Subscriber Certificate

Total Choice PPO

*Delta Dental** of Massachusetts certifies that you have the right to benefits for services according to the terms of your *Contract*. This Subscriber Certificate is part of your *Contract*.

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

There are no preexisiting conidition limitations or exclusions under this Subscriber Certificate.

President & CEO

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

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Introduction

This Subscriber Certificate, together with the attached *Schedule of Benefits*, your Enrollment Form and Application, and any applicable Riders, Endorsements, Amendments, or Supplemental Agreements constitutes the *Contract* between you and *Delta Dental*. We urge you to read it carefully.

The dental services described in your *Schedule of Benefits* are covered as of your *Effective Date*, unless your benefits are subject to a *Waiting Period*. Additionally, there are limitations and restrictions on your coverage, which are found in your *Schedule of Benefits*. Please refer to the *Schedule of Benefits*, attached to this Subscriber Certificate, which outlines the specific services covered under this Subscriber Certificate and the extent of coverage for those services. You are entitled to these benefits on a non-discriminatory basis, including those benefits that are mandated by state and federal law.

If your group has purchased any supplemental coverage, those benefits will be described in a separate Rider. Please make sure you have a copy of the proper Rider, if applicable. Your *Plan Sponsor* can supply you with them.

Additionally, there are some limitations or restrictions on your membership, which are found in Parts III and IV of this Subscriber Certificate and on the *Schedule of Benefits*.

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

If you have any questions, contact your *Plan Sponsor* or *Delta Dental's* Customer Service department. *Delta Dental* telephone numbers are listed at the end of this Subscriber Certificate.

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, or sex. *Delta Dental* does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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 Subscriber Certificate.

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, 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)

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 third parties 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.

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

Member Rights and Responsibilities

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

- file *Grievances* about *Delta Dental* or a *Participating Dentist*.
- receive 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 an explanation of the 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
- receive, at your request, interpreter and translation services related to administrative procedures for 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
- familiarize yourself with *Delta Dental* benefits, policies and procedures, by reading this Subscriber Certificate and other *Delta Dental* written materials, or calling Customer Service.

You have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-872-0500.

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ំពី បេ, អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នា
បៅកនុងភាសា អរស់អ្នក បោយមិនអ្ស់ប្ាក់ ។ បែើមបីនិយាយជាមួយអ្នករកដប្រ សូម 1-800-872-0500។

Chinese:
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話
[在此插入數字1-800-872-0500。

Vietnamese: quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-872-0500.

Arabic: ذلك. لك حث عم تمرمج تاصلب 1-800-872-0500 ذإ ناكدلي وأ لد د صخش دعسته ةلئسأ صو صخب
ضلاررويةكتغلب ذ م ذ ود ةاة

Korean: 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-800-872-0500 로 전화하십시오.

French: vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez1-800-872-0500.

Russian: то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону1-800-872-0500.

Spanish: tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al1-800-872-0500.

German: haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-872-0500 an.

Tagalog: may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa1-800-872-0500.

Gujarati: વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો િ ત કરિ મ ટે,આ 1-800-872-0500 પર કોલ કરો.

Hindi: के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी ्िुभाषषए से बात करने के लिए , 1-800-872-0500 पर कॉॅि करें।

Italian: hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare1-800-872-0500.

Japanese:
についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合, 1-800-872-0500 までお電話ください。

Portuguese: você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-872-0500.

French Creole: se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan1-800-872-0500.

Polish: masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer1-800-872-0500.

Amharic: ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-872-0500 ይደውሉ።

Greek: Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-872-0500.

Lao: ຖ້າທ່ານ, ຫ ູ ືຄົນທ ່ທ່ານກ ້ໍາລັງຊ ່ວຍເຫ ູ ືອ, ມ ຄ ໍາຖາມກ ່ຽວກັບ], ທ ່ານມ ສີດທ ່ ່ຈະໄດ ້ຮັບການຊ ່ວຍເຫ ູ ືອແລະຂ ໍ ້ມ ູນຂ ່າວສານທ ່ ່ເປ ັນພ າສ າຂ ອງທ ່ ່ານບ ໍ ່ມ ຄ ່າໃຊ ້ຈ ່າຍ. ການໂອ ້ ລ ົ ມກ ັ ບນ າຍພ າສ າ, ໃຫ ້ ໂ ທຫ າ 1-800-872-0500.

