DELTA DENTAL

Delta Dental Premier

Coverage Summary for
Wellesley College
Group Number
007816

Deductible: $50 per individual / $100 per family. Deductible waived for Diagnostic and Preventive categories.
Calendar Year Maximum: $2,000 per person.

Category / Procedure	**Qualifications**	**Co-insurance** In Network	**Co-insurance** Out of Network
Diagnostic		100%	100%
Comprehensive Evaluation	Once every 60 months per dentist.		
Periodic Oral Exam	Twice per calendar year.		
Full Mouth X- rays	Once every 60 months.		
Bitewing X-rays	Twice per calendar year.		
Single Tooth X-rays	As needed.		
Preventive		100%	100%
Teeth Cleaning	Twice per calendar year.		
Fluoride Treatments	Once every 6 months for members under age 19.		
Space Maintainers	Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.		
Sealants	Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who had a recent cavity and are at risk for decay.		
Chlorhexidine Mouthrinse	This is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing.		
Fluoride Toothpaste	This is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.		
Restorative		80%	80%
Silver Fillings	Once every 24 months per surface per tooth.		
White Fillings (Front Teeth)	Once every 24 months per surface per tooth.		
White Fillings (Back Teeth)	Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible up to the submitted charge.		
Temporary Fillings	Once per tooth.		
Stainless Steel Crowns	Once every 24 months per tooth.		
Oral Surgery		80%	80%
Simple Extractions	Once per tooth.		
Surgical Extractions	Once per tooth.		
Periodontics		80%	80%
Periodontal Surgery	Periodontic benefits not provided when rendered in a surgical day care or hospital setting.		
Scaling and Root Planing	Once in 24 months, per quadrant.		
Periodontal Cleaning	Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings.	100%	100%
Endodontics		80%	80%
Root Canal Treatment	Once per tooth.		
Vital Pulpotomy	Limited to deciduous teeth.		
Prosthetic Maintenance		80%	80%
Bridge or Denture Repair	Once within 12 months, same repair.		
Rebase or Reline of Dentures	Once within 36 months.		
Recement of Crowns & Onlays	Once per tooth.		
Emergency Dental Care		80%	80%
Minor treatment for Pain Relief	Three occurrences in 12 months.		
General Anesthesia	Allowed with covered surgical services only.		
Prosthodontics		50%	50%
Dentures	Once within 60 months.		
Fixed Bridges and Crowns	When part of a bridge. Once within 60 months		
Implants	An Endosteal Implant is covered to replace one missing tooth (in lieu of a three unit bridge, and when all adjacent teeth do not require crowns.) Once per 60 months per Implant.		
Major Restorative		50%	50%
Crowns	When teeth cannot be restored with regular fillings. Once within 60 months per tooth		

Orthodontics: Covered at 50% of Maximum Plan Allowance charges to age 19. $2,000 separate LIFETIME maximum.

Dependent Eligibility: Dependents covered up to age 26.

Additional Benefit Information

Domestic Partner Coverage
Deductible waived for Periodontal Cleanings
This plan is eligible for Rollover Max. See the benefit guide for details.

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Delta Dental Premier

Easy Access and Great Value — Your Delta Dental Network

As a Delta Dental Premier subscriber, you have access to the most extensive dental network in Massachusetts, with more than 6,000 dentist locations in Massachusetts.

With Delta Dental Premier, you enjoy the greatest savings in out-of-pocket expenses when visiting a dentist who participates in the Delta Dental Premier network. Participating dentists typically accept discounted fees for their services, and since your co-payments are based on these fees, you pay lower out-of-pocket costs for your care. You will still receive coverage if you visit a non-participating dentist, but your benefit will be at the out-of-network level shown in the right-hand column of this coverage summary.

To find a dentist, simply visit **www.deltadentalma.com** (click on the *Find a Dentist* link and select *Delta Dental Premier*) or call Delta Dental customer service at 1-800-872-0500.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

If you receive a treatment after you have exhausted your maximum or if you receive a treatment that will cause you to exceed your maximum, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate.

Learn More at www.deltadentalma.com

You can find more information about your benefits plan in the *Delta Dental Member Guide*, available from your benefits administrator or online at **www.deltadentalma.com**. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how the claims and appeal processes work, and more about keeping a healthy mouth for life.

Visit **www.deltadentalma.com** to find plan information, review eligibility status, check on claim status, or find a dentist.

If you have any questions or need additional information, you can call customer service at 1-800-872-0500.

Your Plan is Administered by:

Delta Dental of Massachusetts
1-800-872-0500

DELTA DENTAL®

Delta Dental of Massachusetts
465 Medford Street, Boston, MA 02129
www.deltadentalma.com

SP565(11/08)20M

Delta Dental of Massachusetts

Welcome to DeltaCare

DeltaCare is an innovative dental plan that provides you with comprehensive care at a significantly lower cost than most other dental plans—which means great value for you. The plan is unique in its emphasis on preventive services, which are fully covered. DeltaCare works much like a dental HMO, in which you and your family receive all your care from a network of participating dentists. There are no waiting periods for any services. Your coverage begins immediately, so you get the care you need—when you need it.

Using Your Dental Plan

Choosing Your Primary Care Dentist

You and each member of your family covered under DeltaCare must select a Primary Care Dentist (PCD) from the DeltaCare directory.

Please indicate the name and provider number of the PCD in the designated area on your enrollment form. If you do not select a PCD, we will assign one located near your home. To select a PCD, check the *Directory of Participating Dentists* or our Web site at www.deltadentalma.com. You can also call the DeltaCare Unit at (800) 327-6277.

Shortly after your enrollment, each member of your family covered by DeltaCare will receive an ID card with his or her PCD's name and phone number on it. Coverage is effective for all dependents up to age 26.

To change your PCD, simply call our DeltaCare Unit by the 21st day of the month at (800) 327-6277 and let the representative know which DeltaCare dentist you would like as your PCD. The change will be effective at the beginning of the following month. We will send you a new ID card reflecting the change after it becomes effective.

How Your Plan Works

There's never any paperwork for you to fill out when you visit your PCD or a specialist in the DeltaCare network. **Simply provide your dentist with the information that is printed on your ID card.** Your dentist will collect any applicable co-payments for services you receive and take care of all the paperwork for you.

When you are in need of specialty services, you may select a specialist from the DeltaCare network or ask your primary care dentist for a recommendation. However, to receive the maximum value from your benefits, you must receive services from a participating DeltaCare specialist.

Out-of-Pocket Expenses

You will be responsible for the co-payments listed on your co-payment schedule, which you will pay directly to the dentist and, where noted, any additional lab fees associated with certain major restorative procedures. Most preventive and diagnostic services are covered at 100%, which means you won't have any additional out-of-pocket costs on these procedures. Please note there is a $1,000 calendar year maximum on certain specialty services (oral surgery, endodontic services, and periodontic services). If you have reached the maximum amount allowed for these specialty services in a calendar year, the dentist may then charge you his/her usual fee for the services rendered.

Out-of-Network Coverage

(See page 5 for out-of-network orthodontic information.)

DeltaCare provides coverage for out-of-network services; however, the benefits are lower than the coverage we offer when members receive care from a DeltaCare dentist. This means greater out-of-pocket expense for you if you receive services from a non-participating dentist.

