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

Subscriber's Certificate for Delta Dental Individual and Family

*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.

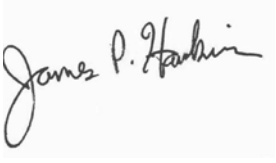
Pre-existing conditions - Dental expenses incurred in connection with any dental procedure started prior to coverage are excluded. No benefits are available for the replacement of teeth missing prior to the member's effective date of coverage.

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.

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: DSM Massachusetts Insurance Company, Inc.

Steven Pollock
President & CEO



James Hawkins
Corporate Clerk

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

Table of Contents

Member Rights and Responsibilities

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

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

خدمات ترجمة فورية/ترجمة

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

អ្នកបកប្រែ ឬកិច្ចការបកប្រែ

បើអ្នកស្នើឱ្យមានអ្នកបកប្រែ និងកិច្ចការបកប្រែដែលជាប់ទាក់ទងទៅនឹង
វិធីចាត់ចែងការ យើងមានផ្តល់ជូន ។

翻譯服務

如果您提出請求 ，我們可以為您提供協助辦理行政手續的翻譯服務 。

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

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

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

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

ບໍລິການນາຍພາສາ/ຕປຕອກະສານ

ຖ້າທ່ານຮ້ອງຂໍ, ຈະມີບໍລິການນາຍພາສາຕລະຕປຕອກະສານ ໃຫ້ກັບທ່ານ ສໍາລັບເລື້ອງທີ່ກ່ຽວຂ້ອງກັບຂັ້ນຕອນການບໍລິການ.

Serviços de tradutor(a)/intérprete Se assim o solicitar, estão disponíveis serviços de tradução e interpretação para os procedimentos administrativos.

Услуги устного/письменного перевода
По Вашему требованию будут предоставлены услуги устного и письменного перевода, связанные с административными процедурами.

Servicios de interpretación/traducción Si usted lo solicita, se encuentran a su disposición servicios de interpretación y traducción para asistirle en procedimientos administrativos.

<u>You have the responsibility to:</u>

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

Part I
Delta Dental of Massachusetts
Outline of Coverage - Delta Dental EPO

Policy number:

1. Description of Benefits:

You have the right to benefits for the following services on a non-discriminatory basis, EXCEPT as limited or excluded elsewhere in this *contract*.

The extent of your benefits is explained in the Benefits Payable Rider incorporated as part of this *contract*.

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

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

COVERED SERVICES FOR MEMBERS AGE 19 OR OLDER

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

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

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

2. Periodic oral evaluation; 2 every 12 months.

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

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

5. Single tooth x-rays; as needed.

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

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

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

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

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

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

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

2. Protective Restorations; once per tooth.

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

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

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

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

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

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

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

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

11. Periodontic services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery); one periodontal surgery per quadrant every 36 months. Scaling and root planing once per quadrant per 24 months.

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

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

The Type 3 services described below may not be provided for *covered individuals* age 19 and older depending on the plan under which you are covered. Please consult your Benefits Payable Rider to determine whether individuals age 19 and older are covered for Type 3 services.

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

Crowns and Onlays

Crowns and onlays:

- Initial placement of crowns and onlays.

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

Dentures and Bridges

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

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

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

COVERED SERVICES FOR MEMBERS UNDER AGE 19

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

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

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

2. Periodic oral evaluation; two every 12 months.

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

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

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

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

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

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

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

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

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

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

available for the following dental services to: (i) restore decayed or *fractured* teeth (teeth must have a good prognosis to qualify for benefit); (ii) remove diseased or damaged natural teeth; (iii) treat oral disease (teeth must have a good

prognosis to qualify for benefit); (iv) repair dentures or bridges; (v) rebase or reline dentures; and (vi) repair or recement bridges, crowns and onlays.

1. Fillings consisting of silver amalgam and synthetic tooth color fillings, but limited to one filling for each tooth surface for each 12 month period. However, synthetic (white) fillings are limited to restorations for posterior permanent teeth. Multi-surface synthetic restorations on posterior primary (deciduous) teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentists charge. No benefits are provided for replacing a filling within 24 months of the date that the prior filling was furnished.

