SUBSCRIBER CERTIFICATE

Missouri Individual Child Only Coverage

January 2024

DentaTrust
Underwritten by DCP, Inc.

DentaQuest
a Sun Life company

DQ1081 (01.24) Child High HB/EN

Missouri DentaTrust

Underwritten by Dental Care Plus, Inc.

Missouri DentaTrust Individual Dental Plan
Policy
Child Only Coverage

Dental Care Plus, Inc. certifies that the *covered individuals* covered under this *Policy* have the right to benefits for services according to the terms of this *Agreement*. This Policy is issued 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, you* may cancel the *Policy* by returning it to us within 10 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 10 day period are solely your financial responsibility.

Guaranteed 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 6. We reserve the right to change premium rates upon renewal of the *Policy*. If we raise the premium rates, we will give *you* at least 45 days' 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.

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 *covered individuals* to obtain benefits from the *dentist* of a *covered individual's* choice; however, if the *covered individual* chooses to obtain benefits from a *non-contracting dentist*, the applicable out of pocket expenses, including 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 the dental condition and treatment of *covered individuals*, and follow recommended treatment instructions given by the *dentist*.
- Provide information to the *dentist* that is necessary to render care to *covered individuals*.
- 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, appeal* or *grievance* 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.

Carry-forward deductible: any portion of the *deductible* amount that is satisfied during the last 3 months of the *benefit period* and is carried forward and applied to the following *benefit period's deductible*.

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 HixfadMO.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. If a dependent is called to active duty, his or her coverage under this Policy will terminate on the date he or she departs for active duty. Upon notice to the Plan of entry into such service, the *pro rata* unearned premium shall be refunded if applicable.

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, including *coinsurance*. 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: (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; (iv) children who have been placed for adoption with the subscriber, if legal adoption is anticipated but not yet finalized; (v) children of any age while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the policyholder for support and maintenance if the mental or physical handicap occurred before attainment of age 25. Proof of such incapacity and dependency must be furnished to the Plan within 31 days of the child's 25th birthday. At reasonable intervals during the 2 years following the child's attainment of the limiting age, the Plan may require proof of the child's disability and dependency. After such two-year period, the Plan may require subsequent proof not more than once each year. 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 Missouri. 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.

Grievance: any complaint submitted in writing by *you,* a representative or *dentist* on your behalf regarding (1) availability, delivery or quality of services, including a compliant regarding an adverse determination; (2) claims payment, handling or reimbursement for service; or (3) any issues related to our contractual relationship with *you*.

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 a *covered individual's* benefits is explained in the *Schedule of Benefits* which is incorporated as a part of this *Policy*.

Class I

Diagnostic and Preventive Services (Please see the *Schedule of Benefits* for limitations for the coverage you have purchased.)

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:

- Initial oral examination (including the initial dental history and charting of teeth); once per *dentist*.
- Periodic exam; once every 6 months.
- X-rays of the entire mouth; once every 60 months.
- Bitewing x-rays (x-rays of the crowns of the teeth); once every 6 months when oral conditions indicate need.
- Single tooth x-rays; as needed.
- Oral and facial photographic images;
- Study models and casts used in planning treatment;
- Routine cleaning, scaling and polishing of teeth; once every 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, once per tooth every 36 months.

Class II

Restorative Services and Other Basic Services (Please see the *Schedule of Benefits* for limitations for the coverage you have purchased.)

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.
- Sedative fillings.
- Stainless steel crowns, under age 15 - Limited to 1 per tooth in 60 months.
- Simple tooth extractions.
- General anesthesia only when necessary and appropriate for covered surgical services only when provided by a licensed, practicing *dentist*.
- Repair of dentures or fixed bridges. Recementing of fixed bridges.
- Rebase or reline dentures; once every 36 months, 6 months after initial installation.
- Tissue conditioning.
- Repair or recement crowns and onlays.
- Adding teeth to existing partial or full dentures.
- Palliative (emergency) treatment of dental pain – minor procedures.
- Periodontal maintenance, 4 in 12 months, following active periodontal therapy

Class III

Complex Dental Services (Please see the *Schedule of Benefits* for frequency and limitations for the coverage you have purchased.)

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

- Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.
- 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, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.

