insertion.

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

11. Periodontic services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy); once per quadrant per 36 months, limited to two quadrants on the same date of service. Scaling and root planing once per quadrant per 36 months; limited to two quadrants on the same date of service.

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

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

Benefits are available for the following dental services and supplies: to replace missing natural teeth with artificial ones and to restore severely decayed or *fractured* teeth (teeth must have a good prognosis to qualify for benefit).

Crowns

- Initial placement of crowns.
- Replacement of crowns; once every 60 months per tooth.

Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each 84 months.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were installed at least 84 months before replacement.

D. Medically Necessary Orthodonture

Orthodontic services for children under the age of nineteen (19) for severe and handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto qualifier. The HLD score used to determine whether a *covered individual* qualifies for coverage is based on *Delta Dental's* calculation and not the score of the treating dentist. Prior authorization is required to qualify for coverage. Authorization will only be given to new cases and not takeover cases.

Part III: Limitations and Exclusions

1. WE LIMIT BENEFITS FOR SOME SURGICAL SERVICES

   No benefits are provided for the following services when the *covered individual's* condition requires that he or she be admitted as an inpatient in a hospital or surgical day care center.

   We will not consider coverage:

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

2. WE PROVIDE BENEFITS ONLY FOR NECESSARY AND APPROPRIATE SERVICES

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

   A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist

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

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

3. WE DO NOT PROVIDE BENEFITS FOR:

   - A service or procedure that is not generally accepted as determined by *Delta Dental*.
   - A service or procedure that is not described as a benefit in this *contract*.
   - Services that are rendered due to the requirements of a third party, such as an employer or school.
   - Travel time and related expenses.
   - An illness or injury that we determine arose out of and in the course of your employment.
   - A service for which you are not required to pay, or for which you would not be required to pay if you did not have this *contract*.

- An illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if you did not have this *contract*. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare. We will not provide benefits if you could have received government benefits by applying for them within the appropriate agency's time limitation.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Consultations.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or *fracture*, such as erosion, abrasion, or attrition.
- Restorations or procedures on teeth that have a poor to hopeless prognosis from a restorative, endodontic or periodontal perspective.
- Services that are meant primarily to change or to improve your appearance. (cosmetic in nature)
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
- Implants when not in lieu of a three unit bridge and transplants.
- Implant abutements when the surgical implants was not benefited.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.(including caries susceptibility tests)
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing overdentures.
- Services related to congenital anomalies.
- Tooth desensitization
- Occlusal adjustment
    - Tooth bleach
    - Computerized tomography (CT) scans, surgical stents, surgical guies for implants

- Transitional implants
- Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomys, root amps , ridge augementations and dental implant placements
- Sinus lifts
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant
- Surgical or non-surgical procedures around dental implants (including but not limited to antimicrobial agents and soft tissue grafts)
- Gingival irrigation
- Nitrous Oxide for members age 19 or older

Part IV: Other *Contract* Provisions

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

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

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

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

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

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

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

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

   E. If, for some reason, you receive services from more than one dentist for the same dental procedure or receive services that are furnished in a series during a planned course of treatment. In such a case the total amount of your benefit will not be more than the amount that would have been provided if only one dentist had furnished all the services.

4. PRE-TREATMENT ESTIMATES

   If your dentist expects that dental treatment will involve a series of covered services (over $300), he or she should file a copy of the treatment plan with *Delta Dental* BEFORE these services are rendered to a *covered individual*. A treatment plan is a detailed description of

the procedures that the dentist plans to perform and includes an estimate of the charges for each service.

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

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

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

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

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

[No benefit is payable for services performed by a non-panel dentist, except in the case of emergency care described in paragraph 5.C., below]

[For services performed by a non-panel dentist, benefit payments will be based upon the amount shown on your Benefits Payable Rider for out-of-network benefits. Payment for services provided by non-panel dentist will be made directly to the *covered individual* and the *covered individual* is responsible for paying the dentist. The dentist may charge the *covered individual* for the difference between the amount paid by *Delta Dental* and the dentist's actual submitted charge.

