Subscriber's Certificate
Delta Dental EPO
Individual Dental Insurance Policy

*Delta Dental** certifies that *you* have the right to benefits for services according to the terms of this policy.

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

***Your* Right to Examine This Policy:** *Your* satisfaction is our number-one priority. *You* have the right to examine this policy for 10 business days from the date of delivery. Should this policy not meet *your* needs, please notify *us*, within 10 business days, with a letter telling *us* of *your* intent to cancel. *You* will receive a full refund of all premiums paid towards the cancelled policy, and *your* policy will be void from its *effective date*. *We* will subtract from the refund any payments made for claims under this policy. If *we* have paid more for claims under this policy than *you* have paid to *us* in premium charges, *we* have the right to collect the excess from *you*.

This policy includes coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act. It will only be offered when the carrier is reasonably assured that an applicant is covered by a plan with the required level of coverage of pediatric dental services.

Pre-existing conditions: There are no preexisting condition limitations under the policy.

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 III, Section 10.B of this policy.

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Delta Dental Individual and Family EPO Pediatric

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 is endorsed or attached here. No agent has authority to change this policy or to waive any of its provisions.

ATTEST: DSM Massachusetts Insurance Company, Inc.



Erik Montlack
President

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

This policy, together with the Outline of Coverage (including the *schedule of benefits*), *your* application, and any additional applicable Riders, Endorsements, and Amendments constitutes *your* entire contract. *We* urge *you* to read it carefully.

Please note that words in *italics* are listed in the "Definitions" section in Part I of this policy.

This policy includes four types of services:

Type 1 includes services to prevent or detect tooth decay and other forms of oral disease.

Type 2 includes services to: (i) restore decayed or *fractured* teeth; (ii) remove diseased or damaged natural teeth; (iii) treat oral disease; (iv) repair dentures or bridges; (v) rebase or reline dentures; and (vi) recement bridges, crowns and onlays.

Type 3 includes services and supplies to: (i) replace missing natural teeth with artificial ones and (ii) restore severely decayed or *fractured* teeth.

Type 4 includes *Medically Necessary Orthodonture* as outlined in *your schedule of benefits*.

The dental services described in this policy are covered immediately as of *your effective date*, unless *your* benefits are subject to a *waiting period*. *You* are entitled to these benefits on a **non-discriminatory basis**, including those benefits that are mandated by applicable state or federal law.

Additionally, there are some limitations or restrictions on *your* benefits, which are found throughout this policy, including but not limited to *your schedule of benefits*, as well as in Part III, the "Other *Contract* Provisions" section of this policy.

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

Notices

NONDISCRIMINATION NOTICE

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or any other protected class recognized under applicable state or federal law. *Delta Dental* does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or any other protected class recognized under applicable state or federal law.

Delta Dental:

- 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 at the end of this *contract*.

If *you* believe that *Delta Dental* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, or any other protected class recognized under applicable state or federal law *you* can file a *grievance* with:

Senior Director of Governance, Risk and Compliance
Compliance Department
465 Medford Street, Suite 400
Boston, MA 02129
Phone: 617-580-2028
Email: privacy@deltadentalmass.com TTY: 711

You can file a *grievance* in person or by mail, fax, or email. If *you* need help filing a *grievance*, *our* Civil Rights Coordinator 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)

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, *we* need to obtain information about *you* and any other person proposed for insurance. Some of that information will be received from *you*, and some will be generated from other sources. That information and any subsequent information collected by *us* may in certain circumstances be disclosed to our third party business partners for the purposes related to our services, marketing, or other business functions, without *your* specific authorization.

You have the right of access and correction with respect to all information collected about *you*. The obligations imposed by M.G.L. Ch. 175I § 4 (c)-(e) upon an insurance institution or insurance representative may be satisfied by another insurance institution or insurance representative authorized to act on its behalf. Information collection and disclosure authorized pursuant M.G.L. Ch. 175I § 4 (c)-(e) is limited to the practices described in the notice issued or available pursuant to this section.

For more information on how *we* use *your* information, please also see https://deltadentalma.com/privacy-policy (For HIPAA/PHI Data collection and disclosure) and https://deltadentalma.com/privacy-policy (for data that is not PHI but data from people when accessing the *Delta Dental* websites).

If *you* wish to have a more detailed explanation of *our* information practices, please contact Delta Dental of Massachusetts, 465 Medford Street, Suite 400, Boston, MA 02129.

Member Rights and Responsibilities

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

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

You have the responsibility to:

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

DELTA DENTAL

Language assistance

ATTENTION: If you speak English, language assistance is available at no cost. Call 800-872-0500 (TTY: 844-233-4524).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-872-0500 (TTY: 844-233-4524).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-872-0500 (TTY: 844-233-4524).

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 800-872-0500 (TTY: 844-233-4524)。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-872-0500 (TTY: 844-233-4524).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-872-0500 (TTY: 844-233-4524).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-872-0500 (TTY: 844-233-4524).

تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل بالرقم 800-872-0500 (الهاتف النصي: 4524-233-844).

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। 800-872-0500 (TTY: 844-233-4524).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-872-0500 (ATS: 844-233-4524).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-872-0500 (TTY: 844-233-4524).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-872-0500 (TTY: 844-233-4524). 번으로 전화해 주십시오.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 800-872-0500 (TTY: 844-233-4524).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-872-0500 (TTY: 844-233-4524).

ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 800-872-0500 (TTY: 844-233-4524). पर कॉल करें।

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-872-0500 (TTY: 844-233-4524).

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Part I: Definitions

Adverse determination: A decision not to authorize a health care service, including a denial, reduction, or termination of, or a failure to provide or make a payment, in whole or in part, for a benefit. A decision by a utilization review agent to authorize a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision.

Benefit determination: A decision to approve or deny a request to provide or make payment for a health care service or treatment.

Connector: means The Commonwealth Health Insurance Connector Authority.

Contract: this policy, together with the attached Outline of Coverage (which includes *your schedule of benefits*)*, your* application, and any additional applicable Riders, Endorsements, and Amendments. The word "*contract*" may also be referred to as "plan" throughout this *contract*.

Covered individual or member: a person who receives dental benefits from *Delta Dental* pursuant to a *contract*, usually including *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 *member* must pay each *plan year* before the plan's payment begins. *Your* deductible amount can be found on *your schedule of benefits.*

Delta Dental: DSM Massachusetts Insurance Company, Inc., doing business as *Delta Dental* of Massachusetts. The term "*Delta Dental*" may also be referred to as "we", "us", or "our" throughout the *contract*.

Dentist: a licensed *dentist* legally authorized to practice dentistry, at the time and in the place services are performed. This *plan* provides for covered services only if those services are performed by or under direction of a licensed *dentist* or Other Dental Provider operating within the scope of their license. See also the "Other Dental Providers" provision in Part III, "Other *Contract* Provisions", in this *contract*.

Delta Dental EPO non-panel dentist: a dentist who has signed an agreement with *Delta Dental* but has not agreed to accept Delta Dental EPO panel dentist allowances for services rendered on member(s) in the *Delta Dental* EPO plan.

Delta Dental EPO panel dentist: a dentist who has signed an agreement with *Delta Dental* to accept reimbursement based on established Delta Dental EPO panel dentist allowances for services rendered on member(s) enrolled in the *Delta Dental* EPO plan.

Effective date: the date, as shown on *our* records, when *your* coverage begins under this *contract*.

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

Family contract: A contract that includes the *subscriber*, the *subscriber's* spouse or registered domestic partner and the domestic partner's eligible dependent children and/or the *subscriber's* dependent children up to the maximum dependent age required by applicable law or listed in *your schedule of benefits*, whichever is later. A family contract also includes dependents required under state or federal law, including but not limited to adopted children, or children under the *subscriber's* or the *subscriber's* spouse's legal guardianship.

Grievance: any oral or written complaint submitted to *Delta Dental* that has been initiated by a *member*, or on behalf of a *member* with the consent of the *member*, concerning any aspect or action of *Delta Dental* relative to the *member* including, but not limited to, review of *adverse determinations* regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 958 CMR 3.000: Health Insurance Consumer Protection.

Inquiry: any communication by or on behalf of a *member* that has not been the subject of an *adverse determination* and that is not a *grievance.*

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 Massachusetts Division of Insurance for this *contract* and the terms and conditions of this *contract* 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.

Non-Participating Dentist: a *dentist* registered under Massachusetts G.L.c. 112, §§ 45, 48 or any fully registered or licensed *dentist* in any other jurisdiction who has not entered into an agreement with *Delta Dental* to furnish services to its *members under its exclusive provider organization arrangement.* The term "non-participating dentist" may also be referred to as "out-of-network".

Participating dentist: a *dentist* registered under Massachusetts G.L.c. 112, ss. 45, 48 or any fully registered or licensed *dentist* in any other jurisdiction and who has entered into an agreement with *Delta Dental* to furnish services to its *members under its exclusive provider organization arrangement.* The term "participating dentist" may also be referred to as "in-network".

Plan: means the terms, conditions and benefits described in this *contract*.

Schedule of benefits or benefit schedule: the part of the *subscriber's contract* which outlines the specific coverage in effect as well as the amount, if any, that *you* may be responsible for paying towards *your* dental care. *Your* schedule of benefits, which is a part of the *subscriber's contract*, also includes limitations and exclusions that apply to *your* dental plan. Your schedule of benefits can be found in the Outline of Coverage section of this *contract*.

Schedule of maximum covered charges: the payment amount that *Delta Dental* sets for the services that may be provided under *your contract* and is on file with the Commissioner of Insurance. Benefits are payable in accordance with the terms and conditions of *your schedule of benefits* attached to this policy and in effect at the time services are rendered.

Subscriber: An individual whose name this policy is under.