- Dentures and Bridges

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

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

- Crowns, Onlays and Inlays

  - Crowns, onlays and inlays as follows, but only when the teeth cannot be restored with the fillings due to severe decay or fractures.

  - Initial placement of crowns, onlays and inlays.

  - Replacement of crowns, onlays and inlays; once each 60 months per tooth.

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 a *covered individual's* 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.

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

Class IV

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 the 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 the *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 the *dentist* has furnished, prescribed, ordered, recommended or approved the service.

2. *THE PLAN* DOES NOT PROVIDE BENEFITS FOR:

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A *dental 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.
- Services that are covered by a health insurance policy or similar coverage in which the *covered individual* is enrolled.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of the *covered individual's* 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*.
- An illness, injury, or dental condition to the extent for which benefits are provided in one form or another through a government program other than Medicaid or Medicare.

- 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.

- Any charge related to an appointment with a *dentist* that the *covered individual* fails to keep.

- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.

- A service rendered by someone other than a *dentist* or a hygienist who is employed by a *dentist*.

- Prescription drugs.

- A service to treat disorders of the joints of the jaw (temporomandibular joints).

- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.

- Restorations for reasons other than decay or *fracture*, such as erosion, abrasion, or attrition.

- Services that are meant primarily to change or to improve the *covered individual's* appearance.

- Repair or reline of an occlusal guard.

- Transplants.

- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.

- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.

- Lab exams.

- Laminate veneers.

- Duplicate dentures and bridges.

- Temporary, complete dentures and temporary fixed bridges or crowns.

- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing over dentures.
- Services related to congenital anomalies. However, this exclusion does not apply to any covered orthodontic services.
- Tooth desensitization.
- Occlusal adjustment.
- Injury incurred as a result of participating in a riot or insurrection or the commission of a felony.
- Services performed outside of the United States.

Part IV

Effective Date, Enrollment and Disenrollment

1. WHEN YOUR COVERAGE BEGINS

The *covered services* described in this *Policy* are covered as of the *effective date* of the *Policy*, as set out in the Application unless benefits are subject to a waiting period, as stated in the *Schedule of Benefits*.

2. ENROLLMENT AND CONTRACT CHANGES

All enrollment applications and any additions or changes to the *Policy* are allowed ONLY when they conform to our Underwriting Guidelines. Coverage for a new spouse shall be effective from the date of marriage if notice and any required premium is provided to us within 31 days. Coverage for newly born children shall be effective from the date of birth if notice and payment of any required premium is provided to us within 31 days.

Newly adopted children shall be covered for an initial period of 31 days from the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting *you* custody of the child for purposes of adoption, and coverage will continue beyond 31 days if notice and payment of any required premium is provided to us before the expiration of this 31 day period. The date of placement for adoption shall be the earlier of a judicial decree of adoption or the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent, including any child placed with *you* for adoption and any child for whom *you* are a party in a suit in which the adoption of the child is sought. A minor for whom guardianship is granted by court or testamentary appointment shall be covered from the date of appointment, if notice is provided on a timely basis. A child, who the court orders to be covered under a *subscriber's* dental coverage, shall be covered from the date of the order, if notice is provided on a timely basis. *You* may be required to submit proof of the court order or relationship to *the Plan*.

3. ENROLLING *DEPENDENTS*.

Under certain situations, *dependents* may be added to your coverage at any time. Qualifying events could be a result of court order, involuntary employment termination, or your spouse's death. Under those circumstances, *you* must notify *the Plan* within 30 days of the qualifying event.

A. Death of Spouse – If your spouse dies, *you* may add your dependent child(ren) to the coverage provided under this *Policy* at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's policy.

B. Court Order – If *you* are required under a court order (whether from this state or another state that recognizes the right of the child to receive benefits under the *subscriber's* health coverage) to provide dental coverage for a child, *the Plan* shall allow *you* to enroll the child under the following circumstances:

1. *You* shall be allowed to enroll in *family coverage* and include the child in

that coverage regardless of any enrollment period restrictions.

2. If *you* are enrolled but do not include the child in the enrollment, we shall allow the noninsuring parent of the child, child support enforcement agency, or any other agency with authority over the welfare of the child to apply for enrollment on behalf of the child.