Part I: Definitions

Adverse Benefit Determination: A *Delta Dental* decision (a) to deny, reduce, or terminate a plan benefit or (b) to reduce payment in part or deny payment altogether for a plan benefit.

Allowable Charge: the dollar amount upon which *Delta Dental* bases its payment and the dollar amount *Participating Dentists* consider to be payment in full. The *Allowable Charge* is typically a discounted rate rather than the actual charge, and is never more than the amount charged by the dentist. For services rendered by *Non-Participating Dentist*, the *Allowable Charge* is a percentage of a usual, customary and reasonable charge, as determined by *Delta Dental*.

Alternate Benefit: in cases where alternative, less costly methods of treatment exist, benefits are provided for the least costly professionally accepted treatment. If the treatment rendered is not the one listed as a covered service under this *Contract*, the difference between *Delta Dental's Allowable Charge* and the cost for the actual treatment rendered is your responsibility.

Annual Maximum Benefit: the maximum dollar amount we will pay toward the cost of covered services rendered during each *Plan Year*. You are responsible for costs for services over the *Annual Maximum Benefit.*

Appeal: is a request for *Delta Dental* to reconsider an *Adverse Benefit Determination* or an Upheld Denial.

Claim: is any request for a plan benefit or benefits made in accordance with the *Contract*. *Delta Dental* will not treat a communication regarding benefits as a *Claim* unless the communication is submitted in accordance with this *Contract*. *Delta Dental* will treat any request for plan benefits that is not made in accordance with this Contract as an incorrectly filed *Claim*. *Delta Dental* will treat the resubmission of a *Claim* as the same original *Claim*, not a new or separate *Claim*.

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 on your *Schedule of Benefits*.

Contract: this Subscriber Certificate, together with the attached *Schedule of Benefits*, your Enrollment Form and Application, and any applicable Riders, Endorsements, Amendments, or Supplemental Agreements.

Covered Individual or Member: a person who is eligible to receive dental benefits from *Delta Dental*. Usually includes *Subscribers* and their enrolled dependents.

Date of Service: the actual date that the dental 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 amount that the *Subscriber* must pay toward covered services before the plan will begin paying any benefits. 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.

Disenrollment: Disenrollment may refer to *Covered Individuals* who are disenrolled because their coverage periods have expired; to former dependents who no longer qualify as dependents, or to *Covered Individuals* who lose coverage under an employer sponsored plan because they have ceased employment, become disabled, retired or died, or because their employer group has canceled coverage under the plan, or reduced the number of hours worked.

Effective Date: the date, as shown on our records provided to us by your *Plan Sponsor*, on which your coverage begins under this *Contract* or an amendment to it.

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

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

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

Grievance: any oral or written complaint a *Member* submits to *Delta Dental* concerning any aspect of the *Member's* coverage or any action of *Delta Dental* concerning the *Member*, except that a *Grievance* does not include a *Claim* or an *Appeal*.

Individual Contract: a *Contract* that includes only the *Subscriber*.

Inquiry: is any communication by or on behalf of a Member to Delta Dental of Massachusetts requesting information concerning a Delta Dental policy, action, or omission that is not related to a *Grievance, Claim* or *Appeal.*

Non-Participating Dentist: With regard to dental services provided in Massachusetts pursuant to this *Contract*, a doctor of dentistry who is duly licensed and qualified under applicable laws to provide such services and who, at the time such services were rendered, was not subject to an agreement with *Delta Dental* to furnish such services pursuant to *Delta Dental's* Total Choice PPO plan.

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

Out of Pocket Maximum: This is the maximum you will pay in *Deductibles*, copays and *Coinsurance* for allowable expenses in the *Plan Year*. Your *Out of Pocket Maximum* will appear in your *Schedule of Benefits*, if applicable.