$100 deductible: Members who receive care from non-participating dentists must satisfy a $100 annual deductible that applies to all services. Each member who receives care from a non-participating provider must satisfy the deductible before receiving benefits.

Reduced benefits: Coverage for out-of-network services is 20% lower than the co-insurance for an in-network DeltaCare panel dentist. This DeltaCare co-payment schedule does not apply to out-of-network services. Out-of-network benefits will be based on either the dentist's charge or the maximum allowable fee for the service, whichever is lower. Coverage is only available for those services covered by your DeltaCare plan, and it is subject to the same limitations and exclusions.

If you choose to receive care from an out-of-network dentist, you'll need to submit a claim form to: Delta Dental, Attn: DeltaCare Unit, PO Box 9695, Boston, MA 02114. We'll reimburse you directly, and you are responsible for making payment arrangements with your dentist. Claims must be submitted to DeltaCare no later than 12 months from the date of service in order to be considered for payment.

Emergency Dental Care

If you need emergency care, contact your PCD immediately. He or she will arrange to get you the care you need. If you can't reasonably reach your PCD (if you are traveling or not in the area, for example) and need emergency care, you should see a local dentist for treatment. You should then contact your PCD to arrange for further care. DeltaCare will provide coverage for emergency services required to reduce swelling, relieve pain, and/or reduce the potential for infection until you can see your PCD for treatment.

Orthodontic Care

We base orthodontic benefits on 24 months of comprehensive treatment. You'll be responsible for the co-payment associated with your treatment, which you'll pay directly to your orthodontist. It's up to you and your orthodontist to make payment arrangements for the patient co-payment.

Out-of-Network Orthodontics

Any care you receive from a non-participating orthodontist will be reimbursed at 20% of the maximum allowable fee or the orthodontist-submitted charge, whichever is less. The $100 deductible for out-of-network services will apply unless it has already been satisfied.

Termination of Coverage

You will be responsible for paying for any care you receive after your coverage terminates, and up to the submitted charge if you seek out-of-network treatment. It is up to you and your orthodontist to establish the terms and conditions of payment after coverage terminates. However, if you've started an orthodontic treatment plan and decide to continue to receive care from your DeltaCare orthodontist after your coverage terminates, your payments will be based on DeltaCare's discounted case fee.

DeltaCare Orthodontic Exclusions

Your plan does not cover the following:

Replacement of lost, stolen, or broken orthodontic appliances; retreatment of orthodontic cases; changes in treatment necessitated by an accident of any kind; surgical procedures incidental to orthodontic treatment; myofunctional therapy; surgical procedures related to cleft palate, micrognathia, macrognathia, or treatment related to temporomandibular joint dysfunctions and/or hormonal imbalance; malocclusions that are so severe they are not amenable to ideal orthodontic therapy; restorative work caused by orthodontic treatment; orthodontic examination and records unless you receive comprehensive treatment; tooth extraction solely for the purpose of orthodontics; **orthodontic treatment started before the effective date of your DeltaCare coverage may or may not be covered. Please refer to your Subscriber Certificate.**

Frequency Limitations

Frequency limitations reflect the availability of coverage only. It is up to you and your dentist to determine the need and frequency of dental procedures.

The following contains the limitations for some common dental procedures. If you would like more information about limitations on services not included in this list, please contact our DeltaCare Unit at (800) 327-6277, for a copy of your Subscriber Certificate.

Cleanings—not to exceed two cleanings in any 12 consecutive months.

Dentures and Partial Dentures—up to one set per arch once every five years provided the existing set is no longer serviceable.

Fixed Bridges, Crowns, and Other Cast Restorations—up to one restoration per tooth or missing tooth space in a five-year period provided the existing restoration is no longer serviceable.

Denture Relines—up to once per denture in any 12 consecutive months beginning six months after delivery of the denture.

Periodontal Treatments (root planing/subgingival curettage)—up to once per quadrant in any 12 consecutive months.

Bitewing X-rays—based on need, up to one series of four films in any six-month period.

Full-mouth X-rays—based on need, up to one set every 24 consecutive months.

Topical Fluoride Treatment—once every six months for members under age 19.

Space Maintainers—(required due to the premature loss of teeth) for members under age 14 and not for the replacement of primary or permanent front teeth.

Chlorhexidine Mouthrinse—this is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing.

Fluoride Toothpaste—this is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.

Sealants—based on need, for unrestored permanent molars only, once per tooth for members under age 16.

Your DeltaCare provider is responsible for determining the best course of treatment for you. If more than one treatment option is appropriate, you can choose a more expensive option than your dentist recommends. In this case, you will be responsible for the difference in cost between the two options as well as the co-payment for the recommended treatment.

Exclusions

1. General anesthesia and the services of a special anesthesiologist.
2. Cosmetic dental care.
3. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, country, or other subdivision.
4. Treatment required by reason of war.
5. Dental services performed in a hospital and related hospital fees.
6. Treatment of fractures and dislocations.
7. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
9. Any service that is not specifically listed as a covered expense.
10. Congenital malformation.
11. Cysts and malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
14. Cases which in the professional judgment of the attending dentist determines a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

Member Co-payments for DeltaCare

As a DeltaCare member, you are responsible for the following co-payments when you receive care from your PCD or a DeltaCare participating specialist. All co-payments should be made directly to the treating dentist. Your DeltaCare plan provides coverage for only those procedures listed in this co-payment schedule.

I. DIAGNOSTIC SERVICES

D0120	Periodic oral evaluation - established patient	$ 0
D0140	Limited oral evaluation problem focused	$ 0
D0145	Oral evaluation for patient under three years of age	$ 0
D0150	Comprehensive oral evaluation - new or established patient	$ 0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$ 0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$ 0
D0180	Comprehensive periodontal evaluation - new or established patient	$ 0
D0210	Full-mouth x-ray series	$ 0
D0220	Single x-ray	$ 0
D0230	Additional x-ray(s)	$ 0
D0240	Occlusal x-ray	$ 0
D0270	Single bitewing x-ray	$ 0
D0272	Two bitewing x-rays	$ 0
D0273	Bitewings - three films	$ 0
D0274	Four bitewing x-rays	$ 0
D0277	Verticle bitewing series (7 to 8 films)	$ 0
D0330	Panoramic x-ray	$ 0
D0460	Nerve vitality test	$ 0
D0470	Diagnostic casts	$ 0
D0999	Unspecified diagnostic procedure, by report†	$ 12.00

Failed appointment without 24-hr notice per 15 min. of appointment time is $ 10.00

† This code may be used for reimbursing Chlorhexidine and prescription strength fluoride toothpaste only when dispensed in the office by a dentist.

