SUBSCRIBER CERTIFICATE

Alabama Individual Child Only Coverage

January 2024

DentaTrust
Underwritten by DCP, Inc.

DentaQuest
a Sun Life company

DQ1343 (01.24) Child High HB/EN

Alabama DentaTrust

Underwritten by Dental Care Plus, Inc.

Alabama DentaTrust Individual Dental Policy
Child Only Coverage

Dental Care Plus, Inc. certifies that the individuals covered under this *Policy* have the right to benefits for services according to the terms of this *Agreement*. This promise is based on the statements and agreements made in the application and payment of the required premiums. Please check your information for errors. An incorrect or incomplete application may cause this *Policy* to be voided and claims to be reduced or denied. This *Policy* is part of your *Agreement.*

Notice to Buyer: This *Policy* provides benefits for *dental services* only. This *Policy* provides benefits for *covered individuals* until the last day of the month in which they obtain the age of 19 only. The *Policy* does not provide any benefits for persons age 19 and older.

Please read this *Policy* carefully. If for any reason you are not satisfied with this *Policy* return the *Policy* to us within 30 days of receipt. Upon return, the *Policy* will be deemed void and any premium will be refunded. In such event, any services received during this 30 day period are solely your financial responsibility.

This *Policy* is renewable. This *Policy* will be subject to renewal 12 months from the *effective date*, subject to our right to cancel as set forth in Part IV, Section 11. We reserve the right to change premium rates upon renewal of the *Policy*. If we do raise the premium rates, at least 60 days prior to the renewal date we will send written notice to your last known address shown on record.

ATTEST: Dental Care Plus, Inc.
10300 Springfield Pike
Cincinnati, OH 45215

Bob Lynn,
President

Contents

Introduction

This *Policy*, including the attached *Schedule of Benefits*, the application and any applicable riders, endorsements and supplemental agreements constitute the *Agreement* between you and Dental Care Plus, Inc. (*the Plan*). We urge you to read it carefully.

The *covered services* described in this *Policy* are covered as of your *effective date*, unless your benefits are subject to a waiting period. Additionally, there are limitations and restrictions on your coverage. Please refer to the *Schedule of Benefits*, attached to this *Policy*, for important information on the benefits provided under your *Policy*. If you have any questions, please contact our Customer Service department.

This *Policy* permits you to obtain your benefits from the *dentist* of your choice; however, if you chose to obtain your benefits from a *non-contracting dentist*, your out of pocket expenses, including your copayments, *coinsurance* and *deductible*, may be higher. See the *Schedule of Benefits* for the difference in *coinsurance* and *deductible* amounts for benefits received from a *non-contracting dentist*.

Subscriber's Rights and Responsibilities

As a Dental Care Plus *subscriber*, you have the right to:

- File a *complaint* or *appeal* about the *covered services* provided to the *covered individuals*.
- Be provided with appropriate information about *the Plan* and its benefits, *contracting dentists*, and policies.

You and *covered individuals* have the responsibility to:

- Ask questions in order to understand your dental condition and treatment, and follow recommended treatment instructions given by your *dentist*.
- Provide information to your *dentist* that is necessary to render care to you.
- Be familiar with *the Plan's* benefits, policies and procedures, by reading our written materials, or calling our Customer Service department.

Part I

Definitions

ACA: the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the *Affordable Care Act* or *ACA.*

Agreement: refers to this *Policy*, including the *Schedule of Benefits*, application, and any applicable riders, endorsements and supplemental agreements.

Appeal: an *appeal* is a request, filed by a *covered individual, covered individual's authorized representative* or a health care provider under *the Plan's* internal *appeal* process, to change a previous decision by *the Plan* on a claim or pretreatment estimate to deny, reduce or terminate benefits.

Authorized representative: an individual who has been authorized by the *covered individual* to file a *complaint* or an *appeal* on the *covered individual's* behalf. An *authorized representative* includes a parent, guardian, or other person authorized to act on behalf of a *covered individual* with respect to health care decisions.

Benefit Period: the period for which any applicable *deductibles*, annual limitations or maximums apply. The period for individual policies runs on a calendar year from the latter of January 1 or enrollment date through December 31.

Coinsurance: the percent of covered dental expenses, after the *deductible* is satisfied, which the *covered individual* must pay until *the Plan* pays the annual limit or maximum payment stated in the *Schedule of Benefits*. Once benefits are exhausted you are solely responsible for payment of all *dental services*.

Complaint: an oral or written compliant submitted, in accordance with the *Policy's* complaint procedures, by a *covered individual, covered individual's authorized representative* or a *dentist* regarding any aspect of *the Plan's* organization as it relates to a *covered individual*.

Contracting Dentist: a licensed *dentist* who has entered into an agreement, either directly or through a network which contracts with *the Plan*, to furnish services to its *covered individuals* and who participates in the designated network for *the Plan*. A *contracting dentist* is considered In-Network. The designated network for *the Plan* is described in the Provider Directory for *the Plan* and is available at HixfadAL.dentalcareplus.com

Copayment: a fixed amount you pay to a *dentist* for a *covered service*.

Covered individual: a *dependent* who is eligible for benefits under this *Policy*, and has enrolled under the *Policy* as described in the Enrollment sections below. A *covered individual* is considered to be "under the age of 19" until the last day of the month in which the *covered individual* obtains the age of 19. This term does not include the *subscriber*, the subscriber's spouse or any children that is not under the age of 19.

