DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 173

To be attached to and form a part of your Delta Dental PPO Provider Arrangement.

Your group has purchased this Rider to change your Delta Dental PPO Provider Arrangement contract as follows:

Definitions: Delta Dental PPO Non Panel Dentists:

A dentist who has not signed an agreement with Delta Dental to accept Delta Dental PPO Panel Dentist allowances for services rendered for subscribers in the Delta Dental PPO plan. A Delta Dental PPO Non Panel Dentist who is under agreement as a Delta Dental participating dentist agrees to accept the contracted allowances for services rendered and not to balance bill subscribers.

A dentist who is not under any agreement and is not participating with Delta Dental will receive a reduced payment from Delta Dental and can balance bill for the difference between Delta Dental's payment and his or her actual charge.

NOTE: Underlined terms are defined in your contract.

DENTAL SERVICE OF MASSACHUSETTS, INC.
d/b/a DELTA DENTAL OF MASSACHUSETTS

Dennis J. Leonard
President & CEO

Incorporated under the laws of the
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DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 715

# Right Start 4 Kids Rider

To be attached to and form a part of your Delta Dental PPO Provider Arrangement

Your group has purchased this Rider. For eligible members, benefits for the covered services described in your Delta Dental PPO Contract are reimbursed as follows:

Benefits for covered individuals up to the age of 13 are reimbursed as follows:

Type 1, 2 and Type 3 services described in your Delta Dental PPO Contract are subject to a $0 deductible.

For Type 1, 2 and Type 3 services described in your Delta Dental PPO Contract, these covered individuals are subject to 0% coinsurance if they visit a participating dentist or a non-participating dentist*.

*In those circumstances where the dentist is not under any agreement with Delta Dental (non-participating), Delta Dental pays the covered member directly for covered services, and the member is responsible for paying the dentist. The dentist will bill the covered member for the difference between the Delta Dental payment and his / her submitted charge and balances resulting from plan specific deductibles and co-payment.

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DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 832

To be attached to and form a part of your Delta Dental PPO contract.

Your group has purchased this Rider to change your Delta Dental PPO contract as follows:

*Covered as a Type I benefit:*

- Type 1 services do not detract from the calendar year maximum.
- Topical fluoride treatments (any age), twice per 12 months.
- Full mouth x-rays are covered once per 36 months.
- Cleanings, exams, bitewing x-rays covered twice per calendar year.
- Periodontal cleanings are covered 4 times per calendar year regardless of periodontal history, not to be combined with regular cleanings.

*Covered as a Type II benefit:*

- Fillings consisting of silver amalgam and synthetic tooth color fillings; limited to one filling for each tooth surface for each 24-month period.
- Palliative treatment is covered 3 times every 6 months.

*Covered as a Type III benefit:*

- Crowns paid as a Type III benefit without any restrictions regarding tooth condition or adjacent teeth; limited to once per tooth per 60 months.
- Bone grafts (including sinus lifts) and barrier membranes are covered in conjunction with implants and at extraction sites under Type III Major Services - covered once per tooth every 60 months.
- An endosteal implant (a device surgically inserted into the bone to provide support for a single restoration) when the implant replaces permanent teeth through the second molars; limited to once per tooth per 60 months.

**TMJ-MPD**

- Occlusal orthotic device – limited to once every 5 years; the allowance includes all appliance adjustments OR occlusal orthotic device adjustment - Once per year after 6 months of appliance insertions.
- Occlusal guard for MPD-TMJ – limited to once every 5 years; the allowance includes all appliance adjustments OR occlusal guard adjustment - Once per year after 6 months of appliance insertions.
- Occlusal adjustment complete - limited to once every 5 years.

***TMJ benefits are subject to annual calendar year maximum and deductible*

*Additional benefits:*

- Deductibles met in the 4th quarter are carried over to the following calendar year.
- Dependents are covered up until the end of the month in which they turn 26.