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

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

[No benefit is payable for services performed by a non-panel dentist, except in the case of emergency care described in paragraph 5.C., below]

[For services performed by a non-panel dentist, benefit payments will be based upon the amount shown on your Benefits Payable Rider for out-of-network benefits. Payment for services provided by non-panel dentist will be made directly to the *covered individual* and the *covered individual* is responsible for paying the dentist. The dentist may charge the *covered individual* for the difference between the amount paid by *Delta Dental* and the dentist's actual submitted charge.

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

C. Emergency Care

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

6. COVERING WORK IN PROGRESS

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

7. TIME LIMIT

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

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

8. SUBROGATION

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

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

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

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

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

10. SUBSCRIPTION CHARGE

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

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

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

11. WE MAY CHANGE YOUR *CONTRACT*

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

In addition to the notice describing the change being made, you can also call our Customer Service department to get information on your plan change. The telephone

numbers are listed at the end of this certificate.

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

12. WHEN YOUR COVERAGE BEGINS

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

Delta Dental will accept for enrollment eligible employees and dependents, who have been determined eligible for enrollment by the *Connector*. This eligibility is based upon *Delta Dental's* underwriting guidelines and your *Plan Sponsor*. The dental services described in this certificate are covered immediately as of your *effective date*, unless your benefits are subject to a waiting period or there exist some limitations or exclusions on your membership which are found in Part III of this certificate.

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

13. WHEN YOUR COVERAGE ENDS

There are no conversion privileges under the *contract*. However, a *member* may have the right to continue dental coverage for a period of time under state law and under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You also shall be entitled to continue coverage under this *contract* for a period of thirty-one (31) days after you leave the group insured by this *contract* unless, during such period, you are otherwise be entitled to similar benefits. You and certain family members may be entitled to continue participating in this plan for a limited period even under conditions (such as your death or termination of employment) that would otherwise make you ineligible for coverage, so long as you pay the appropriate subscription in full. Contact your *plan sponsor* for more detailed information regarding continuation of coverage.

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

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

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

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

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

C. If you become divorced or legally separated, your spouse's coverage under an existing family membership will continue so long as you remain a *subscriber* of the plan, unless a court judgment provides otherwise. This coverage will continue until either you or your spouse remarries, or until the date of coverage termination stated in the judgment of divorce or separation, whichever is earlier. If you remarry and your divorce judgment so provides, your former spouse will have the right, for an additional subscription charge, to continue to receive such benefits as are available to you by means of the issuance of an individual plan. Coverage shall continue regardless of whether the judgment of divorce or separate support was entered prior to the *effective date* of your *contract.*

D. Notice of cancellation of coverage of the divorced or separated spouse shall be mailed to the divorced or separated spouse at such person's last known address, together with notice of the right to reinstate coverage retroactively to the date of cancellation.

E. Claims paid on behalf of a divorced or separated spouse or on behalf of a dependent who is not residing with you shall be paid to the physician, hospital or other provider of covered services or to the person on whose behalf such services were performed, unless the person is a minor child. In the event the person on whose behalf such services were performed is a minor, payment shall be made to the physician, hospital or other provider of such services or to the parent or custodian with whom the child resides.

14. TERMINATION OF A *CONTRACT*

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

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

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

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

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

The following provisions govern cancellation of your *contract*; provided, however, that for coverage issued through the *Connector*, termination will be initiated by the *Connector* and we will terminate your *contract* in accordance with the policies and procedures of the *Connector.*

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

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

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

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

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

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

b. We may cancel your coverage if you have not paid your subscription charges, or if coverage is provided under a policy issued through the *Connector* and the *Connector* collects subscription charges for such coverage, your coverage may be canceled by the *Connector*. Cancellation will be effective on a date we choose, or a date specified by the *Connector*, as applicable, but not earlier than the subscription charge due date. If you are a *subscriber* of a group plan, the *Plan Sponsor* will owe us the subscription charge due for the period between the due date and the cancellation date. You agree that we may use your rights against the *Plan Sponsor* to collect those subscription charges.