Covered service: a *dental service* or supply covered under the terms of the *Agreement* that is not otherwise limited or excluded from *the Agreement*, and is subject to the terms and conditions of *the Agreement*.

Date of service: the actual date that the service was completed. With multi-stage procedures, the *date of service* is the final completion date (the insertion date of a crown, for example).

Deductible: amount you must pay in a *benefit period* for *covered services* before *the Plan* will pay benefits. The amount of the *deductible* is shown in the *Schedule of Benefits*.

Dental Service: a procedure or service rendered by a dental care provider within the scope of his or her license or certificate.

Dentist: any dental or medical practitioner *the Plan* is required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides *dental services* which are within the scope of his or her license or certificate.

Dependent: children of the *subscriber* from the moment of birth up to the last day of the month in which they obtain the age of nineteen (19). Children include (i) biological children and stepchildren; (ii) children named in a divorce decree or qualified medical child support order as being the responsibility of the *subscriber* for dental benefits coverage; (iii) legally adopted children, or children for which the *subscriber* has legal custody; and (iv) children who have been placed for adoption with the *subscriber*, if legal adoption is anticipated but not yet finalized. In no event shall this coverage include a child on active duty in any military service of any country.

Effective Date: the date, as shown on our records, on which coverage begins under this *Policy* or any amendment.

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

Federally Facilitated Marketplace or FFM: the health benefit exchange established by *ACA* for the state of Indiana. The FFM can be reached at www.healthcare.gov or 1-800-318-2596 .

Fee schedule: the payment amount for the *covered services* that may be provided by *contracting dentists* under this *Policy*. Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* attached to this *Policy* and in effect at the time services are rendered.

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

Individual (or single) coverage: coverage that includes only one *covered dependent*.

Injury: (1) all damage to the *covered individual's* mouth due to an accident; and (2) all complications arising from that damage. But, the term does not include damage to teeth, appliances or dental prostheses which results solely from chewing or biting food or other substances.

Non-Contracting Dentist: a licensed *dentist* who has not entered into an agreement with *the Plan* to furnish services to its *covered individuals*. A *non-contracting dentist* is considered Out-of-Network.

Out of Pocket Maximum: the maximum amount a *subscriber* will pay (including *deductibles*, and *coinsurance*) for *covered services* in any benefit period. Any applicable *out of pocket maximum* is listed in the *Schedule of Benefits*.

Plan year deductible: this *deductible* must be satisfied each plan year.

Policy: this contract of insurance including the *Schedule of Benefits*.

Qualified Health Plan or QHP: a health plan or stand-alone dental plan that satisfies all of the certification requirements established by the *ACA* and applicable federal regulations, and is certified by and offered on the *FFM*.

Qualified Individual: an individual who has been determined eligible to enroll through the *FFM* in a child only *Qualified Health Plan* in the individual market.

Schedule of Benefits: the part of this *Policy* which outlines the specific coverage in effect as well as the amount, if any, that you may be responsible for paying towards the dental care provided to *covered individuals*.

Subscriber: the policyholder who has enrolled *covered dependents*. This is a child only policy, the subscriber has no coverage or benefits under the *Policy*. The *subscriber* assumes all of the *subscriber's* responsibilities on behalf of the covered *dependent(s)*.

The Plan: refers to Dental Care Plus, Inc.

You: the *subscriber*.

Part II

Benefits

Covered individuals have the right to benefits for the following *covered services*, EXCEPT as limited or excluded elsewhere in this *Policy*. Some benefits may be limited to an annual dollar limit for each *covered individual* for each *benefit period* shown in the *Schedule of Benefits*. The extent of your benefits is explained in the *Schedule of Benefits* which is incorporated as a part of this *Policy*.

This Part II summarizes the benefits covered by this Policy. Attached to and incorporated as part of this Policy is a complete list of covered dental procedures by current dental terminology (CDT) code.

DIAGNOSTIC AND PREVENTIVE SERVICES

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

Comprehensive oral examination (including the initial dental history and charting of teeth); once every six months.

Periodic exam; once every six (6) months.

X-rays of the entire mouth; once every sixty (60) months.

Bitewing x-rays (x-rays of the crowns of the teeth); once every six (6) months when oral conditions indicate need. Single tooth x-rays; as needed.

Study models and casts used in planning treatment; once every sixty (60) months. Routine

cleaning, scaling and polishing of teeth; Once every six (6) months.

Fluoride treatment Topical Fluoride - Varnish - 2 every 12 months, Topical application of fluoride (excluding prophylaxis) - 2 every 12 months.

Space maintainers required due to the premature loss of teeth; not for the replacement of primary or permanent anterior teeth.

Sealants on unrestored permanent molars. 1 sealant per tooth every 36 months.

Palliative (emergency) treatment of dental pain – minor procedures.

RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth; (b) repair dentures or bridges; (c) rebase or reline dentures; (d) repair or recement bridges, crowns and onlays; and (e) remove diseased or damaged natural teeth. Examples of these services include:

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings. However, synthetic (white) fillings are limited to single surface restorations 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.

Periodontal maintenance, including cleaning and scaling and root planing procedures, following active periodontal therapy; 4 in 12 months. Periodontal scaling and root planing; once every twenty-four (24) months per quadrant.

Protective restorations.

