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

Subscriber's Certificate for Delta Dental Premier Individual Dental Insurance Policy

Members Under Age 19

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

Your Right to Examine This Policy - Your satisfaction is our number one priority. You have the right to examine this policy for 10 business days from the date of delivery. Should this policy not meet your needs please return to us, within 10 business days, the original policy with a written letter informing us of your intent to cancel. You will receive a full refund of all premiums paid towards the cancelled policy and your policy will be void from its effective date. We will subtract from the refund any payments made for claims under this *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.

Pre-existing conditions - Dental expenses incurred in connection with any dental procedure started prior to coverage are excluded. No benefits are available for the replacement of teeth missing prior to the member's effective date of coverage.

This Policy is renewable - This policy will be up for renewal 12 months from your effective date. We reserve the right to change premium rates upon renewal of the policy. We agree to keep your coverage in force as long as you continue to pay the premiums on time and as long as grounds do not exist which permit us to cancel this policy in accordance with Part IV, Section 10.B of this policy.

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

ATTEST: Dental Service of Massachusetts, Inc.

Fay Donohue

David Abelman

President & CEO Corporate Clerk

Incorporated under the laws of the Commonwealth of Massachusetts as a not-for-profit organization.
*Dental Service of Massachusetts, Inc. is doing business as Delta Dental

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Part I
Delta Dental of Massachusetts
Outline of Coverage - Delta Dental Premier National

Policy number:

1. Description of Benefits and Coinsurance Amounts:

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

Type 1 services prevent or detect tooth decay and other forms of oral disease. There is no deductible on Type 1 services.
Examples of Type 1 services include:

1. Comprehensive oral examination, including the initial dental history and charting of teeth: This is covered once per patient per location per lifetime.
2. Periodic oral evaluation. This is covered twice every 12 months.
3. X-rays of the entire mouth. This is covered once every 36 months.
4. Bitewing x-rays (x-rays of the crowns of the teeth). This is covered twice every 12 months when oral conditions indicate need.
5. Single tooth x-rays are covered as needed.
6. Routine cleaning, scaling, and polishing of teeth are covered twice every 12 months.
7. Fluoride treatment for *covered individuals* under 19 years of age. These are covered once every 3 months.
8. Space maintainers required due to the premature loss of teeth. These are covered only for *covered individuals* under age 19.
9. Sealants on unrestored permanent molars. These are covered once per patient per location every 36 months.
10. Chlorhexidine mouth rinse: This is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing
11. Fluoride toothpaste: This is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.

Type 2 includes services to restore decayed or *fractured* teeth with fillings; repair dentures or bridges; rebase or reline dentures; and repair or recement bridges or crown or onlays; and treat oral disease and injury involving the teeth and oral tissues with certain oral surgical procedures; and treat diseased gum tissue or bone with certain periodontal services; and treat diseased teeth with certain endodontic services.
Examples of these services include:

1. Fillings consisting of silver amalgam and, in the case of front teeth, synthetic tooth color fillings are covered, but are limited to one filling for each tooth surface for each 12-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 granted. The patient is responsible up to the dentist's charge. No benefits are provided for replacement of a filling within 12 months of the date that the prior filling was furnished.

2. Sedative fillings.
3. Stainless steel crowns on primary teeth and on permanent teeth: #2-5, #12-15, #18-21, #28-31 are covered 4 times per patient per day.
4. Repair of dentures or fixed bridges are covered. Recementing of fixed bridges is covered.
5. Rebase or reline dentures are covered once every 24 months.
6. Repair or recement crowns and onlays are covered.
7. Simple tooth extractions are covered.
8. General anesthesia is covered only when necessary and appropriate for covered surgical services and when provided by a licensed, practicing dentist.
9. Adding teeth to existing partial or full dentures is covered.
10. Palliative (emergency) treatment of dental pain as a minor procedure is covered.
11. Certain surgical services to treat oral disease or injury are covered. This includes surgical tooth extractions and extractions of impacted teeth.
12. Periodontal 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) are covered. Periodontic benefits are determined according to our "Periodontal Guidelines."
13. Endodontic services for root canal treatment of permanent teeth are covered, including the treatment of the nerve of a tooth, the removal of dental pulp, and the pulpal therapy. Vital pulpotomy is limited to deciduous teeth.