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

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

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

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

C. Cancellation due to loss of eligibility

Your *contract* will be canceled when you are no longer eligible in the group through which the *contract* was issued. If your *contract* is canceled because you are no longer eligible, we will continue to provide benefits only if you started receiving services for a procedure before the cancellation date and that procedure requires two or more visits and the treatment is completed within 30 days of the termination date. In such a case, the benefits described in this *contract* are available after your cancellation date for services related to that procedure.

15. BENEFITS AFTER CANCELLATION

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

If we cancel your *contract* for any reason other than for a fraudulent claim or misrepresentation, we will continue to provide benefits only if before the cancellation date you started receiving services for a procedure that requires two or more visits and the treatment is completed within 30 days of the termination date. In such a case, the benefits described in this *contract* are available after your cancellation date for services related to that procedure.

16. NOTICES

A. To you: When we send a notice to your *plan sponsor* we will send it by first class mail. Once we mail the notice or bill we are not responsible for its delivery. It will be your

plan sponsor's responsibility to notify you. This applies to your bill for subscription charges as well as to a notice of a change in the subscription charge or a change in the *contract*. If your name or mailing address should change, you should notify your *plan sponsor* at once. Be sure to give your *plan sponsor* your old name and address as well as your new name and address.

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

17. ENROLLMENT AND *CONTRACT* CHANGES

All enrollment applications and any additions or changes to a *contract* are allowed ONLY when they conform to our Underwriting Guidelines on file with the Massachusetts Division of Insurance, or, for policies issued through the *Connector*, in accordance with the policies and procedures of the *Connector*.

18. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after the *effective date* of this *contract*. If before a *subscriber's effective date* he or she started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure.

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* EPO *subscriber* identification number and any necessary information needed to file your claim. If you fail to inform your dentist within 12 months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

Nothing in this certificate of coverage will prohibit a *covered individual* from seeking emergency care whenever the individual is confronted with an *emergency medical condition*, which in the judgment of a prudent layperson would require pre-hospital emergency services. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent. A *covered individual* shall not be discouraged from using a local pre-hospital emergency medical service system, the 911 telephone number or the local equivalent. No *covered individual* shall be denied coverage for medical and transportation expenses incurred as a result of an *emergency medical condition*.

19. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

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

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

20. COORDINATION OF BENEFITS

Delta Dental will coordinate benefits (COB) when you or your dependents have another plan that covers the same services as your *contract*. *Delta Dental* will apply COB according to applicable 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 the primary plan. The primary plan will provide benefits according to its terms of coverage. The primary plan does not consider the coverage of any other plan. The plan that provides benefits next is the secondary plan. The secondary plan provides benefits toward the remaining balance of covered services subject to its terms of coverage and 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. The amount paid by *Delta Dental*, when added to the amount paid by the primary plan, will not exceed the lesser of: 1) the provider's submitted charge, or 2) the amount allowed under your *contract*

21. RIGHT TO RECOVER OVERPAYMENTS

If we pay more than 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 described in the Benefits Section of this *contract*. If you have any questions about COB and your *contract*, please contact our Customer Service department. The telephone numbers are listed at the end of this certificate.

22. QUALITY ASSURANCE

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

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

The Quality Management Program addresses the following standards

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

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

23. UTILIZATION REVIEW

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

Any utilization review conducted under your dental *contract* is done retrospectively or at the time a claim for services has been submitted for reimbursement. In order for a submitted claim to be covered, the procedure must be included as one of the "Covered Procedures" in your certificate. If a procedure is not a covered procedure then the claim for that procedure will be denied in accordance with the terms of your certificate and the group policy. Coverage of certain procedures may also be limited by frequency, age, *effective dates* of coverage, etc which are all contractually stated within your certificate. There are also a number of listed procedures which are only considered a covered expense if a patient presents with a specified health history and/or has been diagnosed with a specified condition. During the claims review of these specific procedures, there may be a determination by a licensed dental practitioner that the procedure that was performed was not determined to be medically appropriate in accordance with the criteria that has been established in accordance with our utilization review program. In these situations, the claim for that procedure may be denied or partially reimbursed in accordance with the benefit for an alternate procedure.