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

***You* and *yours*:** means the *member*.

IMPORTANT NOTE: This policy is one part of *subscriber's contract* with *Delta Dental*. Additional definitions can also be found in *your* Outline of Coverage, as applicable, which is another part of *your contract*.

Make sure *you* have a copy of *your* Outline of Coverage.

Part II: Limitation and Exclusions

See the *Schedule of Benefits* in the Outline of Coverage for details on the limitations and exclusions that apply to this *contract*.

Part III: Other *Contract* Provisions

1. OTHER DENTAL PROVIDERS

Delta Dental permits benefits under this *contract* to be provided by Other Dental Providers (ODPs), such as dental hygienists, who are authorized or licensed under applicable state law and/or regulations to deliver dental care or treatment to patients independently, without the presence or supervision of a *dentist*. In such cases, all references to "*dentist*" in this *contract* are hereby intended to also include these Other Dental Providers.

2. BENEFIT PAYMENTS FOR SERVICES BY A *PARTICIPATING DENTIST*

The amount of *coinsurance* and *deductibles*, if any, that *you* may be required to pay *your participating dentist* is explained in *your schedule of benefits*. Payments are made directly to a *participating dentist* from *Delta Dental*.

A. **Massachusetts Participating Dentists**
The In-Network benefit allowance is based on the *Delta Dental* EPO contracted allowance or the dentist's submitted fee if lower.

B. Out-of-State Participating Dentists
For service performed by out of state *Delta Dental* EPO *panel dentists*, the In Network benefit allowance is based on the *Delta Dental* PPO contracted allowance or the dentist's submitted fee if lower.

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

When *your participating dentist* provides covered services based on the *Delta Dental* EPO contracted allowance, 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 a treatment when *you* have already exhausted *your* maximum or *you* received a treatment, which will cause *you* to exceed *your* maximum benefit allowed for services, *you* may be billed at *Delta Dental's* negotiated rate. An example of when *you* may be billed at *Delta Dental's* negotiated rate is if you exceed the maximum dollar amount for a *member* in a *plan year*. To avoid any unexpected out of pocket expenses, *you* can visit *Delta Dental's* web site, www.deltadentalma.com, or call Customer Service to determine *your* remaining benefits.

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

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

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

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

4. PRE-TREATMENT ESTIMATES

If *your* dental treatment is expected to involve a series of covered services (over $300), *you* or *your dentist* should file a copy of the treatment plan with *Delta Dental* BEFORE these services are rendered to a *member*. A treatment plan is a detailed description of the procedures that the *dentist* plans to perform and includes an estimate of the charges for each service.

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

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

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

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

A. **Massachusetts *Non-participating Dentists***

For services performed by a non-participating dentist, the benefit for each type of service will be based on the maximum fee allowance for each state or the dentist's submitted fee if 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.

Any *participating dentist* or *non-participating dentist* may bill *members* for the difference between the *Delta Dental* payment and any amounts that may result from plan specific *deductibles*, *coinsurance*, or amounts in excess of the plan maximums.

B. Out-of-State *Non-participating Dentists*

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

C. Emergency Care

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

6. COVERING WORK IN PROGRESS

For multi-stage procedures (the insertion date of a denture, for example), *Delta Dental* will be responsible for paying the claim if the *date of service* occurred after *your effective date.*

7. TIME LIMIT

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

If benefits are denied because a *Delta Dental EPO panel dentist* or *participating dentist* fails to submit a claim on time, *you* will not be responsible for paying the *dentist* for the portion of the *dentist's* charge that would have been a benefit under *your plan*. *You* will be responsible for *your* relevant *coinsurance* or *deductibles*, if any.

This provision applies only if *you* properly inform *your Delta Dental EPO panel dentist* or *participating dentist* that *you* are a *member* by presenting *your subscriber* identification card. If *you* do not properly identify *yourself* as a *member*, *you* may be responsible for the cost of any services rendered.

8. SUBROGATION

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

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

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

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

If *you* receive services from a *Delta Dental EPO panel dentist* or a *participating dentist* who practices and treats *you* outside Massachusetts, *you* must help *us* obtain all dental records or other related information *we* need. *Delta Dental* will not pay the *dentist* for providing this information in order to determine if those services are covered under this *contract*. If the *dentist* does not provide the required information, *we* may not provide benefits for his or her services. All services provided by a *non-participating dentist* are *your* responsibility and *benefit determinations* will be made based on the benefits available to *you* and information provided to *us* by the *dentist*.

10. PREMIUM PAYMENT

A **Payments**: The amount of money that *you* pay to *us* for *your* benefits under this *contract* is called *your* premium payment. *You* are responsible to pay to *Delta Dental* the total premium 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 28 days will be given for the payment of each payment due after the first premium, during which grace period the policy shall continue in force. If premium payments have not been paid within 31 days after the payment due date, we may end this agreement upon written notice to you, as of the date to which premium payments 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 premium 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 for payment, a subsequent acceptance of premium by *us* or by any agent duly authorized by *us* to accept such premium shall reinstate the policy without requiring an application for reinstatement. However, if *we* or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, *we* will reinstate the policy upon *our* approval of such application or, without such approval, on the 45th day following the date of such conditional receipt unless *we* have previously notified the *subscriber* in writing of our 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 thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provision endorsed here or attached here 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 60 days before the date of reinstatement.