II. PREVENTIVE SERVICES

D1110	Adult cleaning	$ 0
D1120	Child cleaning	$ 0
D1203	Fluoride excluding cleaning (to age 19)	$ 0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$ 0
D1330	Oral hygiene instruction	$ 0
D1351	Sealant application - through age 15, unrestored permanent molars, once per tooth	$ 0
D1352	Preventive resin restoration in permanent tooth for moderate to high caries risk patients	$ 0
D1510	Space maintainer - fixed, unilateral	$ 98.00
D1515	Space maintainer - fixed, bilateral	$ 165.00
D1520	Space maintainer - removable, unilateral	$ 68.00
D1525	Space maintainer - removable, bilateral	$ 158.00
D1550	Recementation of space maintainer	$ 0
D1555	Removal of fixed space maintainer	$ 0

III. MINOR RESTORATIVE SERVICES

D2140	One surface silver filling, primary or permanent	$ 12.00
D2150	Two surfaces silver filling, primary or permanent	$ 14.00
D2160	Three surfaces silver filling, primary or permanent	$ 17.00
D2161	Four or more surfaces silver filling, primary or permanent	$ 20.00
D2330	One surface white filling: front tooth	$ 14.00
D2331	Two surfaces white filling: front tooth	$ 17.00
D2332	Three surfaces white filling: front tooth	$ 20.00
D2335	Four or more surfaces white filling: front teeth	$ 26.00
D2390	White crown, front	$ 26.00
D2391	One surface white filling: back tooth	$ 18.00
D2392	Two surfaces white filling: back tooth	OPT
D2393	Three surfaces white filling: back tooth	OPT
D2394	Four or more surfaces white filling: back teeth	OPT
D2410	Gold foil - one surface	OPT
D2420	Gold foil - two surfaces	OPT
D2430	Gold foil - three surfaces	OPT

IV. MAJOR RESTORATIVE SERVICES

D2542	Onlay - metallic - two surfaces	$ 323.00
D2543	Onlay - metallic - three surfaces	$ 290.00
D2544	Onlay - metallic - four or more surfaces	$ 339.00
D2642	Onlay - porcelain/ceramic - two surfaces	$ 299.00
D2643	Onlay - porcelain/ceramic - three surfaces	$ 316.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$ 353.00
D2710	Crown - resin-based white	$ 105.00
D2720	Crown - resin with high noble metal††	$ 315.00
D2721	Crown - resin with pred. base metal	$ 257.00
D2722	Crown - resin with noble metal	$ 274.00
D2740	Crown - porcelain/ceramic substrate	$ 375.00*
D2750	Crown - porcelain and high noble metal††	$ 345.00*
D2751	Crown - porcelain and base metal	$ 313.00*
D2752	Crown - noble metal	$ 323.00*
D2780	Crown - ¾ cast high noble metal††	$ 345.00*
D2781	Crown - ¾ cast predominantly base metal	$ 343.00*
D2782	Crown - ¾ cast noble metal	$ 349.00*
D2783	Crown - ¾ porcelain/ceramic	OPT
D2790	Crown - high noble metal††	$ 359.00*
D2791	Crown - base metal	$ 313.00*
D2792	Crown - full cast noble metal	$ 328.00*
D2794	Crown - titanium††	$ 435.00*
D2910	Recement inlay, onlay or partial coverage restoration	$ 10.00
D2915	Recement cast or prefabricated post and core	$ 9.00
D2920	Recement crown	$ 10.00
D2930	Crown - stainless steel: baby tooth	$ 26.00
D2931	Crown - stainless steel: permanent tooth	$ 26.00
D2932	Crown - prefabricated resin	$ 30.00
D2933	Crown - prefabricated stainless steel with resin window	$ 23.00
D2940	Sedative filling	$ 10.00
D2950	Core build-up, including any pins	$ 87.00
D2951	Pin retention in addition to filling, per tooth	$ 5.00
D2952	Post and core in addition to crown, indirectly fabricated	$ 120.00
D2953	Each additional indirectly fabricated post - same tooth	$ 15.00

** Includes co-payment and lab fee for this procedure.*

D2954	Prefabricated post and core (in addition to crown)	$ 98.00
D2957	Each additional prefab post - same tooth	$ 15.00
D2970	Temporary crown (fractured tooth)	$ 75.00
D2971	Additional procedure to construct new crown under existing partial denture framework	$ 68.00
D2980	Crown repair, by report	$ 20.00

V. ENDODONTIC SERVICES

D3110	Pulp cap: direct	$ 7.00
D3120	Pulp cap: indirect	$ 7.00
D3220	Pulp removal on baby tooth	$ 16.00
D3221	Pulpal debridement primary and permanent teeth	$ 19.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$ 16.00
D3230	Pulpal therapy (resorbable filling) - front, primary tooth (excl. final restoration)	$ 12.00
D3240	Pulpal therapy (resorbable filling) - back, primary tooth (excl. final restoration)	$ 12.00
D3310	Root canal treatment: front tooth	$ 74.00
D3320	Root canal treatment: bicuspid	$ 85.00
D3330	Root canal treatment: molar	$ 105.00
D3346	Retreatment of previous root canal therapy - front	$ 85.00
D3347	Retreatment of previous root canal therapy - bicuspid	$ 95.00
D3348	Retreatment of previous root therapy - molar	$ 125.00
D3410	Surgical root canal treatment: front tooth	$ 75.00
D3421	Surgical root canal treatment: bicuspid (first root)	$ 60.00
D3425	Surgical root canal treatment: molar (first root)	$ 87.00
D3426	Surgical root canal treatment: each additional root	$ 51.00
D3430	Retrograde filling - per root	$ 16.00

VI. PERIODONTIC SERVICES

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$ 42.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$ 30.00
D4240	Gingival flap procedures, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant	$ 84.00
D4241	Gingival flap procedures, including root planing, one to three contiguous teeth or bounded teeth spaces per quadrant	$ 53.00
D4245	Apically positioned flap	$ 130.00
D4249	Crown lengthening - hard tissue	$ 87.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$ 112.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$ 85.00
D4341	Periodontal scaling and root planing - four or more teeth, per quadrant	$ 23.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$ 16.00
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis	$ 40.00
D4910	Periodontal maintenance following active therapy	$ 7.00

VII. REMOVABLE PROSTHODONTICS

D5110	Complete denture, upper††	$ 390.00*
D5120	Complete denture, lower††	$ 388.00*
D5130	Immediate denture, upper††	$ 420.00*
D5140	Immediate denture, lower††	$ 434.00*
D5211	Upper partial denture: resin base††	$ 277.00
D5212	Lower partial denture: resin base††	$ 300.00
D5213	Upper partial denture: metal††	$ 420.00*
D5214	Lower partial denture: metal††	$ 420.00*
D5225	Upper partial denture: flexible base††	$ 390.00
D5226	Lower partial denture: flexible base††	$ 419.00
D5281	Unilateral partial denture	$ 195.00
D5410	Adjust denture: complete, upper	$ 9.00
D5411	Adjust denture: complete, lower	$ 7.00
D5421	Adjust denture: partial, upper	$ 8.00
D5422	Adjust denture: partial, lower	$ 8.00
D5510	Repair broken complete denture base	$ 15.00
D5520	Replace missing or broken teeth: complete denture, per tooth	$ 14.00
D5610	Base repair: partial denture	$ 15.00
D5620	Cast framework repair	$ 21.00
D5630	Repair or replace broken clasp	$ 17.00
D5640	Replace partial denture tooth, per tooth	$ 14.00
D5650	Add tooth to existing partial denture	$ 17.00
D5660	Add clasp to existing partial denture	$ 19.00
D5670	Replace all teeth on upper denture	$ 135.00
D5671	Replace all teeth on lower denture	$ 135.00
D5710	Rebase denture: complete, upper	$ 42.00
D5711	Rebase denture: complete, lower	$ 40.00
D5720	Rebase denture: partial, upper	$ 45.00
D5721	Rebase denture: partial, lower	$ 40.00
D5730	Reline denture: complete, upper (chairside)	$ 30.00
D5731	Reline denture: complete, lower (chairside)	$ 30.00
D5740	Reline denture: partial, upper (chairside)	$ 24.00
D5741	Reline denture: partial, lower (chairside)	$ 27.00
D5750	Reline denture: complete, upper (laboratory)	$ 39.00
D5751	Reline denture: complete, lower (laboratory)	$ 39.00
D5760	Reline denture: partial, upper (laboratory)	$ 37.00
D5761	Reline denture: partial, lower (laboratory)	$ 35.00
D5820	Temp partial denture, upper	$ 149.00
D5821	Temp partial denture, lower	$ 140.00
D5850	Tissue conditioning: upper	$ 15.00
D5851	Tissue conditioning: lower	$ 19.00
D5860	Overdenture: complete, by report	OPT
D5861	Overdenture: partial, by report	OPT