3. *You* may not terminate coverage for the child unless written evidence is provided to us that the order is no longer in effect, that the child is or will be enrolled under other reasonable dental coverage that will take effect on or before the effective date of termination.

4. ENROLLMENT THROUGH THE FEDERALLY FACILITATED MARKETPLACE AND PREMIUM PAYMENTS

Notwithstanding the requirements of Part IV, Sections 2 and 3 of this *Policy*, if coverage is obtained through the *FFM*, the *FFM* will enroll *Qualified Individuals* and *dependents* and terminate coverage in accordance with the requirements of the *FFM* and applicable federal laws and regulations.

The Plan is required to process enrollments in accordance with the procedures established by the *FFM*, which require *the Plan* to enroll an individual only if the *FFM* notifies *the Plan* that the individual is a *Qualified Individual* or a *Qualified Individual's* dependent.

For coverage obtained through the *FFM*, 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*, and premiums will be due monthly thereafter unless a different payment interval is permitted by *the Plan.*

A. Annual open enrollment periods.

1. Notice of annual open enrollment period. Starting in 2014, the *FFM* will provide you with a written annual open enrollment notification no earlier than the first day of the month before the annual open enrollment period begins and no later than the first day of the annual open enrollment period.

2. Effective date for coverage.
   a) If coverage is selected between the 1st and the 15th of a month, your *effective date* for coverage will be the first day of the following month.

   b) If coverage is selected after the 15th of a month, your *effective date* for coverage will be the first day of the following month plus one additional month. (For example, coverage selected on January 20th will have an *effective date* of March 1st).

3. First Month's Premium Payment. We must receive your first month's premium payment by no later than 30 calendar days from the *effective date*.

B. Special enrollment periods.

1. Special enrollment period triggering events. The *FFM* must allow *Qualified Individuals* and their dependents to enroll in a *QHP* or change from one *QHP* to another as a result of the following triggering events:

    a) Loss of minimum essential coverage.

    b) Gaining or becoming a dependent through marriage, birth, adoption or placement for adoption.

    c) Gaining status as a citizen, national, or lawfully present individual.

    d) Enrollment or non-enrollment in a *QHP* was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the *FFM* or the United States Department of Health and Human Services ("HHS"), or its instrumentalities, or a non-*FMM* entity providing enrollment assistance or conducting enrollment assistance activities. For purposes of this triggering event, misconduct includes failure to comply with applicable federal standards or other applicable Federal or State laws as determined by the *FFM*.

    e) Violation by *QHP* of a material provision of its contract.

    f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

    g) Relocation to a new service area of the *FFM*.

    h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *QHP* or change from one *QHP* to another one time per month.

    i) Demonstration to the *FFM*, in accordance with guidelines issued by HHS, that you or your *dependent* meets other exceptional circumstances as the *FFM* may provide.

2. Special enrollments are administered by the *FFM*. For additional information on special enrollment triggering events and how to enroll in or change a *QHP* during a special enrollment period, *you* should contact the *FFM* at 800-318-2596 or visit the *FFM* website at www.healthcare.gov .

3. Length of special enrollment periods. Unless specifically stated otherwise in the applicable *FFM* rules, a *Qualified Individual* or your *dependent* has 60 days from the date of a triggering event to select a *QHP*.

4. Effective dates of coverage after a special enrollment period.

    a) Regular effective dates. Unless an exception applies, for a *QHP* selection received by the *FFM* between—

i. the 1st and the 15th day of any month, the *effective date* will be the first day of the following month, and

ii. the 16th and the last day of any month, the *effective date* will be the first day of the second following month.

b) Special effective dates.

i. If *you* have a new *dependent* as a result of adoption, your new *dependent* will be covered for an initial period of 31 days from the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting *you* custody of the child for purposes of adoption. Coverage will continue for your *dependent* beyond 31 days, provided *you* notify the *FFM* within 60 days after the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting *you* custody of the child for purposes of adoption and we receive any required premiums within 30 calendar days from the date *you* enroll your new *dependent*.

ii. If *you* have a new *dependent* as a result of birth, your new *dependent* will covered for an initial period of 31 days from the date of birth. Coverage will continue for your *dependent* beyond 31 days, provided *you* notify the *FFM* within 60 days after the date of the birth and we receive any required premiums within 30 calendar days from the date *you* enroll your new *dependent*.

iii. If *you* have a new d*ependent* as a result of marriage or your *dependent's* loss of minimum essential coverage, and *you* notify the *FFM* within 60 days of the date of marriage, or loss of minimum essential coverage and we receive any required premiums within 30 calendar days from the date *you* enroll your new *dependent*, the *effective date* for your *dependent* will be on the first day of the month following the date of marriage or loss of minimum essential coverage.