D. Changes: *We* may change *your* premium. Each time *we* change the premium, *we* will send *you* a notice at least 30 days before the effective date of change.

11. *WE* MAY CHANGE THE *SUBSCRIBER'S CONTRACT*

Delta Dental shall issue and deliver to the *subscriber* prior notice of material modifications in covered services under this *contract* at least 60 days before the effective date of the modifications, unless a shorter time is required by applicable law. *Delta Dental* will determine in its discretion which changes are considered material modifications. *We* are required to notify the *subscriber* of this change.

In addition to the notice describing the change being made, *you* can also call *our* Customer Service department to get information on *your* plan change. The telephone numbers are listed at the end of this policy.

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

12. WHEN *YOUR* COVERAGE BEGINS

The *subscriber is* responsible for maintaining with *Delta Dental* an accurate and up-to-date list of covered *members* with *Delta Dental*.

The *subscriber* is responsible for informing *us* when the *subscriber's* dependents are eligible as a *member* under this *contract*. This eligibility is based upon *Delta Dental's* underwriting guidelines. The dental services described in this *contract* are covered immediately as of *your effective date*, unless *your* benefits are subject to a *waiting period* or there exist some limitations or exclusions on *your* membership which may also be found in the *schedule of benefits,* which is part of this *contract.*

Those *members* covered under a *family contract* are eligible for coverage as outlined in *the schedule of benefits*. Certain dependent children required to be covered under state or federal law, who are over the maximum dependent age listed in *your schedule of benefits*, may be eligible to continue coverage under a *family contract* if *Delta Dental* is notified within 72 days of the child reaching maximum dependent age, and if *you* complete a disabled dependent application. 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*.

13. WHEN *YOUR* COVERAGE ENDS

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

1. The *subscriber* is no longer enrolled in the *plan*.
2. The *subscriber's* dependent child under *your Family Contract* reaches his or her 26th birthday. If the *subscriber's* dependent child is either mentally or physically handicapped upon reaching 26 years and is not capable of earning his or her own living, the child can continue coverage under *your Family Contract* through special arrangements. The *subscriber* must apply for this coverage within 72 days of the child's 26th birthday. Also, the *subscriber* must supply *us* with any medical or other information that we may need to determine if the *subscriber's* child is eligible to continue coverage under *your Family Contract*.
3. If the *subscriber* becomes divorced or legally separated, the *subscriber's* spouse's coverage under an existing family membership will continue so long as the *subscriber* remains a s*ubscriber* of *Delta Dental*, unless a court judgment provides otherwise. This coverage will continue until either the *subscriber* or the *subscriber's* spouse remarries, or until the date of coverage termination stated in the judgment of divorce or separation, whichever is earlier. If the *subscriber* remarries and *the subscriber's* divorce judgment so provides, the *subscriber's* former spouse will have the right, for an additional premium, to continue to receive such benefits as are available to the *subscriber* by means of the issuance

of an individual plan. *Delta Dental* may request a copy of the *subscriber's* divorce decree in order to aid with activities related to coordination of benefits. This provision shall apply to any policy issued or renewed within or without the Commonwealth and which covers residents of the Commonwealth.

4. The *subscriber* is no longer a Massachusetts resident.

14. TERMINATION OF A *CONTRACT* AND DISENROLLMENT

This section explains the criteria by which *your contract* may be terminated.

A. The *subscriber* may cancel the *contract* for any reason. To do so, the *subscriber* must give *us* notice in writing at least 30 days prior to the termination date. If the *subscriber* cancels the *contract*, the *subscriber* must wait at least one year after the cancellation date before the *subscriber* can apply for a new policy. However, if the contract is issued through the *Connector*, the *subscriber* may cancel the *contract* in the following manner. If the *subscriber* provides *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 the *subscriber* in the notice of termination. If the *subscriber* 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 the *subscriber* requests an earlier termination effective date. If the *subscriber* is newly eligible for Medicaid or a Children's Health Insurance Program, the last day of coverage is the day before such coverage begins.

   If the *subscriber's* premium is paid for a period beyond *your* cancellation date, *we* will refund the premium for that period to the *subscriber* provided no claim payments have been made for services rendered after the termination date.

B. *We* may cancel *your contract*.
   We may cancel your *contract* if the *subscriber* has not paid the *subscriber's* premium. Cancellation will be effective on a date *we* choose, but not earlier than the premium due date. The *subscriber* will owe *us* the premium due for the period between the due date and the termination date.

   We may also, upon due notice to the *subscriber*, 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 which led *us* to believe *you* were eligible for this coverage when in fact *you* were not. In such a case, termination will be as of *your effective date*. *We* will refund the *subscriber* the premium the *subscriber* has 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 the *subscriber* has paid us in premium, *we* have the right to collect the excess from the *subscriber*.

b) *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.