2. Protective restorations; once per tooth.

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

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

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

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

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

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

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

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

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

12. Endodontic services for root canal treatment; once per permanent teeth per lifetime including the treatment of the nerve of a tooth, the removal of dental pulp, and

pulpal therapy. Vital pulpotomy is limited to deciduous teeth on covered members. Apicoectomy once per tooth per lifetime.

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

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

Crowns

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 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.

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.

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

3. 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.

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

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

6. 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.

7. 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 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

Connector: means The Commonwealth Health Insurance Connector Authority.

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

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

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

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

***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.

Exclusive Provider Organization(EPO): An organization that requires that members visit panel dentists only; care from non-panel dentists is not covered except in some cases for an emergency. This *contract* provides benefits on an EPO unless an out-of-network benefit option is purchased, in which case the available out of network benefits will be described in Part IV, Paragraph 4 of this *contract* and in the Benefits Payable Rider accompanying this *contract*.

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

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

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

Subscriber: an individual whose name this policy is under.

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

Part III: Limitations and Exclusions

1. WE LIMIT BENEFITS FOR SOME SURGICAL SERVICES

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

   We will not consider coverage:
   - ☐ if 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.
- ☐ Restorations or procedures on teeth that have a poor to hopeless prognosis from a restorative, endodontic or periodontal perspective.
- ☐ Services that are meant primarily to change or to improve your appearance.
- ☐ 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
- ☐ Implants abutements when the surgical implants are not benefited.
- ☐ 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.
- ☐ Tooth desensitization.
- ☐ Occlusal adjustment.

- Surgical or non-surgical procedures around dental implants (including but not limited to antimicrobial agents and soft tissue grafts.
- Gingival irrigation
- Nitrous Oxide for members age 19 or older

Part IV: Other Contract Provisions

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

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

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*

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

      No benefit is payable for services performed by a non-panel dentist, except in the case of emergency care described in paragraph 4.C., below.

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

No benefit is payable for services performed by a non-panel dentist, except in the case of emergency care described in paragraph 4.C., below.

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

C. Emergency Care

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

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 EPO 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 EPO 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 EPO 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 *Delta Dental* invoice, or in accordance with the procedures established by the *Connector*, as applicable.

B. Grace Period: A grace period of 31 days will be granted for the payment of each subscription falling due after the first premium during which grace period the policy shall continue in force. If subscription charges have not been paid within 31 days after the date on which payment is due, *Delta Dental*, upon written notice to you, may terminate this *contract* as of the date to which subscription charges have been paid. If you are receiving advance payments of the premium tax credit under the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended, and you previously paid at least one full month's premium during the *Plan Year*, the grace period is extended to three (3) consecutive months.

If your *contract* is written through the *Connector* and your subscription charges are paid by the *Connector*, the *Connector* will terminate coverage if you are delinquent in payment.

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; provided that your subscription charge will not change more than once every *Plan Year*. 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.

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 unmarried dependent child under your *family contract* reaches their 26th birthday.
C. However, if your unmarried dependent child is either mentally or physically handicapped upon reaching 26 years and is incapable of earning his or her own living, special arrangements can be made for your child to continue coverage under your *family contract*. You must apply for this continued coverage 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. Whenever your dependent child's coverage under your *family contract* ends, the coverage for any offspring of that dependent child also ends.
E. 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.
F. 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.

However, if your *contract* is issued through the *Connector*, you may cancel your contract in the following manner. If you provide us with notice at least fourteen (14) days prior to the proposed effective date of termination, the last day of coverage is the termination date specified by you in the notice of termination. If you provide us with notice less than fourteen (14) days prior to the proposed effective date of termination, the last day of coverage is the date determined by us, if we are able to effectuate termination in fewer than fourteen (14) days and you request an earlier termination

effective date. If you are newly eligible for Medicaid or a Children's Health Insurance Program, the last day of coverage is the day before such coverage begins.

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. 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.