†† *Includes any adjustments for six months.*

VIII. FIXED PROSTHODONTICS

D6210	Pontic: cast high noble metal†††	$ 338.00*
D6211	Pontic: predominantly base metal	$ 308.00*
D6212	Pontic: cast noble metal	$ 323.00*
D6240	Pontic: porcelain fused to high noble metal†††	$ 342.00*
D6241	Pontic: porcelain fused to pred. base metal	$ 308.00*
D6242	Pontic: porcelain fused to noble metal	$ 318.00*
D6250	Pontic: resin with high noble metal†††	$ 311.00
D6251	Pontic: resin with pred. base metal	$ 224.00
D6252	Pontic: resin with noble metal	$ 255.00

OPT = *An alternative benefit. Your plan covers the least expensive method of appropriate care for this condition, yet an alternative procedure can also be applied at the discretion of you and your dentist at a higher out-of-pocket cost to you.*

** Includes co-payment and lab fee for this procedure.*

D6545	Retainer - cast metal for resin bonded fixed prosthesis	$ 120.00
D6602	Inlay - cast high noble metal, two surfaces†††	$ 285.00
D6603	Inlay - cast high noble metal, three or more surfaces†††	$ 277.00
D6604	Inlay - cast predominantly base metal, two surfaces	$ 244.00
D6605	Inlay - cast predominantly base metal, three or more surfaces	$ 275.00
D6606	Inlay - cast noble metal, two surfaces	$ 450.00
D6607	Inlay - cast noble metal, three or more surfaces	$ 275.00
D6610	Onlay - cast high noble metal, two surfaces†††	$ 292.00
D6611	Onlay - cast high noble metal, three or more surfaces†††	$ 315.00
D6612	Onlay - cast predominantly base metal, two surfaces	$ 292.00
D6613	Onlay - cast predominantly base metal, three or more surfaces	$ 183.00
D6614	Onlay - cast noble metal, two surfaces	$ 292.00
D6615	Onlay - cast noble metal, three or more surfaces	$ 413.00
D6720	Crown - resin with high noble metal†††	$ 180.00
D6721	Crown - resin with pred. base metal	$ 240.00
D6722	Crown - resin with noble metal	$ 240.00
D6750	Crown - porcelain fused to high noble metal††† & ††††	$ 345.00*
D6751	Crown - porcelain fused to predominantly base metal††††	$ 313.00*
D6752	Crown - porcelain fused to noble metal††††	$ 323.00*
D6780	Crown - ¾ cast high noble metal†††	$ 343.00*
D6781	Crown - ¾ cast predominantly base metal	$ 343.00*
D6782	Crown - ¾ cast noble metal	$ 343.00*
D6790	Crown - cast high noble metal†††	$ 336.00*
D6791	Crown - cast base metal	$ 313.00*
D6792	Crown - cast noble metal	$ 328.00*
D6930	Recement fixed partial denture (bridge)	$ 14.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$ 99.00
D6972	Prefabricated post with core buildup	$ 105.00
D6973	Core build-up for retainer, including any pins	$ 62.00
D6976	Additional indirectly fabricated post - same tooth	$ 15.00
D6977	Each additional prefab post - same tooth	$ 15.00

††† *For members who reside outside of Massachusetts, if precious and semi-precious metals are used, they will be charged to the enrollee at the additional cost of the metal. This applies to crowns, bridges, and cast post and cores.*

†††† *Porcelain on molars is considered optional treatment.*

IX. ORAL AND MAXILLOFACIAL SURGERY

D7111	Extraction, coronal remnants - baby tooth	$ 10.00
D7140	Extraction, erupted tooth or exposed root; includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary	$ 14.00
D7210	Surgical tooth removal, minor smoothing of socket bone and closure	$ 27.00
D7220	Impacted tooth removal: soft tissue	$ 32.00
D7230	Impacted tooth removal: partially bony	$ 42.00
D7240	Impacted tooth removal: completely bony	$ 50.00
D7241	Removal of impacted tooth: completely bony with unusual surgical complications	$ 60.00
D7250	Surgical removal of residual tooth roots	$ 27.00
D7286	Biopsy of soft tissue	$ 35.00
D7288	Brush biopsy - transepithelial sample collection	$ 20.00
D7310	Alveoloplasty in conjunction with extractions, four or more teeth or tooth spaces - per quadrant	$ 21.00
D7311	Bone recontouring (done with extractions) - one to three teeth or tooth spaces, per quadrant	$ 25.00
D7320	Alveoloplasty not in conjunction with extractions, four or more teeth or tooth spaces - per quadrant	$ 30.00
D7321	Bone recontouring (done without extractions) - one to three teeth or tooth spaces, per quadrant	$ 23.00
D7471	Excision - bone tissue	$ 34.00
D7472	Removal of torus palatinus	$ 69.00
D7473	Removal of torus mandibularis	$ 55.00
D7510	Incision and drainage of abscess	$ 20.00
D7960	Frenulectomy (frenectomy or frenotomy)	$ 50.00

X. ORTHODONTIC SERVICES

Please contact your local DeltaCare Service Team using the phone number listed on the back side of your ID card for a detailed breakdown of the following all-inclusive orthodontic fees.

Pre-orthodontic treatment visit (applied to treatment fee if patient proceeds with treatment)	$ 25.00
Pre-orthodontic records (applied to treatment fee if patient proceeds with treatment)†††††	$ 200.00
Dependent children to age 19 *Comprehensive care up to 24 months*	$ 3350.00
Adults and covered dependents over age 19 *Comprehensive care up to 24 months*	$ 3550.00

This comprehensive orthodontic treatment includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers, and office visits for a maximum of two years after the completion of active treatment. For treatment plans extending beyond 24 months of active treatment, the patient will be subject to a monthly office visit fee, not to exceed $75/month.