Out of State Delta Dental: A business entity, other than *Delta Dental*, that holds the license to use the *Delta Dental* name in a jurisdiction other than Massachusetts.

Participating Dentist: With regard to dental services provided in Massachusetts pursuant to this *Contract*, a doctor of dentistry who is duly licensed and qualified under applicable laws to provide such services and who, at the time such services were rendered, had entered into and was subject to an agreement with *Delta Dental* to furnish such services pursuant to *Delta Dental's* Total Choice PPO plan.

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

Plan Year: a consecutive 12- month period during which the plan provides benefits under this *Contract*. A *Plan Year* may or may not correspond with the calendar year. Your *Plan Year* will appear in your *Schedule of Benefits*.

Schedule of Benefits: the part of your *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* is attached to this Subscriber Certificate.

Subscriber: an employee certified by the *Plan Sponsor*, who is eligible to receive dental benefits from *Delta Dental*.

Waiting Period: the period of time that must pass after your *Effective Date* before a *Covered Individual* is eligible for benefits under this *Contract.* If applicable, the *Waiting Period* is listed in your *Schedule of Benefits*.

Part II: Benefits

You have the right to benefits on a non-discriminatory basis for the services listed in the *Schedule of Benefits*, except as limited or excluded elsewhere in this *Contract*, including the *Schedule of Benefits*. The benefits may be limited to an *Annual Maximum Benefit* payment for each *Covered Individual* for each *Plan Year*. The extent of your benefits is explained in the *Schedule of Benefits* which is incorporated as a part of this *Contract.* Please refer to your *Schedule of Benefits* for the benefits covered under this *Contract*.

If you received treatment that is excluded from coverage under your plan, 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 benefit.

As a Total Choice PPO member, you have the right to see any in-network provider. From time to time, your dentist may wish to refer to you another dentist for specialty services. Please be aware that your dentist may refer you to any specialty dentist they wish, even if that dentist is not a *Participating Dentist*. To avoid any unexpected out of pocket expenses, we recommend that you confirm whether a dentist is a *Participating Dentist* before you receive treatment. In order to locate an in-network provider, you may call Customer Service for assistance or to request a copy of a provider directory. You can also obtain information regarding participating providers by visiting our website at www.deltadentalma.com. In order to locate a participating provider, select "Total Choice PPO" when prompted to enter the plan name.

Part III: Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of this *Contract*, including your *Schedule of Benefits.* We will not provide benefits for any dental service that is not necessary and appropriate to diagnose or to treat your dental condition.

A. To be necessary and appropriate, a service must be consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of (1) those teeth that are decayed or *Fractured* or (2) those teeth where supporting structure is weakened by disease (including periodontal, endodontic and related diseases). Dental care must be furnished 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 Subscriber Certificate:

We determine what services are covered under this *Contract*. Coverage decisions are made 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.

2. WE DO NOT PROVIDE BENEFITS FOR:

The *Schedule of Benefits* provides a summary of dental services or items for which coverage is excluded under this Subscriber Certificate.

Please note that we will not provide coverage:

- if you have reached your *Annual Maximum Benefit*;
- if your balance is due to your *Deductible*;
- if the services were provided by a dentist who is not duly licensed in the state in which he or she practices; or
- if the services were rendered after your coverage termination date

Part IV: Other *Contract* Provisions

1. BENEFIT PAYMENTS FOR SERVICES RENDERED BY A *PARTICIPATING DENTIST*

   IN-NETWORK SERVICES:

   For services performed by a *Participating Dentist*, the In-Network payment is based on the *Allowable Charge* or the dentist's submitted fee, if lower. *Delta Dental* pays the *Participating Dentist* directly for covered services. The dentist will bill covered *Members* for balances resulting from plan specific *Deductibles* and any *Coinsurance*.

   If you have received a covered service when you have already exhausted your *Annual Maximum Benefit* or you received a covered service which will cause you to exceed your *Annual Maximum Benefit* you will only be responsible for charges up to *Delta Dental's* negotiated rate, provided that the service that you received is not excluded from coverage under the terms of this *Contract*.