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

d) *We* may cancel *your Contract* if *you* are no longer a resident of Massachusetts.

If we cancel *your contract*, a written notice will be sent to the *subscriber's* last known home address. The notice will include the date *your contract* was terminated and that *we* will honor dental services that are covered under the *contract* for covered *members* prior to the effective date of the termination.

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*.

Time Limit on Certain Defenses: After 2 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 2-year period. After this policy has been in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements 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.

15. BENEFITS AFTER TERMINATION

If the *subscriber* terminates this *contract* no benefits will be provided for services that *you* receive after *your* termination date.

If *we* terminate this *contract* for any reason other than for a fraudulent claim or misrepresentation, *we* will continue to provide benefits only if before the termination 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* termination date for services related to that procedure. If *you* have purchased benefits for orthodontic services, the policy of continuing benefits will not apply to these orthodontic services.

16. NOTICES

A. To the *subscriber*: *We* will send notices to the *subscriber* including, but not limited to, notices for changes in premium charges as well as notice for any changes in the *contract*.

B. To *us*: Send letters or inquiries to Delta Dental of Massachusetts, Suite 400, Boston, Massachusetts 02129. Always include *your* name and *Delta Dental subscriber* identification number.

17. ENROLLMENT AND *CONTRACT* CHANGES

All enrollment forms and any additions or changes to a *contract* are allowed ONLY when they conform to *our* underwriting guidelines as approved by the Massachusetts Division of Insurance.

18. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after the *effective date* of this *contract*.

In order for *you* to receive any of the benefits for which *you* may have a right, *you* must inform *your dentist* that *you* are a *member* and supply him or her with *your Delta Dental subscriber* identification number and any necessary information needed to file *your claim*. If *you* do not properly identify yourself as a *member* within 12 months after the services are rendered, *we* will no longer be obligated to provide any benefits for those services.

Emergency Care:

Nothing in this *contract* will prohibit a *member* from seeking emergency care whenever the individual is confronted with an *emergency medical condition*. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent.

19. *WE* ARE NOT RESPONSIBLE FOR THE ACTS OF *DENTISTS*

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

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

20. COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies if *you* have another plan that provides coverage for services that are benefits under the *subscriber's contract*. *Delta Dental* will administer the COB according to the applicable state Coordination of Benefits law (including the provisions of the Massachusetts Division of Insurance's regulations regarding COB, the "COB Regulations") and this *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 known as the primary plan. The primary plan is responsible for providing benefits in accordance with its terms and conditions of coverage without regard to coverage under any other plan. The plan that provides benefits next is the secondary plan. It provides benefits toward any remaining balance for covered services in accordance with its terms and conditions of coverage, including its COB provision.

When this *contract* is the secondary plan, *we* will provide benefits toward the remaining balance for covered services after coverage is provided by the primary plan These benefits are determined by the terms of this *contract*, subject to the COB Regulations.

> IMPORTANT: No statement in this section should be interpreted to mean that *we* will provide any more benefits than those described in this *contract*. If *you* have any questions about COB and this *contract*, please contact *our* Customer Service department. The telephone numbers are listed at the end of this *contract*.

21. RIGHT TO RECOVER OVERPAYMENTS

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

22. LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 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 3 years after the time written proof of loss is required to be furnished.

23. 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 *subscriber* resides on such date is hereby amended to conform to the minimum requirements of such statutes.

24. OFFICE OF PATIENT PROTECTION

You can contact the Office of Patient Protection in Massachusetts at 50 Milk Street, 8th Floor, Boston, MA 02109 or via phone at 800-436-7757.

25. 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 the *subscriber's contract* can be done either retrospectively or at the time a claim for services has been submitted for reimbursement or payment. In order for a submitted claim to be covered, the procedure must be included as one of the covered services in the *subscriber's contract*. If a procedure is not a covered service then the claim for that service will be denied in accordance with the terms of the *subscriber's contract*. Coverage of certain procedures may also be limited by frequency, age, effective dates of coverage, etc. Please refer to this *contract* and *your schedule of benefits* for more information on *your* coverage.

All claims are processed within 30 working days of *us* obtaining all necessary information. For all claims submissions *your dentist* will receive an explanation of benefits that details how each submitted procedure was reimbursed and/or the reason for denial. For all claims where there is a *member* financial responsibility, the *member* will also 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*, to determine the status or outcome of a decision with *Delta Dental*, *you* can submit *your inquiry* to *us*:

In writing:

Delta Dental of Massachusetts
465 Medford Street, Suite 400
Boston, Massachusetts 02129

By telephone: 800-872-0500

web site: www.deltadentalma.com

26. *GRIEVANCE* PROCESS:

Delta Dental will accept *grievances* by telephone, by mail, or by electronic means.