††††† *This fee is built into the all-inclusive orthodontic fees listed, but will be a separate co-payment if you choose not to continue treatment with this dentist. The fee includes: records solely for the purpose of orthodontics (pre-records), intraoral-complete series (including bitewings), cephalometric film, panoramic film, tomographic survey, oral/facial images (includes intra and extra oral images), diagnostic casts.*

XI. ADDITIONAL PROCEDURES

D9110	Emergency treatment for relief of pain	$ 10.00
D9211	Regional block anesthesia	$ 0
D9212	Trigeminal division block anesthesia	$ 0
D9215	Local anesthesia	$ 0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$ 8.00
D9440	After-hours office visit	$ 25.00
D9999	Unspecified diagnostic procedure, by report	$ 10.00

** Includes co-payment and lab fee for this procedure.*

15. Dental services received from any dental office other than the assigned PCD's office, unless expressly authorized in writing from DeltaCare.
16. Prophylactic removal of impactions (asymptomatic nonpathological).
17. Specialist consultations for non-covered benefits.
18. Implant placement or removal, appliances placed on or services associated with implants.
19. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility with the DeltaCare program. Example: teeth prepared for crowns, root canals in progress, orthodontic treatment.
20. Occlusal guards for bruxism (grinding) or TMJ.
21. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly generally accepted method of treatment.
22. A service rendered by someone other than a licensed dentist or a hygienist that is employed by a licensed dentist.
23. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration, or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits.
24. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full-mouth reconstruction and are not a benefit of the DeltaCare program.
25. Tooth desensitization.

Member Rights and Responsibilities

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

- Be provided with appropriate information about Delta Dental and its benefits, providers, and policies.
- Be informed of your diagnosis, the proposed treatment, and prognosis by your dentist.
- Give informed consent before beginning any dental treatment and be made aware of the consequences of refusing treatment.
- Obtain a copy of your dental record, in accordance with the law.
- Be treated with respect and have your dignity and need for privacy recognized.

You have the responsibility to:

- Ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by providers.
- Provide dentists with the information necessary to care for you.
- Be familiar with Delta Dental benefits, policies, and procedures by reading Delta Dental's written materials or calling the DeltaCare Unit.

Where to Get More Information

If you have any questions, please contact our DeltaCare Unit at (800) 327-6277.

This information should be used only as a guide for your dental plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, please see the Subscriber Certificate. Copies of the Subscriber Certificate are available through your benefits administrator.

At your request, interpreter and translation services related to administrative procedures are available to you or a covered family member.

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

អ្នកបកប្រែ ឬកិច្ចការបកប្រែ
បើអ្នកស្នើឱ្យមានអ្នកបកប្រែ ឬឯកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងទៅនឹង
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翻譯服務
如果您提出要求，我們可以為您提供相關的行政禮節的翻譯服務。

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

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

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

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

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

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

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

Your Plan is Administered by:

Delta Dental of Massachusetts
1-800-327-6277

DELTA DENTAL®

Delta Dental of Massachusetts
465 Medford Street, Boston, MA 02129
www.deltadentalma.com

SP633(10/10)5M

Subscriber's Certificate

DeltaCare

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

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

ATTEST: Dental Service of Massachusetts, Inc.

Fay Donohue
President & CEO

Myra Green
Corporate Clerk

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

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

SP103-FDS_DeltaCare – revised May 2010

Table of Contents

Introduction

This certificate is part of the *contract* between you and *Delta Dental*. We urge you to read it carefully.

Please note that the words in *Italics* are listed in Part I, "Definitions".

This certificate includes four types of services:

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

2. Type II 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.

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

4. Type IV includes services to prevent and correct misalignment of the teeth (orthodontics).

The dental services described in this *contract* 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 state and federal law.

Additionally, there are some limitations or restrictions on your membership, which are found in Part IV of this certificate.

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

If you have any questions, contact your *plan sponsor* or *Delta Dental's* DeltaCare Customer Service department. *Delta Dental's* telephone numbers are listed at the end of this certificate.

Member Rights and Responsibilities

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

- file grievances about *Delta Dental* or the participating dentists. In the case of an adverse determination, *Delta Dental* may include alternative treatment options that are covered and are appropriate and consistent with general principles of professional dental practice.
- 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

Interpretation/Translation Services

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خدمات ترجمة فورية/ترجمة

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

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

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

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

Part I: Definitions

Adverse determination: means a decision by *Delta Dental* to deny, reduce, or modify the availability of any dental care services, because your condition failed to meet the requirements for coverage based on necessity, appropriateness of care, level of care, or effectiveness.

Complaint: means any inquiry made by you or on your behalf to *Delta Dental* that is not explained or resolved to your satisfaction within ten (10) business days of the inquiry; or involves an *adverse determination*.

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

Covered Individual: a person who receives dental benefits under the DeltaCare program. This usually includes *subscribers* and their dependents.

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

DeltaCare Primary Care Dentist: a dentist who has entered into an agreement with *Delta Dental* to furnish services to DeltaCare *covered individuals*. Each *covered individual* selects a *DeltaCare primary care dentist* upon enrollment in DeltaCare.

Disenrollment: *Covered individuals* who are disenrolled because they have moved out of our service area or whose continuation of coverage periods has expired. They are former dependents that no longer qualify as dependents, or covered individuals who lose coverage under an employer sponsored plan because they have ceased employment. They are disenrolled because their employer group has canceled coverage under the plan, reduced number of hours worked, or they have become disabled, retired or died. The involuntary disenrollment rate amongst all insured is extremely low as currently defined.

Effective Date: the date, as shown on our records, 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 your unmarried dependent children under 19 years of age, as well as their unmarried children under 19 years. 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 19 years may be eligible to continue coverage under a family membership if *Delta Dental* is notified within 72 days of the child's nineteenth birthday.

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

Grievance**:** refers to any oral or written complaint submitted to *Delta Dental* by you or on your behalf concerning any aspect or action of *Delta Dental*. This is including, but not limited to, review of *adverse determinations* regarding the scope of your coverage, denial of services, quality of care and administrative operations.

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

Inquiry: means any question or concern communicated by you or on your behalf to *Delta Dental*, which has not been the subject of an *adverse determination*.

Maximum Fee Allowance: The payment amount that *Delta Dental* sets for the non-participating dentist services that may be provided under this *contract*. Benefits are payable in accordance with the Outline of Reimbursement as filed and approved by the Division Of Insurance for this contract for Massachusetts dentists and the terms and conditions of the applicable Benefits Payable Rider attached to this certificate and in effect at the time services are rendered.

Plan Sponsor: the *plan sponsor* is your agent and is not the agent of *Delta Dental*. The *plan sponsor* sends to us the subscription charge due from you and receives all notices from us for you. We will send your *plan sponsor* any subscription refund due to you. It is the *plan sponsor's* responsibility to notify you of changes to your benefits or your charges.

Quality Assurance Management: a program that provides specific policies and procedures to ensure that minimum standards are met and proper evaluations are conducted in order to provide insureds with quality care.

Specialist: a dentist who is either board eligible or board certified to perform specialty care. The DeltaCare *specialist* works with your *DeltaCare primary care dentist* to coordinate treatment for specialty services that are needed.

Subscriber: an employee or member, certified by the *plan sponsor*, who is eligible to receive dental benefits under the DeltaCare program.

Utilization Review: a formal process designed to monitor the use of, or evaluate the medical necessity, appropriateness or efficiency of healthcare services.