2. WHEN YOUR IN-NETWORK DENTIST *MAY* CHARGE YOU MORE

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

   A. If you receive a treatment that is excluded under your plan, you may be billed at the dentist's normal rate rather than the negotiated rate.

   B. If your dentist renders services or uses materials that are more expensive than those customarily furnished by most dentists, benefits may be provided towards the service with the lower fee. This is sometimes referred to as an *Alternate Benefit*. In this case, you may be responsible for the difference between the *Allowable Charge* for the service with the lower fee and *Allowable Charge* for service with the higher fee. Please see your *Schedule of Benefits* for additional information.

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

3. PRE-TREATMENT ESTIMATES

If your dentist determines that the services to be rendered to you will exceed $300, we suggest that your dentist file a copy of the treatment plan with *Delta Dental* BEFORE these services are rendered in order to determine if any coverage may be provided by *Delta Dental*. 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.

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. Please note that a pre-treatment estimate is not a guarantee of payment and not required to obtain care.

4. BENEFIT PAYMENTS FOR SERVICES RENDERED BY *NON-PARTICIPATING DENTISTS*

A. OUT-OF-NETWORK SERVICES:

For services performed by *a Non-Participating Dentist*, the out-of-network benefit *Coinsurance* for each type of service may be up to 20 percentage points higher than the in-network dentist *Coinsurance*. Payments made to the *Non-Participating Dentist* shall be a percentage of the dentist's fee, up to a usual and customary charge, and not a percentage of the amount paid to *Participating Dentists*. The *Coinsurance* will be applied against the fee allowed by *Delta Dental* or the dentist's submitted fee, if lower. Please see your Schedule of Benefits for you *Coinsurance* amount.

For services performed by a *Non-Participating Dentist*, *Delta Dental* pays the *Subscriber* directly for covered services, and the *Member* is responsible for paying the dentist. The dentist will bill the covered *Subscriber* for the difference between the *Delta Dental* payment and his / her submitted charge and balances resulting from plan specific *Deductibles* and *Coinsurance.*

B. EMERGENCY CARE

When a *Covered Individual* requires emergency care as the result of an *Emergency Medical Condition* and cannot reasonably reach a Total Choice PPO dentist, payment for such care will be paid at the same level as if the *Covered Individual* had been treated by a Total Choice PPO dentist, once you notify *Delta Dental* that you sought such emergency care.

5. TIME LIMIT

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

If benefits are denied because a *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 paid by *Delta Dental*. You will still be responsible for your relevant *Coinsurance* or *Deductibles*, if any.

This provision applies only if you properly identify yourself as a *Covered Individual* by presenting your *Subscriber* identification card. If you do not properly identify yourself as a *Covered Individual*, you may be responsible for the cost of any services rendered.

6. SUBROGATION

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

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

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

Participating Dentists have agreed to give us all information necessary to determine your benefits under this *Contract*. *Participating Dentists* have agreed not to charge for this service.

If you receive services from a *Non-Participating Dentist*, you must obtain all dental records or other related information we need in order to determine if those services are covered under this *Contract*. *Delta Dental* will not pay you or the dentist for providing this information. If the dentist does not provide the required information, we may not provide benefits for his or her services, even if they would otherwise be covered under this *Contract*. All services provided by a *Non-Participating* are your responsibility and benefit determinations will be made based on the benefits available to you and information provided to us by the dentist.

8. PREMIUM PAYMENTS

A. Is the amount of money that your *Plan Sponsor* pays to *Delta Dental* for your benefits under this *Contract* is called your subscription charge or premium payment. Your *Plan Sponsor* is responsible to pay to *Delta Dental* the total subscription charges by

the due date indicated on each monthly invoice sent to your *Plan Sponsor*. If subscription charges have not been paid within 30 days after the date on which payment is due, *Delta Dental*, upon written notice to the *Plan Sponsor*, may terminate the *Plan Sponsor's* contract as of the date to which subscription charges have been paid. *Delta Dental* is not responsible if your *Plan Sponsor* fails to pay us. This is true even if your *Plan Sponsor* has charged you for all or part of the subscription charge.

