Subscriber's Certificate
Delta Dental Premier

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

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

ATTEST: Dental Service of Massachusetts, Inc.

Steven Pollock
President & CEO

David Abelman
Corporate Clerk

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

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

SP028-FDS_ Delta Dental Premier National II – revised June 2013

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 three types of services:

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

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

The dental services described in this *contract* are covered immediately as of your *effective date*, unless your benefits are subject to a waiting period. Additionally, there are some limitations or restrictions on your membership, which are found in Parts III and IV of this certificate.

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's* 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 Premier Participating 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

You have the responsibility to:

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

Part I: Definitions

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

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

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

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

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

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

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

Delta Dental Premier Non-panel Dentist: a dentist who has not signed an agreement with *Delta Dental* to accept *Delta Dental Premier* allowances for services rendered on *subscribers* in the *Delta Dental Premier* plan. A *Delta Dental Premier Non-panel Dentist* will be reimbursed by *Delta Dental* up to the maximum fee allowance for each geographic area or the dentists submitted fee if less.

Delta Dental Premier Panel Dentists: a dentist who has signed an agreement with *Delta Dental* to accept reimbursement based on an established allowance for services rendered on *subscribers* enrolled in the *Delta Dental Premier* plan.

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

Family Contract: a *contract* that includes you, your spouse and your dependent children under 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 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.

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

Maximum Fee Allowance: The payment amount that *Delta Dental* sets for the *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.

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

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.

Schedule of Maximum Covered Charges: the payment amount that *Delta Dental*, in conjunction with your *plan sponsor*, sets for the services that may be provided under this *contract* and is on file with the Commissioner of Insurance. Benefits are payable in accordance with the terms and conditions of the applicable Benefits Payable Rider attached to this certificate and in effect at the time services are rendered.

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

Table of Allowance: the payment amount that *Delta Dental*, in conjunction with your *plan sponsor*, sets for the services that may be provided under this *contract* and on file with the Commissioner of Insurance. Benefits are payable in accordance with the terms and conditions of the applicable Benefits Payable Rider attached to this certificate and in effect at the time services are rendered.

Part II: Benefits

You have the right to benefits for the following services, EXCEPT as limited or excluded elsewhere in this *contract*. Payments for these benefits are based on the *Delta Dental Premier Panel Dentist's profile fee* unless your group has purchased a *table of allowance* or *schedule of maximum covered charges* program. The benefits are limited to a maximum dollar payment for each *covered individual* for each calendar year. The extent of your benefits is explained in the Benefits Payable Rider your group has purchased.

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

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

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

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

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

2. Periodic oral evaluation; once every six months.

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

4. Bitewing x-rays; once every six months when oral conditions indicate need.

5. Single tooth x-rays; as needed.

6. Routine cleaning, scaling and polishing of teeth; once every six months.

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

8. Fluoride treatment for *covered individuals* under 19 years of age; once every six months

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

10. Emergency oral evaluation problem focused exams.

11. Sealants for unrestored permanent molars; once per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who have had a recent cavity and are at risk for decay.

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

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

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

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

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

2. Sedative fillings; once per tooth.

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

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

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

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

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

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

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

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

11. Tissue conditioning; two treatments every 36 months.

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

13. Adding teeth to existing partial or full dentures.

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

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

1. Dentures and Bridges

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

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

Temporary partial dentures as follows:

1. 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.

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

2. Crowns and Onlays

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

1. Initial placement of crowns and onlays.

2. Replacement of crowns and onlays; once each 60 months per tooth.

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

Part III: Limitations and Exclusions

1. WE LIMIT BENEFITS FOR SOME SURGICAL SERVICES

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

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

   We will not consider coverage: if your non-payment was due to reaching your maximum or 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 an other are available, in whole or in part, through a government program or would have been available if you did not have this *contract*. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare. We will not provide benefits if you could have received government benefits by applying for them within the appropriate agency's time limitation.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Consultations.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
- Implants when not in lieu of a three unit bridge and transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.

- Temporary, complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing overdentures.
- Services related to congenital anomalies. However, this exclusion does not apply to orthodontic services that may be covered by your group’s orthodontic rider.
- Tooth desensitization.
- Occlusal adjustment.

Part IV: Other Contract Provisions

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

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

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

When your *panel dentist* provides covered services, he or she must accept the negotiated fee allowance as payment in full. But in the following cases you will be responsible for the difference between the *Delta Dental maximum fee allowance* payment and the dentist's actual charge for covered services.

A. If you have received the maximum benefit allowed for services. For example, the maximum dollar amount for a *covered individual* in a calendar year, including the service that caused you to reach the maximum.

B. 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.

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

D. 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.

E. If the *Delta Dental* payment is based on a *schedule of maximum covered charges* or a standard *table of allowance*.

3. 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 applies 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.