Part II : Plan Description

1. In the DeltaCare program, patients who use a *DeltaCare primary care dentist* do not need to file claim forms. If you do not use a *DeltaCare primary* care dentist you are responsible for filing a claim form directly with *Delta Dental*.

2. At the beginning of coverage, each *subscriber* and his or her dependent(s) must select a *DeltaCare primary care dentist* from a list provided by *Delta Dental*. If no dentist is selected, one will be assigned to you by *Delta Dental*. To receive maximum benefit levels, *covered individuals* must receive all their dental care from the selected *DeltaCare primary care dentist* or from a *specialist* to which they are referred by the *DeltaCare primary care dentist*. Requests for changes of primary care dentist can be made over the phone by contacting the DeltaCare Unit using the phone number listed on the back side of your ID card. Changes will take effect on the first day of the month following the request. If you choose to receive dental care from a dentist other than your *DeltaCare primary care dentist* (or a referred *specialist*), please see Item 6.

   If your Primary care dentist decides to leave the DeltaCare network of dentists, *Delta Dental* will provide you at least thirty (30) days notice before disenrollment of your *DeltaCare primary care dentist* from our network. If you are currently undergoing a dental procedure, you should return to the disenrolled dentist to complete your treatment. To ensure continuous access to dental care, *Delta Dental* will automatically assign you to a new *DeltaCare primary care dentist* and this information will be contained in your notification letter. You may continue with the assigned provider or you may contact *Delta Dental's* Customer Service department to select another *DeltaCare primary care dentist*.

3. The *DeltaCare primary care dentist* assumes responsibility for coordination of dental care needed by the patient as defined in the benefits section.

4. If treatment warrants the use of a *specialist*, your *DeltaCare primary care dentist* may refer you to a *specialist* to provide treatment. The *covered individual* is responsible for paying any co-payments for specialty care directly to the *specialist*. Benefits for specialty care services including periodontal and endodontic services and oral surgery are limited to a $1,000 calendar year maximum.

5. Each *covered individual* selects or is assigned a *DeltaCare Primary Care Dentist* who is participating in the DeltaCare network. For services performed by primary care and specialty DeltaCare dentists, the in-network benefit allowance is based on the DeltaCare schedule of patient co-payments. The primary care dentist has agreed to accept *Delta Dental*'s monthly per member per month payment plus applicable patient co-payments as full payment. The DeltaCare *specialist* has agreed to accept the DeltaCare specialty fee schedule as payment in full for covered services. Network dentists may not bill the patient for amounts other than those listed on the schedule of patient co-payments. You will, however, be responsible for the difference between the Plan payment and the dentist's actual charge for covered services in excess of the maximum fee allowance for specialty services.

6. For services performed by non-panel dentists, the out-of-network benefit for each type of service will be twenty percent lower than the average in-network benefit level by type of service. These reduced co-insurance percentages will be applied against the maximum fee allowance or the dentist's submitted fee if lower.

   Additionally, a one hundred dollar ($100) per covered individual deductible, which is separate and distinct applies to all services and has no aggregate family maximum deductible amount.

   Delta Dental pays the *covered individual* directly for covered services, and the member is responsible for paying the dentist.

7. When a *Covered Individual* has the sudden onset of a dental condition that requires immediate treatment to relieve pain, the member must call his or her *DeltaCare Primary Care Dentist* and have their care provided or referred by the *DeltaCare Primary Care Dentist.* If the *covered individual* is out of the area or after making reasonable effort as determined by *Delta Dental*, is unable to see his or her *DeltaCare Primary Care Dentist*, then only minor dental procedures for pain relief (such as pulpectomy or temporary filling) are covered. Submit a claim for reimbursement to *Delta Dental* of Massachusetts; Attention: DeltaCare, 465 Medford Street, Boston, MA 02129.

   Nothing in this section will prohibit a *covered individual* from seeking emergency care whenever the individual is confronted with an *emergency medical condition* which in the judgment of a prudent layperson would require pre-hospital emergency services. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent. Coverage will not be denied for dental expenses incurred as a result of such emergency condition.

8. We will allow your *DeltaCare primary care dentist* to authorize a standing referral for specialty dental care provided by a DeltaCare *specialist* when:

    a) The *DeltaCare primary care dentist* determines that such referrals are appropriate;

    b) The DeltaCare *specialist* agrees to a treatment plan for you and provides your *DeltaCare primary care dentist* with all necessary clinical and administrative information on a regular basis;

    c) The dental care services to be provided are consistent with the terms of your subscriber certificate; and

    d) Nothing in this section shall be construed to permit a DeltaCare *specialist* who is subject to a referral to authorize any further referral of you to any other dentist without our approval.

Part III: Benefits

You have the right to benefits for the following services on a non-discriminatory basis, EXCEPT as limited or excluded elsewhere in this *contract.* Co-payments, which are the responsibility of the *covered individual*, may apply for certain procedures. For the list of valid services and corresponding co-payments, please refer to the subscriber benefit flyer, which is incorporated as part of this certificate. Benefits for specialty care services including periodontal and endodontic services and oral surgery are limited to $1,000 per calendar year.

Your schedule of co-payments is outlined in your subscriber benefit flyer.

A. Diagnostic and Preventive Services

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

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

2. Periodic oral evaluation; twice per calendar year.

3. Full mouth intraoral radiograph examination or panoramic examination according to the frequency recommended by the Food and Drug Administration's "Guidelines for Prescribing Dental Radiographs" but not to exceed once every 24 months.

4. Posterior bitewing examination according to the frequency recommended by the Food and Drug Administration's "Guidelines for Prescribing Dental Radiographs" but are limited to not more than one series of four films in any six-month period.

5. Single tooth x-rays; as needed.

6. Routine cleaning, scaling and polishing of teeth based upon the individual needs assessment of the patient but not to exceed two treatments in any 12 consecutive months.

7. Topical fluoride treatment based upon individual risk assessment of the patient but not to exceed two treatments for *covered individuals* under 19 years in any 12 consecutive months.

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

9. Emergency oral evaluation problem-focused exams.

10. Sealants based upon individual risk assessment needs of the patient but are for unrestored permanent molars only, once per tooth for members through age 15.

B. Restorative Services and Other Basic Services

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

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

2. Sedative fillings; once per tooth.

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

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

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

6. Endodontic services for root canal treatment of permanent teeth including: (i) treatment of the nerve of a tooth; (ii) removal of dental pulp; and (iii) pulpal therapy. Vital pulpotomy is limited to deciduous teeth on covered members.

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

8. Repair of dentures or fixed bridges once each 12 months, and recementing of fixed bridges once per lifetime.

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

10. Tissue conditioning; two treatments every 36 months.

11. Repair or recement crowns and onlays limited to once per tooth.

C. Prosthodontic and Other Services

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

1. Dentures and Bridges

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

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

Adding teeth to existing partial dentures or to a bridge.

Temporary partial dentures as follows:

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

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

2. Crowns and Onlays

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

a. Initial placement of crowns and onlays.

b. Replacement of crowns and onlays which present with evidence of active recurrent decay at the margins or radiographically present under the restoration; once every 60 months per tooth.

D. Orthodontic Services

Benefits are available for the following services and supplies necessary and appropriate to prevent and correct misalignment of the teeth. The misalignment must be severe enough to significantly interfere with the function of the teeth.