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

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

9. WE MAY CHANGE YOUR *CONTRACT*

Delta Dental shall issue and deliver to your *Plan Sponsor* prior notice of material modifications in covered services under this dental plan at least 60 days before the effective date of the modifications. *Delta Dental* will determine it its discretion which changes are considered material modifications. Your *Plan Sponsor* is required notify you of this change. *Delta Dental* is not responsible if the *Plan Sponsor* does not notify you that your *Contract* will 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 certificate.

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

10. WHEN YOUR COVERAGE BEGINS

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

Your *Plan Sponsor* will inform us when you or your dependents are eligible as a *Covered Individual* under this *Subscriber Certificat*e. Your eligibility is based upon *Delta Dental's* underwriting guidelines and your *Plan Sponsor's* guidelines. The dental services described in this certificate are covered immediately as of your *Effective Date*, unless your benefits are subject to a *Waiting Period* or there exist some other applicable limitations or

exclusions on your membership which are found in Part III of this Subscriber Certificate or in your *Schedule of Benefits*.

You, your spouse and your dependent children under the maximum dependent age listed in your *Schedule of Benefits*, as well as their children under the maximum dependent age listed in your *Schedule of Benefits*, are eligible for coverage. Adopted children and children under your own or your spouse's legal guardianship are also eligible for coverage. A physically or mentally handicapped child**,** who is incapable of earning his or her own living and who is over the maximum dependent age listed in your *Schedule of Benefits*, may be eligible to continue coverage under a *Family Contract* if you notify *Delta Dental* via your *Plan Sponsor* within 72 days of the child reaching maximum dependent age and if you complete a disabled dependent application.

11. WHEN YOUR COVERAGE ENDS

There are no conversion privileges under the *Contract*. However, a *Covered Individual* may have the right to continue dental coverage for a period of time under state law and under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You and certain family members may be entitled to continue participating in this plan for a limited period even under conditions (such as your death or termination of employment) that would otherwise make you ineligible for coverage, so long as you pay the appropriate subscription in full. Delta Dental is not responsible for administering any such conversion options. Contact your *Plan Sponsor* for more detailed information regarding continuation of coverage.

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

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

A. The *Subscriber* is no longer enrolled in the group. We will cover you under this *Contract* until your *Plan Sponsor* notifies us that you are no longer eligible for coverage.

B. Your dependent child under your *Family Contract* reaches the maximum dependent age listed in your *Schedule of Benefits.*

   However, if your dependent child is either mentally or physically handicapped upon reaching the maximum dependent age listed in your *Schedule of Benefits* and is incapable of earning his or her own living, special arrangements can be made for your child to continue coverage under your *Family Contract*. You must apply for this continued coverage through your *Plan Sponsor* within 72 days of your child's loss of coverage. In addition, you must supply us with any medical or other information that we may need to determine if your child is eligible to continue coverage under your *Family Contract*.

C. If you become divorced or legally separated, your spouse's coverage under an existing family membership will continue so long as you remain a *Subscriber* of the plan, unless a court judgment provides otherwise. This coverage will continue until either you or your spouse remarries, or until the date of coverage termination stated in the judgment of divorce or separation, whichever is earlier. If you remarry and your divorce judgment so provides, your former spouse will have the right, for an additional subscription, to continue to receive such benefits as are available to you by means of the issuance of an individual plan. Delta Dental may request a copy of your 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.

12. TERMINATION OF A *CONTRACT*

A. You or your *Plan Sponsor* may cancel your C*ontract* under the following conditions:

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

   In some circumstances, you may also cancel your *Contract* through your *Plan Sponsor*. To do so, your *Plan Sponsor* must give us notice in writing within 72 days of cancellation. If your subscription charge or premium has been paid for a period beyond your termination date, we will refund the subscription charge for that period to your *Plan Sponsor* provided no *Claim* payments have been made for services rendered after your termination date.