Stainless steel crowns. Once per tooth per sixty (60) months. Simple tooth extractions.

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

Consultations.

Repair of dentures or fixed bridges. Recementing of fixed bridges.

Rebase or reline dentures; once every thirty-six (36) months. 6 months after initial installation.

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

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

Vital pulpotomy and pulpal therapy is limited to deciduous teeth.

COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES

Benefits are available for the following dental services and supplies to treat oral disease including: replace missing natural teeth with artificial ones; and restore severely decayed or fractured teeth. Examples of these services include:

Periodontal 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). Periodontal benefits are determined according to our administrative "Periodontal Guidelines."

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

Inlays are paid as an alternative benefit of amalgam. Implants- once every 60 months.

Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each sixty (60) months.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.

Crowns and Onlays. Once per tooth per sixty (60) months, but only when the teeth cannot be restored with the fillings due to severe decay or fractures:

- Initial placement of crowns and onlays.
- Replacement of crowns and onlays; once each sixty (60) months per tooth.

Occlusal Guards; 1 in 12 months for patients between the ages of 13 and 18.

Implants

An implant is a covered procedure of the plan only if determined to be a dental necessity. Claim review is conducted by a panel of licensed *dentists* who review the clinical documentation submitted by your treating *dentist*. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan. An implant is a *covered service* only for *dependents* under age 19.

Medically Necessary Orthodontics (Please see the *Schedule of Benefits* for frequency and limitations for the coverage you have purchased.)

Orthodontic services which are covered under this *Agreement* are limited to Medically Necessary Orthodontic Treatment, as described in this section. Medical necessity will be determined by *the Plan* after review of the orthodontic case records, which must be submitted for approval prior to the commencement of treatment. *Covered Individuals* must have a severe, dysfunctional, handicapping malocclusion caused by craniofacial anomalies which would constitute an impairment of or the hazard to eat, chew, speak or breath in order for orthodontic services to be deemed Medically Necessary Orthodontic Treatment. An orthodontic case must be dysfunctional in order to be approved for benefits. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.

In order for orthodontic services to be covered under the *Agreement*, prior approval of the orthodontic services by *the Plan* through the PreTreatment Review process is required. Even though pretreatment estimates are not a guarantee of benefits, obtaining a pretreatment estimate is part of the process required for determining whether the orthodontic services are Medically Necessary Orthodontic Treatment and covered under this *Agreement*, and an important part of making a well-informed decision about orthodontic services, including what the *Agreement* may or may not cover.

Part III

Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE *COVERED SERVICES*

   We will not provide benefits for a *dental service* that is not covered under the terms of the *Policy*. We will not provide benefits for a *dental service* that is not necessary and appropriate to diagnose or to treat your dental condition.

   A. To be necessary and appropriate, a *dental service* must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your *dentist*.

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

2. WE DO NOT PROVIDE BENEFITS FOR:

   Below is a summary of dental services or items for which coverage is not provided under this Policy. Attached to this Policy and incorporated as part of this Policy is a list by CDT code of services not covered by this Policy.

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Policy.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Policy.
- A method of treatment more costly than is customarily provided. Benefits will be based on

the least costly method of treatment.

- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints), except for covered medically necessary orthodontics for individuals under age 19.
- Services that are meant primarily to change or to improve your appearance.
- Repair or reline of an occlusal guard.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Lab exams.
- Photographs.
- Duplicate dentures and bridges.
- Services related to congenital anomalies unless otherwise covered. However, this exclusion does not apply to covered orthodontic services.
- Occlusal adjustment.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- Service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Tooth bleach.
- Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
- Transitional implants.
- Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomies, root amps, ridge augmentations and dental implant placements.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
- Cone Beam Imaging and Cone Beam MRI procedures.
- Nitrous oxide.
- Oral sedation.
- Topical medicament center.

Part IV

Other Contract Provisions

1. BENEFIT PAYMENTS FOR SERVICES BY A *CONTRACTING DENTIST*

The amount if any, that you may be required to pay your *Contracting Dentist* is explained in the *Schedule of Benefits*. Payments are made directly to *Contracting Dentists*.

2. WHEN YOUR *CONTRACTING DENTIST* MAY CHARGE YOU MORE

When your *Contracting Dentist* provides covered services, he or she must accept the *Fee Schedule* amount as payment in full. But in the following cases you will be responsible for the difference between *the Plan* payment and the dentist's actual charge for covered services:

A. If you have received the maximum benefit allowed for services. For example, the maximum dollar amount for a *covered individual* in a calendar year, including the service that caused you to reach the maximum.

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

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

3. PRE-TREATMENT ESTIMATES

If your dentist expects that dental treatment will involve a series of covered services (over $600), he or she should file a copy of the treatment plan with *the Plan* BEFORE these services are rendered to a *covered individual*. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service.

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

IMPORTANT NOTE: Pre-treatment estimates are calculated based on current available benefits and the patient's eligibility. Estimates are subject to modification and eligibility that apply at the time services are completed and a claim is submitted for payment. The pre-treatment estimate is NOT a guarantee of payment or a preauthorization.