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

Delta Dental Premier Non-panel Dentists

For services performed by a *Delta Dental Premier Non-panel Dentists,* the benefit for each type of service will be based on the maximum fee allowance for each geographic area or the dentists' submitted fee if lower. You will be responsible for paying the dentist the difference between the dentists' fee and the amount paid by *Delta Dental.*

To find out if your dentist participates with *Delta Dental* ask your dentist if he or she has an agreement with us, call our Customer Service department, or check the directory of *Delta Dental Premier Panel Dentists* on file with your *plan sponsor*.

5. TIME LIMIT

All claims for benefits under this *contract* for services by a *Delta Dental Premier Panel Dentist or a Delta Dental Premier Non-panel Dentist* must be submitted within **one year** of the date that you complete the service.

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

6. SUBROGATION

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

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

You agree that when you claim benefits under this *contract*, you give 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 Premier Panel Dentists have agreed to give us all information necessary to determine your benefits under this *contract*.

If you receive services from a *Delta Dental Premier Non-panel 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 out-of-state *Delta Dental Premier Non-panel Dentist* does not provide the required information, we may not provide benefits for his or her services.

8. 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. We will send your *plan sponsor* a bill and will expect payment. *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. Changes: We may change your subscription charge. Each time we change the subscription charge, we 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.

9. WE MAY CHANGE YOUR CONTRACT

We may change a part of your *contract*. We will send your *plan sponsor* a notice each time we do so. We will expect him or her to notify you. We are not responsible if he or

she does not. Your *contract* will be changed whether or not your *plan sponsor* has notified you.

The notice will describe the change being made. You can also call our Customer Service department to get information on your plan change. Telephone numbers are listed at the end of this certificate.

The notice will tell you the *effective date* of the change. The change will apply to all benefits for services you receive on or after the *effective date*. There is one exception: if before the *effective date* of the change you started receiving services for a procedure requiring two or more visits, we will not apply the change to services related to that procedure. If your group has purchased benefits for orthodontic services, this limitation will not apply to these benefits.

10. WHEN YOUR COVERAGE ENDS

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

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

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

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

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 through your *plan sponsor w*ithin 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*.

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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 of divorce or separation, whichever is earlier. If you remarry and your divorce judgment so provides, your former spouse will have the right, for an

additional subscription, to continue to receive such benefits as are available to you by means of the issuance of an individual plan.

> The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) may give you and your covered dependents the right to continue your dental coverage. You should contact your *plan sponsor* regarding any rights you may have under the COBRA provision.

11. 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.

2. You may also cancel your *contract* through your *plan sponsor*. To do so, your p*lan 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.

3. 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 re-opening occurs.

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

1. We may cancel your group's *contract* under the terms of our agreement with your group. If your group's *contract* is canceled, your coverage will automatically be terminated as of the same date.

2. 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 c*ontract* than you have paid us in subscription charges, we have the right to collect the excess from you.

B. We may cancel your *contract* if your subscription charges are overdue according to the provisions of 940 CMR 9.00. Cancellation will be effective on a date we choose, but not earlier than the subscription charge due date. 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 have been guilty of uncooperative or unethical dealings with us, or for any other cause that is approved by the Commissioner of Insurance.

3. For information regarding benefits after cancellation see Part IV, Section 13 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 before the cancellation date you started receiving services for a procedure that requires two or more visits and the treatment is completed within 30 days of the termination date. In such a case, the benefits described in this *contract* are available after your cancellation date for services related to that procedure. If your group has purchased benefits for orthodontic services, the policy of continuing benefits will not apply to these orthodontic services.

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

13. NOTICES

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.

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

14. 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.

15. WHEN AND HOW BENEFITS ARE PROVIDED

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

In order for you to receive any of the benefits for which you may have a right, you must inform your dentist that you are a *covered individual* and supply him or her with your *Delta Dental 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.

16. 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.

17. 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 Subscriber's Certificate. A copy of the COB Regulations is available from Delta Dental upon request.
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The plan that provides benefits first under the COB rules is known as the primary plan. The primary plan is responsible for providing benefits in accordance with its terms and conditions of coverage without regard to coverage under any other plan. The plan that provides benefits next is the secondary plan. It provides benefits toward any remaining balance for covered services in accordance with its terms and conditions of coverage, including its COB provision.

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

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

18. RIGHT TO RECOVER OVERPAYMENTS

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

Part V: Filing a Claim

1. EXPLANATION OF BENEFITS

Each time we process a claim for you under this *contract*, a written notice may be sent to 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.

2. WHO FILES A CLAIM

A. Delta Dental Premier Panel Dentists

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

B. Delta Dental Premier Non-panel Dentists

If you use a *Delta Dental Premier Non-panel Dentist* 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/her full charge and *Delta Dental's* payment.