Delta Dental will assign a *grievance* to a Complaints & Grievances Specialist who will ensure that a person who is (or persons who are) knowledgeable about the matters at issue in the *grievance* review the matter. The Complaints & Grievances Specialist will provide the *member* with a written resolution of a *grievance* within 30 business days of receipt. The written resolution will identify the specific information considered and an explanation of the basis for the decision.

Delta Dental will establish a system for maintaining records of *grievances* and responses to g*rievances* and will maintain the records for a period of seven years.

27. APPEAL OF AN *ADVERSE DETERMINATION*

How to file an appeal:

You have a right to appeal an *adverse determination* under this *contract*. *You* may appeal an *adverse determination* by submitting a written request for appeal to *Delta Dental.*

In writing:

Delta Dental of Massachusetts
465 Medford Street, Suite 400
Boston, Massachusetts 02129

By telephone: 800-872-0500

web site: www.deltadentalma.com

Delta Dental receives an appeal on the earlier of (a) the date *Delta Dental* begins to process the appeal or (b) three business days after the date on which the appeal is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope addressed to the above name and address. The postmark on any such envelope will be proof of the date of mailing.

Submission of Comments and Other Information:
You have the right to submit documents, written comments, or other information in support of an appeal.

Appeal Deadline:
You must file an appeal of an *adverse determination* or decision to uphold an adverse decision after an appeal (an "Upheld Denial") within 180 days following *your* receipt of the notice of original *adverse determination* or notice of Upheld Denial, as applicable. Failure to comply with this deadline may cause *you* to forfeit any right to any further review of an *adverse determination* or Upheld Denial under this *contract* or in a court of law.

Number of Appeals:
The number of appeals *you* are permitted to make depends on whether the *adverse determination* is based on a contractual limitation or a scientific or clinical determination.

In the event that an *adverse determination* is made on the basis of a contractual limitation, *you* may appeal such an *adverse determination* once.

In the event that an *adverse determination* is made on the basis of a scientific or clinical determination, *you* may appeal such *adverse determination*. If, upon review, *Delta Dental* denies *your* appeal, then *you* may appeal the Upheld Denial, which results in *you* having a total of two appeals following the initial *adverse determination.*

Part IV: Filing a Claim

EXPLANATION OF BENEFITS

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

WHO FILES A CLAIM

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

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

WHEN *YOU* FILE A CLAIM

When *you* file a claim for the services of a *Delta Dental EPO non-panel 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 a *member* to *us* at *Delta Dental's* main office or to any authorized agent of the *subscriber*, with information sufficient to identify the *subscriber*, shall be deemed notice to *Delta Dental*.

You must 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*; (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 *contract*.

Claim forms: *You* 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 *us* at our 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 *we* are 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 *participating dentists.* Claim payments for services performed by *non-participating 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 *contract*.



Delta Dental of Massachusetts
465 Medford Street
Suite 400
Boston, MA 02129

Customer Service:
800-872-0500

web site: www.deltadentalma.com

DELTA DENTAL

Outline of Coverage

Delta Dental Individual and Family EPO Pediatric
***Benefit Schedule*, Limitations, and Exclusions**

This plan is available for members under age 19.

		In-Network *Participating Dentist*			Out-of-Network *Non-Participating Dentist*		
Service Type	**Benefit Description**	***Delta Dental* Pays**	***You* Pay**	**Waiting Period**	***Delta Dental* Pays**	***You* Pay**	**Waiting Period**
1	Diagnostic and Preventive Services	100%	0%	None	80%	20%	None
2	Restorative and Other Basic Services	75%	25%	None	55%	45%	None
3	Prosthodontic and Other Major Services	50%	50%	None	30%	70%	None
4	Orthodontic Services	50%	50%	None	30%	70%	None

Plan Year Deductible	**In-Network**	**Out-of-Network**
Individual *Deductible*	$50	
Applies To	Type 2, Type 3	
One Individual *Deductible* applies to covered dental expenses received from both In-Network *dentists* and Out-of-Network *dentists*		

Maximums (per *Member*)	**In-Network**	**Out-of-Network**
Plan Year Maximum	Not applicable	Not applicable

Out of Pocket Maximum per *Plan Year*	**In-Network**	**Out-of-Network**
For each *Member* under age 19	$350. Limited to $700 per family	Not applicable

DSM Massachusetts Insurance Company, Inc., doing business as Delta Dental. 465 Medford Street, Suite 400, Boston, MA 02129 800-872-0500