Comprehensive active care and Limited active care is determined by *Delta Dental*.

COMPREHENSIVE ACTIVE CARE is care of an extensive nature, which is part of a complete course of orthodontic treatment including orthodontic records and initial exam. LIMITED ACTIVE CARE is care of a minor nature consisting of one or more than one of

the following services: minor treatment for tooth guidance; minor treatment to control harmful habits; interceptive orthodontic treatment; and orthodontic treatment accomplished solely through the use of functional appliances.

Part IV Exclusions

Exclusions

We do not provide benefits for:

1. Any service that is not specifically listed as a covered expense.

2. Cosmetic dental care.

3. Dental conditions arising out of and due to *subscriber*'s employment or for which Worker's Compensation is payable. Services which are provided to the *subscriber* by state government or agency thereof, or are provided without cost to the *subscriber* by any municipality, county or other subdivision.

4. Treatment required by reason of war.

5. Dental services performed in a hospital and related hospital fees.

6. Treatment of fractures and dislocations.

7. Replacement of fixed and removable prosthetics (crowns, bridges, full or partial dentures and other appliances) due to loss, theft or damage.

8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

9. General anesthesia.

10. Dental expenses incurred in connection with any dental procedure started prior to *subscriber*'s eligibility with the DeltaCare program. Example: teeth prepared for crowns or root canals in progress.

11. Treatment of congenital malformations.

12. Treatment of cysts and malignancies.

13. Dispensing of drugs.

14. Cases which, in the professional judgment of the attending dentists, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

15. Prophylactic removal of impactions (asymptomatic nonpethological) or extraction solely for purpose of orthodontia.

16. “Specialist consultations” for non-covered benefits.

17. Implant placement or removal, appliances placed on or services associated with implants.

18. Occlusal Guards.

19. Accidental Injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

20. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly generally accepted method of treatment.

21. A service rendered by someone other than a licensed dentist or a hygienist that is employed by a licensed dentist.

22. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits.

23. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full mouth reconstruction and are not a benefit of the DeltaCare program.

24. Tooth desensitization.

25. Any service not specifically listed as a covered expense.

Orthodontic Limitations and Exclusions

1. Orthodontic treatment must be provided by a member of the DeltaCare orthodontic panel.

2. A consultation fee may be charged if treatment is not required or you elect not to start treatment after a diagnosis and consultation has been completed.

3. Surgical services; including orthognathic surgery.

4. Lost, stolen or broken orthodontic devices.

5. Retreatment of orthodontic cases is excluded

6. Changes in treatment necessitated by an accident of any kind.

7. Myofunctional therapy.

8. Surgical procedures related to cleft palate, micrognathia, or macrognathia.

9. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance.

10. Malocclusions that are so severe that they are not amenable to ideal orthodontic therapy.

11. Restorative work caused by orthodontic treatment.

12. Orthodontic examination and records unless you receive comprehensive treatment.

13. Tooth extraction solely for the purpose of orthodontics.

14. Artificial devices to increase the height of teeth. This includes crowns and onlays.

15. Orthodontic expenses incurred in connection with orthodontic treatment started by another dental carrier prior to *subscriber's* eligibility with DeltaCare program. Payments, if any, are subject to proration based on DeltaCare's Total Case Fee.

16. Orthodontic expenses incurred in connection with orthodontic treatment started by a Delta Dental Premier or Delta Dental PPO provider prior to *subscriber's* eligibility with DeltaCare program will be paid under guidelines of the plan in effect prior to DeltaCare.

17. We do not provide benefits for orthodontic expenses incurred in connection with orthodontic treatment started *with no insurance coverage* and prior to *subscriber's* eligibility with DeltaCare program.

Part V Other Contract Provisions

1. 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.

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

DeltaCare primary care dentists have agreed to give us all information necessary to determine your benefits under this *contract*. Massachusetts State law requires Massachusetts *non-participating dentists* to provide this information also. *DeltaCare primary care dentists* have agreed not to charge for this service.

We will treat any medical information we receive about you as confidential.

3. SUBSCRIPTION CHARGE

A. Payments: The amount of money that your *plan sponsor* pays to *Delta Dental* for your benefits under this *contract* is called your subscription charge within 30 days from the due date. Your *plan sponsor* is responsible to pay to *Delta Dental* the total subscription charges by the due date indicated on each monthly invoice. 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 this Agreement 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 your 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 those changes in subscription charges.

4. 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. Your *plan sponsor* will notify you of this change. *Delta Dental* is not responsible if the *plan sponsor* does not notify you that your *contract* will be changed.

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 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*. 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. If your *plan sponsor* has purchased benefits for orthodontic services, this limitation will not apply to these benefits.

5. 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* or family member under this certificate of coverage. This eligibility is based upon *Delta Dental's* underwriting guidelines and your *plan sponsor*. 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 limitations or exclusions on your membership.

You, your spouse and your unmarried dependent children under 19 years of age, dependents who are **full-time students** up to age 23 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 over 19 years, may be eligible to continue coverage under a family contract if *Delta Dental* is notified within 72 days of the child's nineteenth birthday, and by completing a disabled dependent application.

6. WHEN YOUR COVERAGE ENDS

There are no conversion privileges under the *contract.* However, a *covered individual* may have the right to continue dental coverage for a period of time under state law and under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You and certain family members may be entitled to continue participating in this plan for a limited period even under conditions (such as your death or termination of

employment) that would otherwise make you ineligible for coverage, so long as you pay the appropriate subscription in full. Contact your *plan sponsor* for more detailed information regarding continuation of coverage.

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

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

B. Your unmarried dependent child under your *family contract* becomes 19 years of age or marries, whichever comes first.

C. However, if your unmarried dependent child is either mentally or physically handicapped upon reaching 19 years and is incapable of earning his or her own living, special arrangements can be made for your child to continue coverage under your *family contract*. You must apply for this continued coverage through your *plan sponsor* within 72 days of your child's nineteenth birthday. In addition, you must supply us with any medical or other information that we may need to determine if your child is eligible to continue coverage under your *family contract*.

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

D. Whenever your dependent child's coverage under your *family contract* ends, the coverage for an offspring of that dependent child also ends.

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

F. If you relocate outside of the service area.

7. TERMINATION OF A CONTRACT

A. You or your *plan sponsor* may cancel your *contract*.

1. Your *plan sponsor* may cancel your *contract* for any reason. To do so, your *plan sponsor* must give us notice in writing at least 30 days prior to the termination date.

2. You may also cancel your *contract* through your *plan sponsor*. To do so, your *plan sponsor* must give us notice in writing within 72 days of cancellation. If your subscription charge is paid for a period beyond your cancellation date, we will refund the subscription charge for that period to your *plan sponsor* provided no claim payments have been made for services rendered after your termination date.

3. If you cancel your *contract*, you must wait at least one year after your cancellation before you can enroll again as a *subscriber*. You can only enroll on your group's anniversary date or when a special open enrollment occurs.

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

1. We may cancel your group's *contract* under the terms of our agreement with your group. If your group's *contract* is canceled or not renewed, your coverage 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. The notice will be sent by either first class or certified mail, postage pre-paid to your last-known home address.

2. If you or your employer replaced your dental plan with another insured or self-insured dental plan, the provisions of this notice will not apply.