NOTE: Underlined terms are defined in your contract.

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President

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DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
RIDER 833

To be attached to and form a part of your Delta Dental PPO contract.

Your group has purchased this Rider to change your Delta Dental PPO contract as follows:

*Covered as a Type I benefit:*

- Type 1 services do not detract from the calendar year maximum.
- Topical fluoride treatments (any age), twice per 12 months.
- Cleanings, exams, bitewing x-rays covered twice per calendar year.
- Periodontal cleanings are covered 4 times per calendar year regardless of periodontal history, not to be combined with regular cleanings.

*Covered as a Type II benefit:*

- Fillings consisting of silver amalgam and synthetic tooth color fillings; limited to one filling for each tooth surface for each 24-month period.

*Covered as a Type III benefit:*

- Crowns paid as a Type III benefit without any restrictions regarding tooth condition or adjacent teeth; limited to once per tooth per 60 months.
- Bone grafts (including sinus lifts) and barrier membranes are covered in conjunction with implants and at extraction sites under Type III Major Services - covered once per tooth every 60 months.
- An endosteal implant (a device surgically inserted into the bone to provide support for a single restoration) when the implant replaces permanent teeth through the second molars; limited to once per tooth per 60 months.

**TMJ-MPD**

- Occlusal orthotic device – limited to once every 5 years; the allowance includes all appliance adjustments OR occlusal orthotic device adjustment - Once per year after 6 months of appliance insertions.
- Occlusal guard for MPD-TMJ – limited to once every 5 years; the allowance includes all appliance adjustments OR occlusal guard adjustment - Once per year after 6 months of appliance insertions.
- Occlusal adjustment complete - limited to once every 5 years.

***TMJ benefits are subject to annual calendar year maximum and deductible*

*Additional benefits:*

- Deductibles met in the 4th quarter are carried over the following calendar year.
- Dependents are covered up until the end of the month in which they turn 26.

NOTE: Underlined terms are defined in your contract.

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DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
BENEFITS PAYABLE RIDER 1010

To be attached to and form a part of your Delta Dental PPO Provider Arrangement 2

Your group has purchased this Rider. Benefits for the covered services described in your Delta Dental PPO Contract are reimbursed as follows:

**IN-NETWORK BENEFITS (Delta Dental Premier Network & Delta Dental PPO Network):**

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each calendar year. In the case of a family contract, the total deductible payment for all covered individuals shall not exceed $150 for Type 2 and Type 3 services. This means you must pay the first $50 or $150 of benefits provided in each calendar year.

**OUT-OF-NETWORK BENEFITS:**

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each calendar year. In the case of a family contract, the total deductible payment for all covered individuals shall not exceed $150 for Type 2 and Type 3 services. This means you must pay the first $50 or $150 of benefits provided in each calendar year.

| | **In-Network Benefits** | | **Out-of-Network Benefits** |
|---|---|---|---|
| ***Diagnostic and Preventive Services (Type 1 Benefits)*** | | | |
| Dental Service pays 100% of charges up to the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers. | You pay nothing. | Dental Service pays 100% of the usual, customary and reasonable fee. | You pay 0% of the usual, customary and reasonable fee |
| ***Restorative and other Basic Services (Type 2 Benefits)*** | | | |
| Dental Service pays charges up to 80% of the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers. | You pay up to 20% of the schedule amount. | Dental Service pays 80% of the usual, customary and reasonable fee | You pay 20% of the usual, customary and reasonable fee |
| ***Prosthodontic and Other Services (Type 3 Benefits)*** | | | |
| Dental Service pays charges up to 60% of the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers. | You pay up to 40% of the schedule amount. | Dental Service pays 60% of the usual, customary and reasonable fee | You pay 40% of the usual, customary and reasonable fee |

Your total benefits are limited to a maximum of $1,500 for each member for each calendar year.