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

When a claim has been denied or partially denied based on medical appropriateness, this

is considered an *adverse determination*. These decisions are reviewed by qualified and appropriately licensed health professionals and only after receiving any relevant clinical information necessary to make the decision.

If you wish to make an *inquiry*, determine the status or outcome of a decision with *Delta Dental*, you can submit your *inquiry* to us: In writing:
Attention: Customer Service
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129
By telephone:1-800-872-0500 website:www.deltadentalma.com

24. *GRIEVANCE* PROCESS:

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

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

In writing:

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

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

Internal Levels of Review:

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

Internal *Grievance* Process:

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

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

provide you or your authorized representative, if any, a written resolution of a *grievance* within thirty (30) business days of receipt of the written *grievance*.

Written Decision:

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

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

Reconsideration:

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

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

25. INVOLUNTARY DISENROLLMENT RATE

Delta Dental will annually notify you of the involuntary member disenrollment rate. For purposes of this provision "involuntary disenrollment" means termination of coverage due to any of the reasons contained in 14.B.1.a or 14.B.1.c of this Part IV.

Part V: Filing a Claim

EXPLANATION OF BENEFITS

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

WHO FILES A CLAIM

Delta Dental EPO Panel Dentists:

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

Delta Dental EPO Non-panel Dentists:

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

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

WHEN YOU FILE A CLAIM

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

Part VI: Index

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

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

DSM MASSACHUSETTS INSURANCE COMPANY, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS

Delta Dental EPO Basic Exclusive Network Plan
Benefits Payable Rider

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

Benefits for the covered services described in your Delta Dental EPO Contract are reimbursed as follows:

DEDUCTIBLES

Type II and Type III services described below are subject to a $100.00 deductible for each covered individual in each Plan Year. In the case of a family contract, the total deductible for all covered individuals in a family shall not exceed $300.00 for Type II and Type III services.

	In-Network Benefits	**Out-of-Network Benefits**	
Diagnostic and Preventive Services (Type I Benefits)			
Delta Dental pays 100% of charges up to the fee schedule amounts for services provided by a Delta Dental EPO Panel Provider.	You pay nothing for these services.	No benefits are payable for services provided by a non-participating provider.	You are responsible for the entire amount billed by a non-participating provider.
Restorative and other Basic Services (Type II Benefits)			
For members age 19 or older, Delta Dental pays 30% of charges up to the fee schedule amounts for services provided by a Delta Dental EPO Panel Provider. For members under age 19, Delta Dental pays 40% of the charges up to the fee schedule amounts for services provided by a Delta Dental EPO Panel Provider.	For members age 19 or older, you pay 70% of the fee schedule amounts for these services. For members under age 19, you pay 60% of the fee schedule amounts for these services.	No benefits are payable for services provided by a non-participating provider.	You are responsible for the entire amount billed by a non-participating provider.
THE FOLLOWING BENEFITS FOR PROSTHODONTIC AND OTHER SERVICES AND ORHTHODONTIC COVERAGE ARE AVAILABLE ONLY FOR MEMBERS UNDER AGE 19			
Prosthodontic and Other Services (Type III Benefits)			
Delta Dental pays 40% of charges up to the fee schedule amounts for services provided by a Delta Dental EPO Panel Provider.	You pay 60% of the fee schedule for these services.	No benefits are payable for services provided by a non-participating provider.	You are responsible for the entire amount billed by a non-participating provider.
Orthodontic Coverage			
Delta Dental pays 40% of charges up to the fee schedule amounts for services provided by a Delta Dental EPO Panel Provider.	You pay 60% of the fee schedule for these services.	No benefits are payable for services provided by a non-participating provider.	You are responsible for the entire amount billed by a non-participating provider.

COVERED SERVICES FOR MEMBERS AGE 19 OR OLDER

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

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

1. Comprehensive Oral Examination (including the initial dental history and charting of teeth); once every 60 months per dentist.