4. BENEFIT PAYMENTS FOR SERVICES BY *NON-CONTRACTING DENTISTS*

Benefits for covered services provided by a *Non-Contracting Dentist* are based on the lesser of the dentist's fees, or the amounts indicated on the *Fee Schedule* for services that may be provided by *contracting and non-contracting dentists* under this Policy. Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* attached to this Policy and in effect at the time services are rendered. You will be responsible for paying the dentist any deductible, copayment or coinsurance amount applicable to the covered service and the difference between the dentist's fee and the amount paid by *the Plan* after any deductible or coinsurance amounts are calculated.

To find out if your dentist participates with *the Plan* ask your dentist if he or she has an agreement with us, call our Customer Service department or visit our website.

5. EMERGENCY CARE

Nothing in this Policy of coverage 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. Emergency dental care is defined in Part I of this Policy. Please refer to your Schedule of Benefits for specifics on emergency care benefits.

6. WHEN YOUR COVERAGE BEGINS

The dental services described in this Policy are covered as of your *effective date*, as defined in your application.

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

You agree that when you claim benefits under this Policy, you give us the right to obtain all dental records and/or other related information that we need from any source for claims processing purposes. This information will be kept strictly confidential and is subject to federal and state privacy and confidentiality regulations.

Contracting Dentists have agreed to give us all information necessary to determine your benefits under this Policy and have agreed not to charge for this service. If you receive services from a *Non-contracting Dentist,* you must obtain all dental records or other related information needed to determine your benefits. We will not pay the dentist in order to obtain this information. If the *Non- contracting Dentist* does not provide the required information, we may not be able to provide benefits for his or her services.

A complete record of the Policyholder's claims experience shall be provided, upon request. This record shall be made available not less than thirty (30) days prior to the date upon which premiums or contractual terms of the Policy may be amended.

8. SUBSCRIPTION CHARGE

The amount of money that you are responsible for paying to *the Plan* for your benefits under this *Agreement* is called your subscription charge. We will send you a notice at least thirty (30) days before any change in your subscription charge goes into effect. Subscription charges will not change more than once every twelve (12) months. We may not change your subscription charge until the present Schedule of Benefits under this Policy has been in effect for twelve (12) months.

9. WE MAY CHANGE YOUR POLICY

We will send a notice each time we change all or part of your Policy, describing the change(s) being made. Changes to the Policy may include the addition or deletion of riders as well as plan design changes. You can also call our Customer Service department to get information on your plan change. Our telephone number is listed at the end of this Policy.

The notice will tell you the *effective date* of the change and the benefits for services you may receive on or after the *effective date*. There is one exception: If before the *effective date* of the change, you started receiving services for a procedure requiring two or more visits, we will not apply the change to services related to that procedure.

10. WHEN YOUR COVERAGE ENDS

Coverage will terminate for a *covered individual* on the last day of the month in which the *covered individual* attains the age of 19 or when the *covered individual* is otherwise no longer eligible for coverage.

The last date of coverage will be the last day of the month after the loss of eligibility. Benefits will be provided in accordance with the *Agreement* in effect at the time a *covered individual's* coverage terminates, for a course of treatment for at least 90 days after the date coverage terminates if the treatment: (i) begins before the date coverage terminates; and (ii) requires two or more visits on separate days to a *dentist's* office.

11. TERMINATION OF A POLICY

A. CANCELLATION BY INSURED

You may cancel your Policy for any reason.

The following termination rules apply when you cancel coverage obtained through the *Exchange*.

1. If you provide us with notice at least fourteen (14) days prior to the proposed effective date of termination, the last day of coverage is the termination date specified by you in the notice of termination.

2. If you provide us with notice less than fourteen (14) days prior to the proposed effective date

of termination, the last day of coverage is the date determined by us, if we are able to effectuate termination in fewer than fourteen (14) days and you request an earlier termination effective date. If we are unable to effectuate termination in fewer than fourteen (14) days, termination will be effective fourteen (14) days from the date of notice. If you are newly eligible for Medicaid or a Children's Health Insurance Program, the last day of coverage is the day before such coverage begins.

The following termination rules apply if coverage is obtained other than through the *Exchange*.

1. You may cancel this Policy at any time by written notice delivered or mailed to us effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, we shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
2. If you cancel your Policy, you must wait at least one year after your cancellation before you can enroll again as a *subscriber*.

B. CANCELLATION OR NONRENEWAL BY THE PLAN

We may, upon thirty (30) days notice to *you*, cancel or non-renew your Policy under any of the following circumstances:

1. Subject to the Time Limitation on Certain Defenses provision set forth in Item 14, if you make any misrepresentation, omission or concealment of a fact or incorrect statements that are: (i) fraudulent; (ii) material either to the acceptance of the risk, or to the hazard assumed by us; or
   (iii) we in good faith would either not have issued this Policy, or would not have issued this Policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to us as required either by the application for this Policy or otherwise. In such a case, cancellation will be as of your *effective date*. We will refund you the subscription charge you have paid us. We will subtract from the refund any payments made for claims under this Policy. If we have paid more for claims under this Policy than you have paid us in subscription charges, we have the right to collect the excess from you.
2. If you have not paid your subscription charges, subject to the Grace Period provision under Section 15 under this Part IV.
3. If you have been guilty of fraudulent dealings with us.
4. If we discontinue a particular product or all coverage in the individual market in Arizona in accordance with Arizona law.

If coverage is obtained through the *Exchange*, terminations will be initiated by the *Exchange*, except for terminations for nonpayment of premium which will be initiated by the *Plan*.