Outline of Coverage for members under age 19

Service Type	Service Description	Service Limitations for *members* under age 19	In-Network *Delta Dental* Pays	Out-of-Network *Delta Dental* Pays
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 *members* receive during a routine preventive dental visit			
1	Comprehensive Oral Evaluation, including initial dental history and charting of teeth	Once per lifetime per provider	100%	80%
1	Periodic oral evaluation	Twice every 12 months	100%	80%
1	Intra oral X-ray image of the entire mouth (Full Mouth Series or Panoramic image)	Once every 36 months	100%	80%
1	Intra oral bitewing x-rays (x-rays of crowns of teeth)	Twice every 12 months when oral conditions indicate need	100%	80%
1	Single tooth x-rays; as needed	Maximum of 4 per visit and no more than 12 per 12 months	100%	80%
1	Routine cleaning, scaling and polishing of teeth	Twice every 12 months	100%	80%
1	Fluoride treatment	Once every 3 months	100%	80%
1	Space maintainers required due to the premature loss of teeth and not for the replacement of primary or permanent anterior teeth	Once per arch or quadrant, per lifetime	100%	80%
1	Limited oral evaluation problem focused exams	Twice every 12 months	100%	80%
1	Sealants for unrestored permanent molars	Once per tooth per 36 months	100%	80%
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			
2	Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings. Synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth are treated as alternate benefit and amalgam allowance granted. The patient is responsible for the difference between the amalgam filling and the Delta Dental negotiated fee for synthetic fillings, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for white fillings	Limited to one filling for each tooth surface for each 24 month period	75%	55%

Service Type	Service Description	Service Limitations for *members* under age 19	In-Network *Delta Dental* Pays	Out-of-Network *Delta Dental* Pays
2	Placement of interim direct restoration	Covered once per tooth	75%	55%
2	Stainless steel crowns on primary teeth	Once per tooth every 24 months. No more than 4 per date of service	75%	55%
2	Certain surgical services to treat oral disease or injury. This includes simple tooth extractions and extractions of impacted teeth	Covered once per tooth	75%	55%
2	Periodontic services on natural teeth only		75%	55%
	Non-surgical procedures	Once per quadrant every 24 months		
	Surgical procedures	Once per quadrant every 36 months		
2	Endodontic services		75%	55%
	Root canal therapy	Once per tooth per lifetime		
	Vital pulpotomy	Limited to once per each primary tooth		
	Apicoectomy	Once per tooth per lifetime		
	Retreatment root canal therapy	Covered once in a lifetime per tooth after 24 months of initial root canal therapy		
2	General Anesthesia when necessary and appropriate for: • The removal of impacted teeth	Covered	75%	55%
2	Palliative dental treatments to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm	Covered. Not covered with other exam codes on the same *date of service*	75%	55%
2	Repair of dentures	Covered. Not a covered benefit within 6 months of insertion	75%	55%
2	Repair of fixed bridges	Covered. Not a covered benefit within 6 months of insertion	75%	55%
2	Recementing of fixed bridges	Covered. Not a covered benefit within 6 months of insertion	75%	55%
2	Rebase or reline of dentures	Once per denture per 24 months, after 6 months of initial placement	75%	55%
2	Repair crowns	Covered after 6 months of initial crown insertion	75%	55%
2	Recement crowns	Covered after 6 months of initial crown insertion	75%	55%
2	Adding teeth to existing partial or full dentures	Covered after 6 months of initial denture insertion	75%	55%

Service Type	Service Description	Service Limitations for *members* under age 19	In-Network *Delta Dental* Pays	Out-of-Network *Delta Dental* Pays
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:			
3	Inlays – Metallic, porcelain and composite resin inlays	Once per 60 months Inlays will be treated as an alternate benefit and will have an amalgam allowance reimbursed		
3	Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them	Once every 84 months	50%	30%
3	Replacement of dentures and fixed bridges	When they cannot be made serviceable and were installed at least 84 months before replacement	50%	30%
3	Interim partial dentures as follows: • To replace any of the six upper or lower front teeth • Only if installed immediately following the loss of teeth during the period of healing	Covered	50%	30%
3	Crowns and Onlays on permanent teeth only for members 12 years and older, but only when the teeth cannot be restored with the fillings described as a Basic Benefit due to severe decay or fractures. Teeth must have a good prognosis to qualify for benefits		50%	30%
	• Initial placement of crowns	Once every 60 months		
	• Replacement of crowns	Once every 60 months		
3	Post and core or crown buildup on permanent teeth only when needed to retain a crown on a tooth with excessive breakdown due to caries and/or *fractures*. Only covered for members 12 years or older	Covered every 60 months per tooth	50%	30%
4	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	Prior authorization is required to qualify for coverage Authorization will only be given to new cases and not takeover cases	50%	30%

*The HLD score used to determine whether a *member* qualifies for coverage is based on *Delta Dental's* calculation and not the score of the treating *dentist*

***Your Plan Year*:**

Your *plan year* is based on a calendar year. Each year, it begins on January 1st and ends on December 31st. Also referred to as "Benefit Period".

Maximum dependent age:

Under *your family contract*, your dependent children are covered to age 26. NOTE - This dependent child age limit will be automatically amended if required by applicable law.

Involuntary Disenrollment Rate

Delta Dental's involuntary disenrollment rate, excluding all administrative disenrollments, members who are disenrolled because they moved out of the service area, members whose continuation of coverage expired, former dependents who no longer qualify as dependents, members who lose coverage under an employer sponsored plan because they have ceased employment or because their employer group canceled coverage under the plan, reduced number of hours worked, or became disabled, retired, or died, equaled less than .001% for the previous calendar year.