2. Periodic oral evaluation; 2 every 12 months.

3. X-rays of the entire mouth; once every 60 months.

4. Bitewing x-rays (x-rays of the crowns of the teeth); 2 every 12 months when oral conditions indicate need.

5. Single tooth x-rays; as needed.

6. Routine cleaning, scaling and polishing of teeth; 2 every 12 months.

7. Periodontal Cleanings following active periodontal treatment; once every 3 months, not to be combined with regular cleanings.

8. Emergency oral evaluation problem focused (limited) exams. 2 in 12 months.

9. Chlorhexidine Mouthrinse; when administered and dispensed in the dentist's office following scaling and root planing.

10. Fluoride Toothpaste; when administered and dispensed in the dentist's office following periodontal surgery.

B. Restorative Services and Other Basic Services (also referred to as "Type 2") Benefits are available for the following dental services to: (i) restore decayed or *fractured* teeth (teeth must have a good prognosis to qualify for benefit); (ii) remove diseased or damaged natural teeth; (iii) treat oral disease (teeth must have a good prognosis to qualify for benefit); (iv) repair dentures or bridges; (v) rebase or reline dentures; and (vi) repair or recement bridges, crowns and onlays.

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

2. Protective Restorations; once per tooth.

3. General anesthesia when necessary and appropriate for covered impacted wisdom teeth only when provided by a licensed, practicing dentist (up to one hour).

4. Palliative dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm. 3 in 12 months.

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

6. Rebase or reline dentures; once per denture every 36 months.

7. Tissue conditioning; two treatments per denture every 36 months.

8. Repair crowns and onlays; once per tooth per 12 months. Recementing of a crown is limited to once every 12 months per tooth.

9. Adding teeth to existing partial or full dentures; once per tooth per denture.

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

11. 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); one periodontal surgery per quadrant every 36 months. Scaling and root planing once per quadrant per 24 months.

12. Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth on covered members. Apicoectomy once per tooth. Retreatment of previous root canal therapy is a benefit once per tooth after 24 months of original root canal.

COVERED SERVICES FOR MEMBERS UNDER AGE 19

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

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

1. Comprehensive Oral Examination (including the initial dental history and charting of teeth); one per lifetime per provider.

2. Periodic oral evaluation; two every 12 months.

3. X-rays (FMX and panoramic radiographs) of the entire mouth; once every 36 months.

4. Bitewing x-rays (x-rays of the crowns of the teeth); two every 12 months when oral conditions indicate need.

5. Single tooth x-rays; maximum of four per visit and no more than 12 per 12 months.

6. Routine cleaning, scaling and polishing of teeth; two every 12 months.

7. Periodontal Cleanings; once every 3 months following active periodontal treatment, not to be combined with regular cleanings.

8. Fluoride treatment for *covered individuals* under 19 years of age; one treatment per 90 days.

9. Space maintainers are covered due to the premature loss of teeth when tooth has not begun to erupt or when migration of adjacent tooth has occurred; not for the replacement of primary or permanent anterior teeth.

10. Emergency oral evaluation problem focused (limited) exams. 2 in 12 months; not covered with palliative treatment or detailed comprehensive exam on same date of service.

11. Sealants for unrestored permanent molars; once per tooth per 36 months.

B. Restorative Services and Other Basic Services (also referred to as "Type 2")
Benefits are available for the following dental services to: (i) restore decayed or *fractured* teeth (teeth must have a good prognosis to qualify for benefit); (ii) remove diseased or damaged natural teeth; (iii) treat oral disease (teeth must have a good prognosis to qualify for benefit); (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 synthetic tooth color fillings, but limited to one filling for each tooth surface for each 12 month period. However, synthetic (white) fillings are limited to restorations for posterior permanent teeth. Multi-surface synthetic restorations on posterior primary (deciduous) teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentists charge. No benefits are provided for replacing a filling within 24 months of the date that the prior filling was furnished.

2. Protective restorations; once per tooth.

3. Stainless steel crowns on deciduous (baby) teeth; once every 24 months per tooth (no more than four per date of service).