C. CANCELLATION DUE TO LOSS OF ELIGIBILITY.

Your Policy will be canceled if you are no longer eligible because you no longer live, reside or work in Arizona. The termination date of this coverage shall be the last day of the month, at 12:01 A.M. Mountain Time, in which we were notified of your move and for which the

subscription charge has been paid.

A *Contracting Dentist* shall notify a *covered individual* of the termination of the *covered individual's* Policy if the covered individual visits the *Contracting Dentist's* office when the *Contracting Dentist* is aware that the *covered individual's* Policy has terminated. The *Contracting Dentist* shall also inform the *covered individual* of the charge for any scheduled dental services before performing the dental services.

D. TIME AT WHICH TERMINATION TAKES EFFECT

Any termination of this Policy under paragraphs A., B. or C of this Section 11 shall take effect at 12:01 A.M. Mountain Time on the effective date of termination.

12. MISSTATEMENT OF AGE

If the age of the *subscriber*, or any of the *subscriber's covered dependents* has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age. If the age of the *subscriber* has been misstated, and if according to the correct age of the *subscriber*, the coverage provided by this Policy would not have become effective or would have ceased prior to the acceptance of the premium, then the liability of the *subscriber* shall be limited to the refund, upon request, of all premiums paid for the period not covered by the Policy.

13. TIME LIMIT ON CERTAIN DEFENSES

Misstatements in the application: After two years from the date of this Policy, only fraudulent misstatements in the application may be used to void the Policy or deny any claim for loss incurred (as defined in the policy) that starts after the two-year period.

14. BENEFITS AFTER TERMINATION

No benefits will be provided for services that you receive after termination of this Policy.

15. GRACE PERIOD

The certificate holder shall be given a 31-day grace period for the payment of any premium falling due after the first premium during which coverage remains in effect. If payment is not received within the 31 days, coverage may be cancelled after the thirty-first day and the certificate holder may be held liable for the payment of the premium for the period of time coverage remained in effect during the grace period.

If a *subscriber* is receiving advance payments of the premium tax credit under the ACA, and the *subscriber* has previously paid at least one full month's premium during the *Benefit Year*, the grace period is extended to three (3) consecutive months. *The Plan* may pend claims made during the second and third months of the extended three (3) month grace period. If the premium is not paid by the end of the grace period, coverage will be terminated as of the end

of the first month of the grace period and claims pended during the second and third months of the grace period will be denied.

16. NOTICES

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

B. To us: Send letters to DentaTrust, c/o Dental Care Plus, Inc., 10300 Springfield Pike Cincinnati, OH 45215. Always include your name and subscriber identification number.

17. CONTRACT CHANGES

Any additions or changes to the Policy are allowed ONLY when they conform to our underwriting guidelines. Coverage for new spouses shall be effective from the date of marriage. Newly born children, newly adopted dependent children or grandchildren shall be covered from the moment of birth or date of adoptive or parental placement with an insured for the purpose of adoption. *The Plan* requires that notification of the birth of a newly born child and payment of the required premium must be submitted within thirty-one (31) days after the birth in order to have the coverage continue beyond the thirty-one (31) day period. A minor for whom guardianship is granted by court order or testamentary appointment shall be covered from the date of appointment. A child, who the court orders to be covered under a subscriber's dental coverage, shall be covered from the date of the order.

Changes to the Policy may result in a change in your subscription charge. Except as provided in section 18, below, *the Plan* must be notified of new covered dependents within thirty-one (31) days. Failure to notify the *Plan* of new dependents within thirty-one (31) days shall result in the *Plan* never recognizing coverage for the new dependent(s) during the thirty-one (31) days.

18. ENROLLMENT THROUGH THE EXCHANGE AND PREMIUM PAYMENTS

Notwithstanding the requirements of Sections 17 and 18 of this Policy, if coverage is obtained through the *Exchange*, the *Exchange* will enroll qualified individuals and enrollees and terminate coverage in accordance with the requirements of the ACA, the rules promulgated under the ACA, including Parts 155 and 156 of Title 45 of the Code of Federal Regulations, and the requirements of the *Exchange*. The open and special enrollment periods and effective dates of coverage in 45
C.F.R. §§ 155.410 and 155.420 will apply with respect to enrollment through the *Exchange*.

The *Plan* is required to process enrollments in accordance with 45 CFR 156.265, which requires the *Plan* to enroll an individual only if the *Exchange* notifies the *Plan* that the individual is a qualified individual as determined by the *Exchange*.

For coverage obtained through the *Exchange*, premium payments will be required to be made directly to the *Plan* in accordance with the *Plan's* available methods for payment. The first premium payment will be due prior to the effective date of coverage, and premiums will be due monthly thereafter unless a different payment interval is permitted by the *Plan.*

19. 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 Policy. 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.

20. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

We will not interfere with the relationship between dentists and patients. You are free to select any dentist. It is your responsibility to find a dentist. We are not responsible if a dentist refuses to furnish services to you. We are not liable for injuries or damages resulting from the acts or omissions of a dentist.