**BENEFIT PAYMENTS**

IN-NETWORK SERVICES:

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

OUT-OF-NETWORK SERVICES:

For services performed by Massachusetts Delta Dental PPO non-panel dentists, the Out-of-Network benefit co-payments for each type of service will be up to 20% lower than the in-network panel dentist co-payments. This co-payment will be applied against the negotiated fees for dentists who are under a contractual agreement with Delta Dental or the dentist's submitted fee if lower. The dentist also agrees not to balance bill subscribers.

In those circumstances where the dentist is not under any agreement with Delta Dental, Delta Dental pays the covered member directly for covered services, and the member is responsible for paying the dentist. The dentist will bill the covered member for the difference between the Delta Dental payment and his / her submitted charge and balances resulting from plan specific deductibles and co-payment.

OUT-OF-STATE DENTIST SERVICES

We will provide benefits for the covered services described in your contract when any dentist outside of Massachusetts furnishes them.

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

For services performed by a Delta Dental non-panel dentist, the out-of-network benefit co-payment for each type of service will be up to 20% lower than the in-network panel dentist co-payment. This co-payment will be applied against the negotiated fees for dentists who are participating with Delta Dental as a Delta Dental participating provider or the dentist's submitted fee if lower. The dentist will bill covered members for balances resulting from plan specific deductibles and co-payments and agrees not to balance bill subscribers.

In those circumstances where the dentist is not participating as a Delta Dental participating provider with Delta Dental, benefits for covered services furnished by out-of state dentists are based on the dentist's fee or the customary fee for that geographic area, whichever is less. Delta Dental pays the covered member directly for covered services, and the member is responsible for paying the dentist. The dentist will bill the covered member for the difference between the Delta Dental payment and his / her submitted charge and balances resulting from plan specific deductibles and co-payments.

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

DENTAL SERVICE OF MASSACHUSETTS, INC.
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Steven Pollock
President and CEO

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DDP-PPA 2 BPR 1010 09/17/19

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
BENEFITS PAYABLE RIDER 3011

To be attached to and form a part of your Delta Dental PPO Provider Arrangement 2

Your group has purchased this Rider. Benefits for the covered services described in your Delta Dental PPO Contract are reimbursed as follows:

**IN-NETWORK BENEFITS (Delta Dental Premier Network & Delta Dental PPO Network):**

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each calendar year. In the case of a family contract, the total deductible payment for all covered individuals shall not exceed $100 for Type 2 and Type 3 services. This means you must pay the first $50 or $100 of benefits provided in each calendar year.

**OUT-OF-NETWORK BENEFITS:**

Type 2 and Type 3 services described below are subject to a $50 deductible for each covered individual in each calendar year. In the case of a family contract, the total deductible payment for all covered individuals shall not exceed $100 for Type 2 and Type 3 services. This means you must pay the first $50 or $100 of benefits provided in each calendar year.

| | **In-Network Benefits** | | **Out-of-Network Benefits** | |
|---|---|---|---|---|
| ***Diagnostic and Preventive Services (Type 1 Benefits)*** | | | | |
| | Dental Service pays 100% of charges up to the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers. | You pay nothing. | Dental Service pays 100% of the usual, customary and reasonable fee. | You pay 0% of the usual, customary and reasonable fee |
| ***Restorative and other Basic Services (Type 2 Benefits)*** | | | | |
| | Dental Service pays charges up to 80% of the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers. | You pay up to 20% of the schedule amount. | Dental Service pays 80% of the usual, customary and reasonable fee | You pay 20% of the usual, customary and reasonable fee |
| ***Prosthodontic and Other Services (Type 3 Benefits)*** | | | | |
| | Dental Service pays charges up to 60% of the schedule amounts stated in this rider for services by Delta Dental PPO Panel Providers. | You pay up to 40% of the schedule amount. | Dental Service pays 60% of the usual, customary and reasonable fee | You pay 40% of the usual, customary and reasonable fee |

Your total benefits are limited to a maximum of $1,500 for each member for each calendar year.