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

5. Palliative dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm. Not covered with other exam codes on the same date of service.

6. Repair of dentures or fixed bridges; not a covered benefit within 6 months of insertion. Recementing of fixed bridges; not a covered benefit within 6 months of insertion.

7. Rebase or reline dentures; once per denture per 24 months after 6 months of initial denture insertion.

8. Repair or recement crowns; recement of a crown after 6 months of initial crown insertion.

9. Adding teeth to existing partial or full dentures; after 6 months of initial denture insertion.

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

11. Periodontic services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) once per quadrant per 36 months, limited to two quadrants on the same date of service. Scaling and root planing once per quadrant 36 months limited to two quadrants on the same date of service.

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

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

Benefits are available for the following dental services and supplies: to replace missing natural teeth with artificial ones and to restore severely decayed or *fractured* teeth (teeth must have a good prognosis to qualify for benefit).

Crowns

- Initial placement of crowns.

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

Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each 84 months.

- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were installed at least 84 months before replacement.

D. Medically Necessary Orthodonture

Orthodontic services for children under the age of nineteen (19) for severe and handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto qualifier. The HLD score used to determine whether a *covered individual* qualifies for coverage is based on *Delta Dental's* calculation and not the score of the treating dentist. Prior authorization is required to qualify for coverage. Authorization will only be given to new cases and not takeover cases.

ANNUAL MAXIMUM BENEFIT (applies only to Covered Individuals age 19 and older)

Total benefits are limited to a maximum of $750 for each *covered individual* every Plan Year.

OUT OF POCKET MAXIMUM (applies only to Covered Individuals under age 19 and only to in-network benefits)

The *out of pocket maximum* is $350 every Plan Year. The *out of pocket* maximum applies per *covered individual*. A family with 2 or more *covered individuals* under age 19 will have an aggregate *out of pocket maximum* of $700 for individuals under age 19. The *out of pocket* maximum applies to in-network benefits only. No out of pocket maximum applies to out of network benefits or to adult coverage.

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

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

OUT-OF-NETWORK SERVICES:

No benefit is payable for services performed by a non-panel dentist, except in the case of emergency care as described in your Subscriber Certificate.

OUT-OF-STATE DENTIST SERVICES

For service performed by out of state Delta Dental PPO panel providers, the In-Network benefit allowance is based on the Delta Dental PPO table of allowance or the dentist's

submitted fee if lower. Delta Dental pays the dentist directly for covered services. The dentist will bill covered members for balances resulting from plan specific deductibles and co-payments.

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

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

Fay Donohue
President and CEO, DSM

NONDISCRIMINATION NOTICE

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

Delta Dental of Massachusetts:

- 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 on your member ID card.

If you believe that Delta Dental of Massachusetts 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)

Delta Dental of Massachusetts PPO and Premier insurance products are offered by Dental Service of Massachusetts, Inc. Delta Dental of Massachusetts EPO and DeltaCare insurance products are offered DSM Massachusetts Insurance Company, Inc.

Foreign Language Assistance

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-233-4522 (TTY: 1-844-233-4524).
Portugese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-233-4522 (TTY: 1-844-233-4524).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-233-4522（TTY：1-844-233-4524）。
French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-233-4522 (TTY: 1-844-233-4524).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-233-4522 (TTY: 1-844-233-4524).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-233-4522 (телетайп: TTY: 1-844-233-4524).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1--xxx 1-844-233-4524 (رقم هاتف الصم والبكم:1-844-233-4522).
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-844-233-4522 (TTY: 1-844-233-4524).។
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-233-4522 (ATS: 1-844-233-4524).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-233-4522 (TTY: 1-844-233-4524).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-233-4522 (TTY: 1-844-233-4524).번으로 전화해 주십시오.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-844-233-4522 (TTY: 1-844-233-4524).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-233-4522 (TTY: 1-844-233-4524).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-233-4522 (TTY: 1-844-233-4524). पर कॉल करें।
Gujarati	**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-844-233-4522 (TTY: 1-844-233-4524).