21. COORDINATION OF BENEFITS AND RIGHT TO RECOVER OVERPAYMENTS

Coordination of Benefits (COB) applies if you or any of your dependents have another plan that provides coverage for services that are benefits under your Policy including: indemnity programs, PPO programs, discounted fee for service programs, point of service programs, and capitation programs.
The following are not treated as plans for the purposes of COB: individual or family insurance, or other *individual coverage*, amounts of hospital indemnity insurance of $200 or less per day, school accident type coverage, benefits for non-medical components of group long-term care policies, Medicaid policies and coverage under other governmental plans unless permitted by law, and an individual guaranteed renewable specified disease policy or intensive care policy that does not provide benefits on an expense-incurred basis. *The Plan* will administer the COB according to any applicable state COB law and this Policy.

A. Definitions:

1. **Claim determination period** means a Benefit Year. However, it does not include any part of a year during which a person has no coverage under this Policy, or before the date this COB provision or a similar provision takes effect.

2. **Custodial parent** means a parent who: (1) is awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Benefit Year without regard to any temporary visitation; or (2) is a guardian of the person or other custodian of a child and is designated as guardian or custodian by a court or administrative agency of this or another state.

3. The plan that provides benefits first under the COB rules is known as the **primary plan**.

The primary plan is responsible for providing benefits in accordance with its terms and conditions of coverage without regard to coverage under any other plan. 4. The plan that provides benefits next is the **secondary plan**. It provides benefits toward any remaining balance for covered services in accordance with its terms and conditions of coverage, including its COB provision.

B. Secondary Plan's Benefits:

The secondary plan's benefits are determined after those of another plan and may be reduced because of the primary plan's benefits. This Plan, as the secondary plan, will provide benefits toward any remaining patient balance for covered services in accordance with this Policy, provided that the amount paid by this Plan as the secondary plan, when added to the amount paid by the primary plan, will not exceed the lesser of the provider's submitted charge or the amount allowed under your *contract*.

C. Order of Benefit Determination Rules:

1. The coverage from both plans shall be coordinated so that the *covered individual* receives the maximum allowable benefit from each plan.
2. A plan that does not contain a COB provision is always primary. An exception to this rule is coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits. An example of this type of coverage is a point-of-service benefit written in connection to a closed (capitation) panel.
3. In determining which plan is the primary and which is the secondary, the following rules shall apply and in this order:

- The plan that covers the c*overed individual* other than as a dependent is the primary plan. The secondary plan is the one that covers that c*overed individual* as a dependent. However, if federal law requires Medicare to be a secondary plan, then this rule may be reversed.
- When both plans cover the c*overed individual* as a dependent child, the plan of the parent whose birthday occurs first in a Benefit Year should be considered as primary. The parents should be married, not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits shall be: 1) the plan of the custodial parent 2) the plan of the spouse of the custodial parent 3) the plan of the noncustodial parent.
- If a determination cannot be made with the rules as set out above, the plan that has covered either of the parents for a longer time should be considered as primary. This rule shall apply if the parents have the same birthday.
- If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule shall apply to claim determination periods or Benefit Years commencing after the plan is given notice of the court decree.

4. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
5. If one of the plans is a medical plan and the other is a dental plan, the medical plan will

always be the primary plan.

6. Whichever plan that covered the c*overed individual* as an employee, member, *subscriber* or retiree longer is the primary plan.

If we pay more than we should have under COB, then you must refund any overpayment to the
Plan.

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 Policy. 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 Policy, please contact our Customer Service department. The telephone number is listed at the end of this Policy.

23. CONFORMITY WITH STATE STATUTES:

Any provision of this Policy that on its effective date is in conflict with the statutes of the state, District of Columbia or territory in which the Subscriber resides on that date is hereby amended to conform to the minimum requirements of such statutes.

24. CHOICE OF LAW

This Policy shall be construed according to the laws of Arizona. This Policy will be automatically revised in order to conform to statutory requirements of the laws of Arizona.

25. LEGAL ACTIONS

No action at law or in equity shall be brought to recover under this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished as required by this Policy. No legal action may be brought after the expiration of two years after the time written proof of loss is required to be furnished.

26. ENTIRE CONTRACT; CHANGES

This Policy, including the *Schedule of Benefits*, and any applicable rider(s) or attachments, and the Application constitute the entire contract of insurance. No change in this Policy shall be valid until approved by an officer of the *Plan* and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Policy or to waive any of its provisions.

27. CHANGE OF BENEFICIARY.

Unless you make an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to You. The consent of the beneficiary, or beneficiaries, will not be requisite to surrender or assignment of this Policy or to any change of beneficiary, or beneficiaries, or to any

other changes in this Policy.

28. IMPORTANT INFORMATION ABOUT YOUR INSURANCE

In the event that you need to contact someone about this coverage for any reason, you should contact your agent. If no agent was involved in the sale of this coverage, or if you have additional questions, you may contact Dental Care Plus, Inc. at the following address and telephone number:

Dental Care Plus, Inc.
10300 Springfield Pike
Cincinnati, OH 45215
Telephone: 1-888-696-9550

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting the agent, or Dental Care Plus, Inc., you should have your Policy number available.

29. REINSTATEMENT

If the renewal premium is not paid before the grace period ends, the Policy will lapse. Later acceptance of the premium by *the Plan* or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the Policy. If *the Plan* or its agent requires an application for reinstatement, the Subscriber will be given a conditional receipt for the premium. If the application is approved the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Plan has previously written the Subscriber of its disapproval. The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than 10 days after such date. In all other respects the rights of the Subscriber and *the Plan* will remain the same, subject to any provisions noted or attached to the reinstated Policy. Any premiums *the Plan* accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

30. STATEMENTS AS REPRESENTATION; EFFECT OF MISREPRESENTATION UPON POLICY

All statements and descriptions in your application for insurance or in negotiations therefor, by or on your behalf, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under this Policy unless: (i) fraudulent; (ii) material either to the acceptance of the risk, or to the hazard assumed by *the Plan*; or
(iii) *the Plan* in good faith would either not have issued this Policy, or would not have issued this Policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to *the Plan* as required either by the application for this Policy or otherwise.