Notwithstanding the above cancellation provision, if your *contract* is issued through the *Connector*, your *contract* will be canceled by the *Connector* and in accordance with the policies and procedures of the *Connector*, or as otherwise agreed to between *Delta Dental* and the *Connector*.

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.

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.

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 *contract*. 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 this *contract*, subject to the COB Regulations. The amount paid by *Delta Dental*, when added to the amount paid by the primary plan, will not exceed the lesser of: 1) the provider's submitted charge, or 2) the amount allowed under your *contract.*

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.

19. CONFORMITY WITH STATE STATUTES

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

20. EMERGENCY MEDICAL CONDITIONS

Nothing in this *contract* will prohibit a *covered individual* from seeking emergency care whenever the individual is confronted with an *emergency medical condition*, which in the judgment of a prudent layperson would require pre-hospital emergency services. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent. A *covered individual* shall not be discouraged from using a local pre-hospital emergency medical service system, the 911 telephone number or the local equivalent. No *covered individual* shall be denied coverage for medical and transportation expenses incurred as a result of an *emergency medical condition*. For purposes of this provision, an "emergency medical condition" is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B).

21. INVOLUNTARY DISENROLLMENT RATE:

Delta Dental will annually notify you of the involuntary member disenrollment rate. For purposes of this provision "involuntary disenrollment" means termination of coverage due to any of the reasons contained in 10.B.a) or 10.B.e) of this Part IV.

22. QUALITY ASSURANCE

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

The Quality Management Program addresses the following standards

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

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

effectiveness.

23. UTILIZATION REVIEW

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

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

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

When a claim has been denied or partially denied based on medical appropriateness, this is considered an adverse determination. These decisions are reviewed by qualified and appropriately licensed health professionals and only after receiving any relevant clinical information necessary to make the decision.

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

Attention: Customer Service
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129
By telephone:1-800-872-0500 website:www.deltadentalma.com

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

   B. Delta Dental EPO Non-panel Dentists: If you use a *Delta Dental EPO 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 EPO Panel Dentist or a Delta Dental EPO 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 EPO 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 EPO 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

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

Delta Dental Individual and Family EPO Basic Exclusive Network Plan
Benefits Payable Rider

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

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

DEDUCTIBLES

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

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

COVERED SERVICES FOR MEMBERS AGE 19 OR OLDER

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

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

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

2. Periodic oral evaluation; 2 every 12 months.

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

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

5. Single tooth x-rays; as needed.

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

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

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

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

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

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

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

2. Protective Restorations; once per tooth.

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

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

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

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

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

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

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

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

11. Periodontic services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery); one periodontal surgery per quadrant every 36 months. Scaling and root planing once per quadrant per 24 months.

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

COVERED SERVICES FOR MEMBERS UNDER AGE 19

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

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

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

2. Periodic oral evaluation; two every 12 months.

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

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

5. Single tooth x-rays; maximum of four per visit and not more than 12 per 12 months.

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

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

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

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

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

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

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

1. Fillings consisting of silver amalgam and synthetic tooth color fillings, but limited to one filling for each tooth surface for each 12 month period. However, synthetic (white) fillings are limited to restorations for posterior permanent teeth. Multi-surface synthetic restorations on posterior primary (deciduous) teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentists charge. No benefits are provided for replacing a filling within 24 months of the date that the prior filling was furnished.

2. Protective restorations; once per tooth.

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

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

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

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

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

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

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

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

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

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

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

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

Crowns

- Initial placement of crowns.

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

Dentures and Bridges

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

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

D. Medically Necessary Orthodonture

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

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

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

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

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

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

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

OUT-OF-NETWORK SERVICES:

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

OUT-OF-STATE DENTIST SERVICES

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

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

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

Fay Donohue
President and CEO, DSM

DSM Massachusetts Insurance Company, 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

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- DSM

NONDISCRIMINATION NOTICE

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

Delta Dental of Massachusetts:

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

If you need these services, visit: http://www.deltadentalma.com or call the number on your member ID card.

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

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

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

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

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

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

Foreign Language Assistance

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