3. WHEN YOU FILE A CLAIM

When you file a claim for the services of a *Delta Dental Premier Non-panel Dentists*, the following rules apply. Obtain an Attending Dentist's Statement claim form from your *plan sponsor* or *Delta Dental*. After we receive your completed forms we will (a) send you a check for your claim to the extent of your benefits under this *contract*; or (b) send you a notice in writing of why we are not paying your claim; or (c) send you a notice in writing of what additional information or records we need to decide if we should pay your claim. It is up to you to pay your dentist.

If you have any questions, contact 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

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
BENEFITS PAYABLE RIDER 604

To be attached to and form a part of your Delta Dental Premier 2 Certificate

Your group has purchased this Rider **for members age 19 and over**. Benefits for services covered by your Delta Dental Premier Contract are reimbursed as set forth below. The covered services and frequency limits described in this Rider supersede those in Part II: Benefits of your Subscriber Certificate.

DEDUCTIBLES

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each [plan, benefit, calendar] year. In the case of a family contract, the total deductible payment for all covered individuals shall not exceed $150 for Type 2 and Type 3 services. This means you must pay the first $50 or $150 of benefits provided in each [plan, benefit, calendar] year.

	In-Network Benefits		**Out-of-Network Benefits**	
Diagnostic and Preventive Services (Type 1 Benefits)				
Dental Service pays 100% of the customary fee for covered services by Delta Dental Premier Panel Providers.	You pay nothing.		Dental Service pays 80% of the customary fee.	You pay 20% of the customary fee.
Restorative and other Basic Services (Type 2 Benefits)				
Dental Service pays 75% of the customary fee for covered services by Delta Dental Premier Panel Providers.	You pay 25% of the customary fee.		Dental Service pays 55% of the customary fee.	You pay 45% of the customary fee.
Prosthodontic and Other Services (Type 3 Benefits) A Six Month Waiting Period Applies to these services. No benefits are payable for services provide in the first six months following the effective date of coverage.				
Dental Service pays 50% of the customary fee for covered services by Delta Dental Premier Panel Providers.	You pay 50% of the customary fee.		Dental Service pays 30% of the customary fee.	You pay 70% of the customary fee.

Your total benefits for covered services are limited to $1,250.00 for each member over the age of 19 each [plan, benefit, calendar] year.

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").

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.

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

Steven J. Pollock
President

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

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
BENEFITS PAYABLE RIDER 603

To be attached to and form a part of your Delta Dental Premier 2 Certificate

Your group has purchased this Rider **for members under age 19**. Benefits for services covered by your Delta Dental Premier Contract are reimbursed as set forth below. The covered services and frequency limits described in this Rider supersede those in Part II: Benefits of your Subscriber Certificate.

DEDUCTIBLES

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each [plan, benefit, calendar] year. In the case of a family contract, the total deductible payment for all covered individuals shall not exceed $150 for Type 2 and Type 3 services. This means you must pay the first $50 or $150 of benefits provided in each [plan, benefit, calendar] year.

	In-Network Benefits		**Out-of-Network Benefits**	
Diagnostic and Preventive Services (Type 1 Benefits)				
Dental Service pays 100% of the customary fee for covered services by Delta Dental Premier Panel Providers.	You pay nothing.		Dental Service pays 80% of the customary fee.	You pay 20% of the customary fee.
Restorative and other Basic Services (Type 2 Benefits)				
Dental Service pays 75% of the customary fee for covered services by Delta Dental Premier Panel Providers.	You pay 25% of the customary fee.		Dental Service pays 55% of the customary fee.	You pay 45% of the customary fee.
Prosthodontic and Other Services (Type 3 Benefits)				
Dental Service pays 50% of the customary fee for covered services by Delta Dental Premier Panel Providers.	You pay 50% of the customary fee.		Dental Service pays 30% of the customary fee.	You pay 70% of the customary fee.
Orthodontic Coverage				
Dental Service pays charges up to 50% of the customary fee.	You pay up to 50% of the customary fee.		Dental Service pays charges up to 30% of the customary fee.	You pay up to 70% of the customary fee.

Your total benefits for covered services are unlimited for each member under the age of 19. Out-of-pocket expenses on in-network covered services is limited to a maximum of $350.00 for each member for each [plan, benefit, calendar] year. In the case of a family contract, the total out-of pocket expenses on in-network covered services for all covered individuals under age 19 shall not exceed $700.00 for each [plan, benefit, calendar] year. There is no out-of-pocket limitation on services rendered by a non-participating provider.

Covered Services include the following:

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 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 crown 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 quadrant 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.

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.

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

Steven J. Pollock
President

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

To be attached to and form a part of your policy

Your contract has been changed as follows:

The name and signature of the officer that appears on your policy has been changed and replaced with the name and signature below.

[

Steve Pollock
President and CEO]

NOTE: Underlined terms are defined in your contract.

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

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

CORP SIG RIDER- Dental Services of MA