31. ADMINISTRATION OF CLAIM AGAINST *THE PLAN* NOT DEEMED WAIVER OF

DEFENSE

Without limitation of any right or defense of *the Plan* otherwise, none of the following acts by or on behalf of *the Plan* shall be deemed to constitute a waiver of any provision of this Policy or of any defense of *the Plan* hereunder: (i) acknowledgement of the receipt of notice of loss or claim; (ii) furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted; or (iii) investigating any loss or claim or engaging in negotiations looking toward a possible settlement of any such loss or claim.

32. RECORDED PERSONAL INFORMATION

If a *covered individual*, after proper identification, submits a written request to us for access to recorded personal information about the individual which is reasonably described by the individual and which we can reasonably locate and retrieve, we will, within thirty (30) business days from the date the request is received: (i) inform the individual of the nature and substance of the recorded personal information in writing, by telephone or by other oral communication; (ii) permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, whichever the individual prefers, unless the recorded personal information is in coded form, in which case we shall provide an accurate translation in plain language and in writing; (iii) disclose to the individual the identity, if recorded, of those persons to whom we have disclosed the personal information within two years prior to the request, and if the identity is not recorded, the names of those persons to whom the information is normally disclosed; and (iv) provide the individual with a summary of the procedures by which the individual may request correction, amendment or deletion of recorded personal information. Any personal information provided pursuant to this section shall identify the source of the information if the source is an institutional source. Medical record information supplied by a medical care institution or medical professional and requested under this section, together with the identity of the medical professional or medical care institution which provided the information, shall be supplied either directly to the *covered individual* or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever we prefer. If we elect to disclose the information to a medical professional designated by the *covered individual*, we will notify the individual, at the time of the disclosure, that the medical professional has provided the information to the medical professional.

Except with respect to corrected personal information, we may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to *covered individuals*.

The obligations imposed by this section may be satisfied by an insurance producer authorized to act on our behalf.

33. CORRECTIONS, AMENDMENTS OR DELETIONS TO RECORDED PERSONAL INFORMATION

Within thirty (30) business days from the date of receipt of a written request from a *covered*

individual to correct, amend or delete any recorded personal information in our possession about the individual, we will either: (i) correct, amend or delete the portion of the recorded personal information in dispute; or (ii) notify the individual of its refusal to make the correction, amendment or deletion, the reasons for the refusal and the individual's right to file a statement as provided below.

If we correct, amend or delete recorded personal information, we will so notify the individual in writing and furnish the correction, amendment or fact of deletion to the following, as applicable: (i) any person specifically designated by the individual who may have, within the preceding two years, received the recorded personal information; (ii) any insurance support organization whose primary source of personal information is insurance institutions if the insurance support organization has systematically received the recorded personal information from the insurance institution within the
preceding seven years, except that the correction, amendment or fact of deletion need not be furnished if the insurance support organization no longer maintains recorded personal information about the individual; and (iii) any insurance support organization that furnished the personal information that has been corrected, amended or deleted.

If an individual disagrees with our refusal to correct, amend or delete recorded personal information, the individual may file with us a concise statement setting forth what the individual thinks is the correct, relevant or fair information and a concise statement of the reasons why the individual disagrees with our refusal to correct, amend or delete recorded personal information.

If the individual files either statement as described immediately above, we will (i) file the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it; (ii) in any subsequent disclosure by us of the recorded personal information that is the subject of disagreement, clearly identify the matter in dispute and provide the individual's statement along with the recorded personal information being disclosed; and (iii) furnish the statement to the persons and in the manner prescribed above.

If the individual so requests, we will reconsider our underwriting decision based on any corrected information or the individual's statement provided above.

Part V

Filing a Claim

1. EXPLANATION OF BENEFITS (EOB)

Each time we process a claim for you under this *Policy*, a written notice will be sent to you explaining your benefits for that claim. This notice will tell you how we paid the claim or the reasons it was denied. The notice is called an Explanation of Benefits or "EOB."

2. WHO FILES A CLAIM

   A. *Contracting Dentists*: *Contracting Dentists* will file claims directly to us for the services covered by this Policy. We will make benefit payments within sixty (60) days to them.

   B. *Non-contracting Dentists*: When you receive covered services from a *Non-contracting Dentist*, either you or the dentist may file a claim. Contact our Customer Service Department at 1-888-696-9550 for claim forms.

3. PROOF OF LOSS

   All claims for benefits under the *Contract* for services must be submitted within ninety (90) days of the date that the *covered individual* completes the service. Failure to submit the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the time required, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the *covered individual*, not later than one (1) year from the time the *covered individual* should have submitted the claim.

   If benefits are denied because a *Contracting Dentist* fails to submit a claim on time, you will not be responsible for paying the dentist for the portion of the dentist's charge that would have been a benefit under the dental plan. This applies only if the *covered individual* properly informed the *Contracting Dentist* that he or she was a *covered individual* by presenting his or her dental plan identification card. The *covered individual* will be responsible for his or her patient liability, if any.