   If you cancel your *Contract*, you can only re-enroll on your *Plan Sponsor's* next anniversary date or when a qualifying life event gives you access to a special *Open Enrollment* period.

B. *Delta Dental* may cancel your *Contract* under the following circumstances:

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

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

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

If you or your *Plan Sponsor* replaced your dental plan with another insured or self-insured dental plan, the provisions of this section will not apply.

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

   a. We may cancel your *Contract* if you make any fraudulent *Claim* or misrepresentation to us or to any dentist, such as an incorrect or incomplete statement on your application card which led us to believe you were eligible for this coverage when in fact you were not, or in the case where a Member has allowed another individual to use his or her identification card. In such a case, cancellation will be retroactive, as of your *Effective Date*. We will refund your *Plan Sponsor* the subscription charge you have paid us. We will subtract from the refund any payments made for *Claims* under this *Contract*. If we have paid more for *Claims* under this *Contract* than you have paid us in subscription charges, we have the right to collect the excess from you.

   b. We may cancel your coverage if your *Plan Sponsor* has not paid your subscription charges to us on your behalf, as described above. You agree that we may use your rights against the *Plan Sponsor* to collect those subscription charges.

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

   d. We may cancel your *Contract* if you move outside of our service area.

   e. We may cancel your *Plan Sponsor's* agreement for non-renewal.

For information regarding benefits after cancellation see Part IV, Section 13 of this certificate.

13. BENEFITS AFTER CANCELLATION

In the event that this *Contract* is terminated, no benefits will be provided for services that you receive after your termination date.

If your *Contract* is cancelled for reasons other than for a fraud or misrepresentation, we will continue to provide certain benefits for specific covered multi-stage procedures, provided that the first treatment visit for that procedure was rendered prior to your

termination date. Multi-stage procedures are those that require two or more visits to complete and include crowns, bridges, dentures and root canals. Coverage will be available up to the limitations listed in your *Contract* provided the treatment is completed within 30 days of the termination date. If your group has purchased benefits for orthodontic services, the policy of continuing benefits will not apply to these orthodontic services.

14. NOTICES

A. To you: When we send a notice to your *Plan Sponsor* we will send it by first class mail. Once we mail the notice or bill we are not responsible for its delivery. It will be your *Plan Sponsor's* responsibility to notify you. This applies to your bill for subscription charges as well as to a notice of a change in the subscription charge or a change in the *Contract*. If your name or mailing address should change, you should notify your *Plan Sponsor* at once. Be sure to give your *Plan Sponsor* your old name and address as well as your new name and address.

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

15. ENROLLMENT AND CONTRACT CHANGES

All enrollment applications and any additions or changes to your *Plan Sponsor's* contract are allowed ONLY when they conform to our Underwriting Guidelines on file with the Massachusetts Division of Insurance. If your group offers more than one *Delta Dental* plan type, you are only eligible to change your plan choice during the annual *Open Enrollment* period.

16. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after your *Effective Date* of coverage. If before a *Member'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 do not properly identify yourself as a *Covered Individual* within 12 months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

Nothing in this Subscriber Certificate will prohibit a *Covered Individual* 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.

17. 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.

18. COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies if you or any of your dependents have another plan that provides coverage for services that are benefits under your *Contract*. *Delta Dental* will coordinate benefits in according to any applicable state coordination of benefits law (including the provisions of the Massachusetts Division of Insurance's regulations regarding COB, the "COB Regulations") and this Subscriber's Certificate. A copy of the COB Regulations is available from *Delta Dental* upon request.

The plan that provides benefits first under the COB rules is known as the primary plan. The primary plan is responsible for providing benefits in accordance with its terms and conditions of coverage without regard to coverage under any other plan. The plan that provides benefits next is the secondary plan. It provides benefits toward any remaining balance for covered services in accordance with its terms and conditions of coverage, including its COB provision.

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

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

19. RIGHT TO RECOVER OVERPAYMENTS

If we pay more than we should have as part of a coordination of benefits issue or otherwise, you must refund any overpayment to *Delta Dental*.