Type 3 includes services and supplies to: replace missing natural teeth with artificial ones; remove diseased or damaged natural teeth; and restore severely decayed or *fractured* teeth; and treat oral disease and injury involving the teeth and oral tissues with certain oral surgical procedures; and treat diseased gum tissue or bone with certain periodontal services; and treat diseased teeth with certain endodontic services. Examples of Type 3 services include:

1. Crowns and onlays are covered only when the teeth cannot be restored with the fillings due to severe decay or *fractures.*
2. Dentures and bridges:
   a) Complete or partial dentures including services to measure, fit, and adjust them are covered once every 84 months. Fixed bridges are covered once every 60 months.
   b) Replacement of dentures are covered, but only when they cannot be made serviceable and were inserted at least 84 months before replacement. Replacement of fixed bridges are covered once every 60 months.
   c) Temporary partial dentures are covered as follows:

1) To replace any of the 6 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.

Type 4 includes services and supplies to: Medically Necessary Orthodonture for covered individuals under the age of 19. Orthodontic services for severe and handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto Qualifier. Requires prior authorization.

3. Frequency Limitations: – Refer to Policy Limits and Exclusions:

1. Comprehensive Oral Examination (including the initial dental history and charting of teeth); once per patient per location per lifetime.
2. Periodic oral evaluation; twice every 12 months.
3. X-rays of the entire mouth; once every 36 months.
4. Bitewing x-rays (x-rays of the crowns of the teeth); twice every 12 months for *covered individuals* when oral conditions indicate need.
5. Routine cleaning, scaling and polishing of teeth; twice every 12 months.
6. Fluoride treatment for *covered individuals* under 19 years of age; once every 3 months.
7. Space maintainers required due to the premature loss of teeth; only for *covered individuals* under age 19.
8. Sealants—Unrestored permanent molars, these are covered once per patient per location every 36 months.
9. Chlorhexidine mouth rinse—this is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing.
10. Fluoride Toothpaste—this is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.
11. Periodontal Treatments (root planing/sub gingival curettage)—are limited to four quadrants during any 24 consecutive months.
12. 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 12-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 given. The patient is responsible up to the dentist's charge. No benefits are provided for replacing a filling within 12 months of the date that the prior filling was furnished.
13. Stainless steel crowns on primary teeth and on permanent teeth: #2-5, #12-15, #18-21, #28-31 are covered 4 times per patient per day.
14. Repair of dentures or fixed bridges. Recementing of fixed bridges.
15. Rebase or reline dentures; once every 24 months.
16. Repair or recement crowns and onlays.

17. Complete or partial dentures including services to measure, fit, and adjust them; once every 84 months. Complete fixed bridges including services to measure, fit, and adjust them; once each 60 months.
18. Replacement of dentures, but only when they cannot be made serviceable and were installed at least 84 months before replacement. Replacement of fixed bridges, but only when they cannot be made serviceable and were installed at least 60 months before replacement.
19. Temporary partial dentures as follows:
    a. 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.
    b. For the replacement of permanent teeth for *covered individuals* who are under 16 years.
20. Crowns and onlays only when the teeth cannot be restored with fillings due to severe decay or *fractures*.
21. Replacement of crowns and onlays; once each 60 months per tooth.

4. Waiting Periods: There are no waiting periods for Type II and III services under this policy.

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

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

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

8. This policy is subject to premium increases at the time of renewal. This policy will be in force for 12 months from the effective date.

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

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

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

Part II: Definitions

Plan-year Deductible: this *deductible* must be satisfied each plan year.

Carry-forward Deductible: any portion of the *deductible* amount that is satisfied during the last three months of the plan 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, whichever is 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.

***Dependent*:** Delta Dental covers *dependent* children up to age 26.

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 or spousal equivalent and your *dependent* children. Dependents are covered up to age 26. **Adopted children** and children under your own or your spouse's legal guardianship are also covered. In addition, **a physically or mentally handicapped child** who is incapable of earning his or her own living and over 26 years may be eligible to continue coverage under a family membership if *Delta Dental* is

notified within 72 days of the child's twenty-sixth birthday and by completing a disabled dependent application.

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

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.

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. Requires prior authorization.

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

Schedule of Maximum Covered Charges: the payment amount that *Delta Dental* 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 individual whose name this policy is under.

Table of Allowance: the payment amount that *Delta Dental* 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 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 our non-payment was due to you reaching your maximum
- if our non-payment was due to you meeting your deductible and having no payment due after such deductible was met.

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. Delta Dental will determine what is necessary and appropriate under the terms of the *contract*: That decision is made by *Delta Dental* based on a review of your 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*.
- 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
- 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 an 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 you have 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.
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.

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 Dentist,* the benefit for each type of service will be based on the maximum fee allowance for each geographic area or the dentist's submitted fee, whichever is lower. You will be responsible for paying the dentist the difference between the dentist's 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 or call our Customer Service department.

5. 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 anything 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.

6. 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.

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

7. SUBSCRIPTION CHARGE

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

B. Grace Period: A grace period of 31 days will be granted for the payment of each subscription falling due after the first premium during which grace period the policy shall continue in force. If subscription charges have not been paid within 31 days after the date on which payment is due, Delta Dental, upon written notice to you, may terminate this Agreement as of the date to which subscription charges have been paid.

C. Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such

application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights there under as they had under the policy immediately before the due date of the defaulted premium, subject to any provision endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid but not to any period more than sixty days prior to the date of reinstatement.

D. Changes: Delta Dental may change your subscription charge. Each time we change the subscription charge Delta Dental will send you a notice at least 30 days prior to the effective date of change.

8. WE MAY CHANGE YOUR CONTRACT

We may change a part of your *contract*. We will send you a notice each time we do so. 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 you have purchased benefits for orthodontic coverage, this limitation will not apply to these benefits.

9. WHEN YOUR COVERAGE ENDS

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

A. The *subscriber* is no longer enrolled in the plan.
B. Your dependent child under your *family contract* reaches their 26th birthday.
C. However, if your dependent child is either mentally or physically handicapped upon reaching 26 years and is incapable of earning his or her own living, special arrangements can be made for your child to continue coverage under your *family contract*. You must apply for this continued coverage within 72 days of your child's twenty-sixth birthday. In addition, you must supply us with any medical or other information that we may need to determine if your child is eligible to continue coverage under your *family contract*.
D. If you become divorced or legally separated, your spouse's coverage under an existing family membership will continue so long as you remain a *subscriber* of the plan, unless a court judgment provides otherwise. This coverage will continue until either you or your spouse remarries, or until the date of coverage termination stated in the judgment 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.

E. The subscriber is no longer a Massachusetts resident.

10. TERMINATION OF A CONTRACT

A. You may cancel your *contract*. You must give us notice in writing at least 30 days prior to the termination date. If you cancel your *contract*, you must wait at least one year after your cancellation before you can enroll again as a *subscriber*.

B. *Delta Dental* may cancel your *contract*.
We may cancel your *coverage* if you have not paid your subscription charges. Cancellation will be effective on a date we choose, but not earlier than the subscription charge due date. You will owe us the subscription charge due for the period between the due date and the cancellation date

A written notice will be sent to your last known home address. The notice will include, the date your dental plan was terminated, the termination was due to non payment of subscription charges, 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

In addition, we may, upon due notice to you, cancel your *contract* under any of the following circumstances:

a) We may cancel your *contract* if you make any fraudulent claim or misrepresentation to us or to any dentist, such as an incorrect or incomplete statement on your application card which led us to believe you were eligible for this coverage when in fact you were not. In such a case, cancellation will be as of your *effective date*. We will refund you the subscription charge you have paid us. We will subtract from the refund any payments made for claims under this *contract*. If we have paid more for claims under this *contract* than you have paid us in subscription charges, we have the right to collect the excess from you.
b) We may cancel your *contract* if your subscription charges are overdue according to the provisions of 940 CMR 9.00. Cancellation will be effective on a date we choose, but not earlier than the subscription charge due date. You will owe us the subscription charge due for the period between the due date and the cancellation date.
c) We may cancel your *contract* if you have been guilty of uncooperative or unethical dealings with us, or for any other cause that the Commissioner of Insurance approves.

d) Time Limit on Certain Defenses: After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability as defined in the policy commencing after the expiration of such two-year period OR Incontestable: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

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

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

11. BENEFITS AFTER CANCELLATION

If you cancel 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 you have purchased benefits for orthodontic services, the policy for continuing benefits will not apply to these orthodontic services.

12. NOTICES

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

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

13. 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.

14. 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 you have purchased benefits for orthodontic services, this limitation will not apply to those 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.

15. 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.

16. 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.

17. 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 shall mean that we will provide more benefits than those described in your *contract.* If you have questions about COB or your *contract*, please contact our Customer Service Department. The telephone numbers are listed at the end of the Subscriber's certificate.

18. LEGAL ACTIONS

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

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 reason(s) 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. TIME LIMIT OF FILING CLAIMS

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.

4. WHEN YOU FILE A CLAIM

When you file a claim for the services of a *non-panel dentist* who is a *non-participating dentist*, the following rules apply.

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

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

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

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

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

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

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

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

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

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

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

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
BENEFITS PAYABLE RIDER 2

To be attached to and form a part of your Delta Dental Premier Individual Dental Insurance Policy

Benefits for the covered services **for members under age 19** in your Delta Dental Premier Individual Dental Insurance Policy are reimbursed as set forth below. The covered services and frequency limits described in this Rider supersede those in your Delta Dental Premier Individual Dental Insurance Policy.

DEDUCTIBLES

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each plan 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 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.
Medically Necessary 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 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 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

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

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
Commonwealth of Massachusetts
as a Non-Profit Organization

CORP SIG RIDER- Dental Services of MA

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).