4. WHEN YOU FILE A CLAIM

   NOTICE OF CLAIM. Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to *the Plan* at Dental Care Plus, Inc., c/o DentaQuest Management, Inc., P.O. Box 2906 Milwaukee, WI 53201-2906, or to *the Plan's* agent, with information sufficient to identify the claimant, shall be deemed notice to *the Plan*. Please include in the notice the name of the Subscriber, and claimant if other than the Subscriber, and the policy number.

   CLAIM FORMS. When *the Plan* receives a request for a claim form for the services of a *Non-contracting Dentist*, it will send the claimant an Attending Dentist's Statement form for filing proof of loss. If the form is not given to the claimant within fifteen (15) days

after receipt of a request from the claimant, the claimant will be deemed to have complied with *the Plan's* requirements of this Policy for filing a completed claims form, if within the time limit under Section 3 of this Part V, the *covered individual* submits a written statement of the nature of the service, and the character and the extent of the service for which the claim is made.

TIME OF PAYMENT OF CLAIMS. We will immediately upon receipt of due written proof of loss: (a) send you a check for your claim to the extent of your benefits under this Policy; or (b) send you a notice in writing of why we are not paying your claim; or (c) send you a notice in writing that the legitimacy of the claim is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary to pay your claim.

If you have any questions, contact our Customer Service department. Our telephone number is listed at the end of this Policy.

i. PAYMENT OF CLAIMS. Benefits will be paid to the subscriber. *The Plan* may pay all or a portion of any dental benefits provided to a *Contracting Dentist*.

5. PHYSICAL EXAMINATION AND AUTOPSY. We, at our own expense, will have the right and opportunity to examine the person of the *Covered Individual* when and as often as it may reasonably require during the pendency of a claim under this *Policy* and to make an autopsy in case of death where it is not forbidden by law.

6. UNPAID PREMIUM. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Part VI

Index

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

SCHEDULE OF BENEFITS

Alabama DentaTrust Individual Dental Plan
Child Only Coverage High Option
(underwritten by Dental Care Plus, Inc.)

To be attached to and form a part of the Dental Care Plus, Inc. (*the Plan*), *Policy* for Alabama DentaTrust Dental Plan coverage.

The *subscriber* has purchased this coverage for the period beginning January 1, 2024, 12:00 AM through December 31, 2024, 11:59 PM, Eastern Time. The monthly premium referred to in the *Policy* is:

One Child Rate: $17.54 per month
Two or More Children Rate: $33.33 per month

The *Policy*, including this *Schedule of Benefits*, refers to various dollar and percentage amounts, as well as other benefit information that may be specific to the *covered individual*. *The Plan* does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan. You should read your *Policy* carefully.

NOTE: The *Policy* only covers children until the last day of the month in which they obtain the age of age 19. There is no coverage under this *Policy* for any person age 19 or older. Further information on eligibility is set forth in the *Policy*.

Benefits for *covered services* described in the *Policy* are reimbursed as follows:

Policy Number:	XXXXXX
Subscriber:	John Doe
Subscriber Address:	123 Main Street, Anytown, XX XXXXX
Dependent[s]:	Jane Doe

SCHEDULE

Coverage Type	**Deductible In-Network**	**Plan Pays In-Network**	**Deductible Out-of-Network**	**Plan Pays Out-of-Network**
Class I - **Diagnostic & Preventive Services**	Per *covered individual*: None	100%	Per *covered individual*: None	100%
Class II - **Restorative and Other Basic Services**	Per *covered individual*: $50 Per Policy: $150	80%	Per *covered individual*: $50 Per Policy: $150	80%
Class III - **Complex Dental Services**	Per *covered individual*: $50 Per Policy: $150	50%	Per *covered individual*: $50 Per Policy: $150	50%
Class IV – **Orthodontics (under age 19)** Medically Necessary	Per *covered individual*: None	50%	Per *covered individual*: None	50%

NOTE: *Non-contracting dentists* are permitted to charge for the difference between the *fee schedule* and the *non-contracting dentist's* billed charges. You may be required to pay more for services obtained from a *non-contracting dentist* than the same services provided by a *contracting dentist*.

SERVICES FOR COVERED INDIVIDUALS UNDER AGE 19

A *covered individual* is considered to be under age 19 until the last day of the month in which the *covered individual* obtains the age of 19.

DEDUCTIBLES

Restorative and other Basic Services, and Complex Dental Services described above are subject to a *deductible* for each *covered individual* in each contract.

OUT OF POCKET MAXIMUM

The *out of pocket maximum* related to in-network *covered services* is limited to $400 per *Policy* with one *covered individual* under age 19 and $800 per *Policy* with two or more *covered individuals* under age 19. The *out of pocket maximum* does not apply to services received from *non-contracting dentists*.

ANNUAL LIMITS and MAXIMUMS

There are no annual limits or maximums on our payment for in-network *covered services*.

WAITING PERIOD

Diagnostic and Preventive Services, Restorative and other Basic Services, Complex Dental Services, and Orthodontic Services are not subject to a waiting period.

NOTE: Italicized terms are defined in the *Policy*.

If you have questions about this coverage, please contact our Account Service Department at [1-855-343-4263].