Definitions:

Annual maximum benefit: the maximum dollar amount paid for covered services for each *member* in a *plan year*.

Coinsurance: the amount that you are obliged to pay for covered services after you satisfy any applicable *Deductible*. *Coinsurance* is typically a percentage of the charge or *allowable charge* for a service rendered and appears in the *Benefit Schedule* table above.

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

Out of Pocket Maximum: This is the maximum *you* will pay in *deductibles*, copays and *coinsurance* for allowable expenses in the *plan year*.

Plan Year: A consecutive 12-month period during which *you* receive benefits under this *contract*. A *plan year* may or may not correspond with a Calendar Year (January 1 through December 31st).

IMPORTANT NOTE: This *benefit schedule* is one part of your *plan sponsor's contract* with *Delta Dental*. Additional provisions and definitions can be found in your *certificate*, which is another part of this *contract*. Please refer to this *benefit schedule*, the *certificate*, and any additional riders and amendments to see all parts of this *contract*.

Limitations

1. *WE* WILL NOT CONSIDER COVERAGE:

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

2. *WE* PROVIDE BENEFITS ONLY FOR NECESSARY AND APPROPRIATE SERVICES

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

A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on:

(1) those teeth that are decayed or *fractured,* or

(2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of *your dentist*.

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

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

Exclusions

We do not provide benefits for:

- A service, supply, procedure, or appliance that is not described as a covered service in this *contract*.
- A service, supply, procedure or appliance or procedure that is not generally accepted as determined by *Delta Dental*. (example: LANAP-Laser Assisted New Attachment Protocol)
- Any procedure rendered in order to save a tooth when it has been determined by *Delta Dental* that there is poor statistical probability that the tooth will survive for 60 months. Poor statistical probability is defined as less than a 70% chance from a restorative, endodontic or periodontal perspective that the tooth will survive. (example: surgical periodontal regenerative procedures to stabilize a tooth loosened due to extensive periodontal disease)
- Incomplete procedures, including partial extractions.
- Any service or supply furnished along with, in preparation for, or as a result of a non-covered service.
- 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 the *subscriber* did not have this *contract*.
- An illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if the *subscriber* did not have this *contract*. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare. *We* will not provide benefits if *you* could have received government benefits by applying for them within the appropriate agency's time limitation.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or *dentists* who are salaried employees of a hospital or other facility.
- Costs associated with cancellation fees for 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.
- 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*.
- Services that are meant primarily to change or to improve *your* appearance.
- Implants.
- Implant maintenance.
- 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.
- Salivary testing.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Orthodontic services and supplies, except as listed in Benefit Schedule above.
- Interim complete dentures and interim fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing overdentures, including associated endodontic procedures such as root canals.

Exclusions - continued

- Precision attachments, semiprecision attachments or copings.
- Diagnostic photographs, cephalometric films, Surgical access of an unerupted tooth, and placement of devices for an eruption of an impacted tooth (unless your coverage includes orthodontic services).
- The replacement of teeth beyond the normal complement of teeth.
- Gingivectomy to aid to the placement of a restoration.
- Pulp caps.
- Services related to congenital anomalies.
- Tooth desensitization.
- Occlusal adjustment.
- Tooth bleaching procedures.
- Surgical stents, surgical guides for implants.
- Transitional implants and interim abutments.
- Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomies, root amps, ridge augmentations and dental implant placements.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
- Surgical or non-surgical procedures around dental implants (including, but not limited to, antimicrobial agents and soft tissue grafts).
- Gingival irrigation.
- Nitrous Oxide.
- Localized delivery of antimicrobial agents.
- Surgical access of an unerupted tooth and placement of device to facilitate eruption of impacted tooth, unless otherwise specified under Orthodontic Benefits.
- Charges associated with office visits rendered after regular office hours.
- Occlusal orthotic device, retainer and night-guard adjustments.
- Tomosynthesis radiographs.
- 3-D scans.
- Vaccinations.
- Antigen/antibody testing.
- Implant supported dentures.
- Treatment, procedures and appliance to treat sleep apnea.
- Administration on neuromodulators/dermal fillers.
- Cleaning and inspection of removable appliances.
- Dental case management procedures.
- Cosmetic procedures.

Outline of Coverage

Policy number: #129776601

1. Description of Benefits and *Coinsurance* Amounts: See *Schedule of Benefits* section above.
2. The annual maximum: See *Schedule of Benefits* section above.
3. Frequency Limitations: – See Limitations section above.
4. Waiting Periods: See *Schedule of Benefits* section above.
5. Pre-existing conditions: There are no preexisting condition limitations under the *subscriber's contract*.
6. This policy is renewable upon becoming eligible for Medicare.
7. 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*.

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 notify *us*, within 10 business days, with a letter telling *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 *contract* than *you* have paid to *us* in subscription premium 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.