**BENEFIT PAYMENTS**

IN-NETWORK SERVICES:

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

OUT-OF-NETWORK SERVICES:

For services performed by Massachusetts Delta Dental PPO non-panel dentists, the Out-of-Network benefit co-payments for each type of service will be up to 20% lower than the in-network panel dentist co-payments. This co-payment will be applied against the negotiated fees for dentists who are under a contractual agreement with Delta Dental or the dentist's submitted fee if lower. The dentist also agrees not to balance bill subscribers.

In those circumstances where the dentist is not under any agreement with Delta Dental, Delta Dental pays the covered member directly for covered services, and the member is responsible for paying the dentist. The dentist will bill the covered member for the difference between the Delta Dental payment and his / her submitted charge and balances resulting from plan specific deductibles and co-payment.

OUT-OF-STATE DENTIST SERVICES

We will provide benefits for the covered services described in your contract when any dentist outside of Massachusetts furnishes them.

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

For services performed by a Delta Dental non-panel dentist, the out-of-network benefit co-payment for each type of service will be up to 20% lower than the in-network panel dentist co-payment. This co-payment will be applied against the negotiated fees for dentists who are participating with Delta Dental as a Delta Dental participating provider or the dentist's submitted fee if lower. The dentist will bill covered members for balances resulting from plan specific deductibles and co-payments and agrees not to balance bill subscribers.

In those circumstances where the dentist is not participating as a Delta Dental participating provider with Delta Dental, benefits for covered services furnished by out-of state dentists are based on the dentist's fee or the customary fee for that geographic area, whichever is less. Delta Dental pays the covered member directly for covered services, and the member is responsible for paying the dentist. The dentist will bill the covered member for the difference between the Delta Dental payment and his / her submitted charge and balances resulting from plan specific deductibles and co-payments.

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

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DDP-PPA 2 BPR 3011 02/06/25

DENTAL SERVICE OF MASSACHUSETTS, INC.
DOING BUSINESS AS DELTA DENTAL OF MASSACHUSETTS
ENDORSEMENT E08-168

To be attached to and form a part of your Delta Dental PPO Provider Arrangement 2

Your group has purchased this Rider. Orthodontic benefits in your Delta Dental PPO Contract are reimbursed as follows:

## ORTHODONTIC SERVICES

Subject to all the terms of your contract, you have the right to benefits for orthodontic services and supplies furnished as follows:

Orthodontic services and supplies are those 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.

**IMPORTANT:** Benefits are provided for members regardless of age.

ALL THE BENEFITS DESCRIBED IN THIS ENDORSEMENT ARE SUBJECT TO A LIFETIME MAXIMUM OF $1,000 FOR EACH MEMBER. Once you have received $1,000 in benefits, no more benefits are available under this Endorsement.

| **In-Network Benefits** | | **Out-of-Network Benefits** | |
|---|---|---|---|
| Dental Service pays charges up to 50% of the contracted fee. | You pay up to 50% of the contracted fee and any amount over the Lifetime Max. | Dental Service pays charges up to50% of the usual, customary and reasonable fee. | You pay up to 50% of the usual, customary and reasonable fee. and any amount over the Lifetime Max. |

**BENEFITS**

1. Your first complete orthodontic exam. This includes: models; photographs; and x-rays (excluding x-rays of the entire mouth).

2. Services and supplies for orthodontic appliances. This includes the construction and insertion of the appliance.

**NOTE:** Your dentist may file a "treatment plan" with Dental Service for a Pre-determination of Benefits: see Part 4, section 4 of your certificate.

**EXCLUSIONS**

In addition to the restrictions described in the contract, we do not provide benefits under this Endorsement for:

1 Surgical services; including orthognathic surgery.

2 Lost or stolen devices.

3. Muscle exercises to prevent or correct misalignments of the teeth (called Myofunctional Therapy).

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

**NOTE:** Underlined terms are defined in your contract.

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