20. QUALITY ASSURANCE

As a *Delta Dental Covered Individual* you have the freedom to seek services from *Delta Dental* dentists or specialists or from the dentist of your choice**.** *Participating Dentists* meet network and credentialing standards and submit *Claims* for covered services directly to *Delta Dental*.

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

Quality Control: *Delta Dental's* quality assurance system includes:

- Utilization reviews to ensure appropriate care
- Compliance audits
- Credentialing
- Customer and member surveys
- Grievance tracking
- Research studies identifying alternative treatment for curing disease

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.

21. 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* 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 your *Contract*. If a procedure is not a covered service then the *Claim* for that service will be denied in accordance with the terms of your *Contract* and the group contract. Coverage of certain procedures may also be limited by frequency, age, *Effective Dates* of coverage, etc. Please refer to this Subscriber Certificate and your *Schedule of Benefits* for more information on your coverage.

All *Claims* are processed within 30 working days of 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 *Subscriber* 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 Benefit 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:

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

By telephone:1-800-872-0500

web site: www.deltadentalma.com

22. *GRIEVANCE* PROCESS:

Delta Dental will accept *Grievances* by telephone, by mail, or by electronic means. Upon receipt of an oral *Grievance*, *Delta Dental* will open a case for the member who submitted it and request that the member submit a written version of such *Grievance* within 10 business days. If you do not submit the written *Grievance* within 10 business days, *Delta Dental* will close the *Grievance* without further action.

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.

23. APPEAL OF AN *ADVERSE BENEFIT DETERMINATION*

How to file an *Appeal*:

You have a right to appeal an *Adverse Benefit Determination* under this *Contract*. Except for urgent care *Claims*, discussed below, you may appeal an *Adverse Benefit Determination* by submitting a written request for *Appeal* to *Delta Dental.*

In writing:

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

By telephone:

1-800-872-0500

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 Benefit Determination* or Upheld Denial within 180 days following your receipt of the notice of original *Adverse Benefit 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 Benefit 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 Benefit Determination* is based on a contractual limitation or a scientific or clinical determination.

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

In the event that an *Adverse Benefit Determination* is made on the basis of a scientific or clinical determination, you may *Appeal* such *Adverse Benefit Determination*. If, upon review, *Delta Dental* denies your *Appeal* (an "Upheld Denial"), then you may *Appeal* the

Upheld Denial, which results you having a total of two *Appeals* following the initial *Adverse Benefit Determination.*

Part V: Filing a Claim

EXPLANATION OF BENEFITS

Each time we process a *Claim* for you under this *Contract*, a written notice may be sent to your dentist called an Explanation of Benefits (EOB) which will explain your benefits for that *Claim*. If you owe money to your dentist for services rendered, an Explanation of Benefits will be forwarded to the *Subscriber* that describes your responsibility.

WHO FILES A CLAIM

Participating Dentists:

Participating Dentists will file *Claims* directly to us for the services covered by this *Contract*. We will make benefit payments to them.

Non-participating Dentists:

If you use a *Non-participating Dentist*, the dentist may file a *Claim* directly with us for the services covered under this *Contract* or you may be asked to file a *Claim*. *Delta Dental* will send payment for *Claims* directly to the *Subscriber*. It is your responsibility to pay your dentist. You will also be responsible for paying the dentist the difference between the *Non-participating Dentist's* charge and *Delta Dental's Allowable Charge* in addition to any applicable *Deductible* and *Coinsurance*.

WHEN YOU FILE A *CLAIM*

When you file a *Claim* for the services of a *Non-participating Dentist*, the following rules apply:

Obtain an attending dentist's statement *Claim* form from your *Plan Sponsor* or *Delta Dental*, complete it, and send it to *Delta Dental*. After we receive your completed forms we will (a) send you a check for your *Claim* to the extent of your benefits, if any, 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 in order to determine if the services rendered to you are covered under you plan. It is up to you to pay your dentist. If you have any questions, contact your *Plan Sponsor* or our Customer Service department. *Delta Dental* telephone numbers are listed at the end of this certificate.

Part VI: Index

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

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