3. We may, upon due notice to your *plan sponsor*, cancel your *contract* under any of the following circumstances:

   a. We may cancel your *contract* if you make any fraudulent claim or misrepresentation to us or to any dentist, such as an incorrect or incomplete statement on your application card which led us to believe you were eligible for this coverage when in fact you were not. In such a case, cancellation will be as of your *effective date*. We will refund your *plan sponsor* the subscription charge you have paid us. We will subtract from the refund any payments made for claims under this *contract*. If we have paid more for claims under this *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 you have not paid your subscription charges. Cancellation will be effective on a date we choose, but not earlier than the

subscription charge due date. If you are a *subscriber* of a group plan, the *plan sponsor* will owe us the subscription charge due for the period between the due date and the cancellation date. You agree that we may use your rights against the *plan sponsor* to collect those subscription charges.

c. We may cancel your *contract* if you 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 relocate outside our service area.

e. We may cancel your *contract* for non-renewal or cancellation of the group *contract* through which you receive coverage.

8. BENEFITS AFTER CANCELLATION

If you or your *plan sponsor* cancels your *contract*, no benefits will be provided for services that you receive after your cancellation date.

9. NOTICES

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

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

10. ENROLLMENT AND CONTRACT CHANGES

All enrollment applications and any additions or changes to a *contract* are allowed ONLY when they conform to our Underwriting Guidelines on file with the Commissioner of Insurance.

11. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after the *effective date* of this *contract*. If before a *subscriber's effective date* he or she started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure, except as noted in Part IV regarding orthodontic treatment in progress.

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 DeltaCare *subscriber* identification number and any necessary information.

12. COORDINATION OF BENEFITS

We will apply Coordination of Benefits (COB) to all the benefits described in your *contract*. The COB program applies if you or any of your dependents have another plan that provides coverage for hospital, medical, dental or other health care expenses.

This program is designed to prevent people from making a profit from health care programs by collecting more than the actual charge for their covered health care services. This practice eventually leads to increased costs of health care for all. COB regulates all benefit payments for covered services so that the total payments received from all insurance programs do not exceed the total charge for those covered services.

Delta Dental will decide Coordination of Benefits (COB) according to the provisions under Commonwealth of Massachusetts Regulations and the guidelines established by the National Association of Insurance Commissioners (NAIC).

The plan that provides benefits first is known as the primary plan. The primary plan is responsible for providing benefits to the full extent of their coverage. The plan that provides benefits next is the secondary plan. It provides benefits towards any remaining balance of covered services as long as the payment, when added to the primary plan's payment, is not more than the total amount of the covered benefit expenses.

When *Delta Dental* is both the primary and secondary plan, *Delta Dental* will provide benefits to the full extent of both plans' coverage not to exceed the submitted charge.

Delta Dental as the secondary plan will provide benefits towards any remaining patient balance of covered services as long as the payment, when added to the primary plan's payment, is not more than the total allowed amount of covered benefit expenses.

13. RIGHT TO RECOVER OVERPAYMENTS

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

IMPORTANT: No statement in this section should be interpreted to mean that we will provide any more benefits than those already described in the Benefits Section of this *contract.* Remember that under COB, the total of the payments made for covered health care services will not be more than the total of the allowed charges for those covered services. We will not provide duplicate benefits for the same services. If you have any questions about COB and your *contract*, please contact our Customer Service department. The telephone numbers are listed at the end of this certificate.

14. QUALITY ASSURANCE:

As a DeltaCare member you have the option to select a participating DeltaCare provider as your primary care dentist and seek services from this participating provider. Should you require specialty services your primary care dentist will refer you to DeltaCare specialists for treatment. For further details about your coverage please refer to the benefit descriptions and exclusions sections of this certificate of coverage.

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

The Quality Management Program addresses the following standards:

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

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

15. UTILIZATION REVIEW

This is the formal process designed to monitor the use of, or evaluate the 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 appropriateness of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients and characteristics of the local delivery system.

The program was developed in conjunction with actively practicing dentists in all specialty areas of expertise and is reviewed at least annually to ensure that criteria are applied consistently.

Any utilization review conducted under your dental *contract* is done retrospectively at the time a claim for services has been submitted for reimbursement. In order for a submitted claim to be covered, the procedure must be included as one of the "Covered Procedures" in your certificate. If a procedure is not a covered procedure then the claim for that procedure will be denied in accordance with the terms of your certificate and the group policy. Frequency, age, *effective dates* of coverage, etc. may also limit coverage of certain procedures, which are all contractually stated within your certificate.

There are also a number of listed procedures which are only considered a covered expense if a patient presents with a specified health history and/or has been diagnosed with a specified condition. During the claims review of these specific procedures, there may be a determination by a licensed dental practitioner that the procedure that was performed was not determined to be medically appropriate in accordance with the criteria that has been established in accordance with our utilization review program. In these situations, the claim for that procedure may be denied or partially reimbursed in accordance with the benefit for an alternate procedure.

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

When a claim has been denied or partial denied based on medical appropriateness, this is considered an adverse determination. These decisions are reviewed by qualified and appropriately licensed dental 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 *utilization review* decisions with *Delta Dental,* you can submit your *inquiry* to us:

In writing: Attention: Customer Service

Delta Dental of Massachusetts
P.O. Box 9595
Boston, MA 02114-9595

By telephone: 1-800-872-0500
By fax: 1-617-886-1420
web site: www.deltadentalma.com

16. GRIEVANCE PROCESS:

You have the right to make inquiries and/or file a complaint with *Delta Dental* of Massachusetts.

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

In writing: Attention: Grievances
Delta Dental of Massachusetts
P.O. Box 9595
Boston, MA 02114-9595

By telephone: 1-800-872-0500
By fax: 1-617-886-1420
web site: www.deltadentalma.com

Internal Levels of Review

Internal Inquiry Process:

Delta Dental will attempt to answer your questions and/or resolve concerns for all issues with the exception of reviews of an *adverse determination*. (If you request a review for an *adverse determination*, this will be handled through the internal *grievance* process discussed below).

Internal Grievance process:

You may file a *grievance* by phone, in person, by mail, or by electronic means. If an oral *grievance* has been presented, we will request your *grievance* in writing.

We will send a written acknowledgement of our receipt of your *grievance* to you or your authorized representative, if any, within ten (10) business days of receipt. We will provide you or your authorized representative, if any, a written resolution of a *grievance* within thirty (30) business days of receipt of the written *grievance*.

Written Decision:

In the event that your *grievance* involves an *adverse determination*, our written response shall include a clinical justification that is consistent with generally accepted principles of professional dental practice and will (a) identify the specific information upon which the *adverse determination* was based and (b) reference and include applicable clinical practice guidelines and review criteria

Reconsideration:

We will always provide you with the opportunity to have a final decision reconsidered where relevant information is received too late to review within the thirty (30) business day time limit or is not received but is expected to become available within a reasonable period.

We will review reconsideration and provide our written response to you as soon as possible following receipt of the additional information. We agree to provide a response no later than thirty (30) business days following your request for reconsideration.

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 carefully read through your *contract*.

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

Customer Service:
617•886•1300
800•872-0500

Corporate Office:
617•886•1000