5. WHEN YOUR COVERAGE ENDS

Coverage will terminate for a *dependent* if the *dependent* is no longer eligible for coverage due to any of the following events, and coverage will terminate for all *covered individuals* if *you* are no longer eligible due to any of the following events:

A. The *subscriber* is no longer enrolled. In such circumstance, coverage for all *covered individuals* terminates.

B. A child under *family coverage* attains the age of 26 (please see Part I for the definition of *family coverage* and eligibility requirements for *dependents*).

C. The spouse of the *subscriber* is no longer the legal spouse of the *subscriber*.

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.

6. TERMINATION OF POLICY

A. You may cancel this *Agreement* as set forth in this section.

1. Termination of coverage obtained through the *FFM*. The following termination rules apply when *you* cancel coverage obtained through the *FFM*.

a) *You* must provide the *FFM* with notice at least 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. *You* can provide notice to the *FFM* either by calling at 1-800-318-2596 or by logging on to your personal account at www.healthcare.gov .

2. Termination of coverage not obtained through the *FFM*. The following termination rules apply if coverage is obtained other than through the *FFM*. *You* may cancel this *Agreement* for any reason. To do so, *you* must give us notice in writing at least 30 days prior to the termination date.

B. This *Agreement* shall renew or continue in force at your option. In compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), renewability is guaranteed. The *Agreement* shall remain in force by timely payment of premiums. However, *the Plan* may cancel or refuse to renew this *Agreement* only for the reasons set forth in this section.

1. We may, upon 30 days' notice to *you* or a longer period if required by state or federal law, cancel or refuse to renew this *Agreement* under any of the following circumstances:

a) We may cancel this *Agreement*, subject to the Time Limit On Certain Defenses provision set forth in Part V, Section 19, if *you* make any fraudulent claim or material misrepresentation to us or to any *dentist*, such as an incorrect or incomplete statement on your application, which led us to believe *you* were eligible for this coverage when in fact *you* were not. In such a case, cancellation will be as of your *effective date*. We will refund *you* the premium *you* have paid us. We will subtract from the refund any payments made for claims under this *Agreement*. If we have paid more for claims under this *Agreement* than *you* have paid us in premium, we have the right to collect the excess

from *you*.

b) We may cancel this *Agreement* if *you* have not paid your premium, subject to the Grace Period provision under Part V, Section 20 of this *Policy*.

c) We may cancel this *Agreement* if we decide to withdraw this product, in which case *you* will be offered a replacement policy.

d) We may cancel this *Agreement* if we withdraw entirely from the individual market.

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

3. Cancellation due to loss of eligibility

This *Agreement* will be canceled if *you* are no longer eligible because *you* no longer reside in Missouri. The termination date of this coverage shall be the last day of the month in which we were notified of your move and for which the premium has been paid.

Part V

Other Contract Provisions

1. BENEFIT PAYMENTS

IN-NETWORK SERVICES:

If a *covered individual* uses the services of a *contracting dentist*, the in-network benefit allowance is based on the *fee schedule* that the *contracting dentist* has agreed to accept as payment in full for the *covered services* listed in the benefits section, except as provided under item 2 below. *The Plan* pays the *contracting dentist* directly for *covered services*.

OUT-OF-NETWORK SERVICES:

If a *covered individual* uses the services of a *non-contracting dentist*, the benefit for *covered services* is set forth in item 5 below.

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

When your *contracting dentist* provides *covered services*, he or she must accept the fee in the *fee schedule* as payment in full. 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 *covered services* as stated in the *Schedule of Benefits*. 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 based on the service with the lower fee.

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

D. 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. The pre-treatment estimate of benefits is valid for 90 days after the date we notify *you*, your covered *dependents* and the *dentist* of the benefits payable for the proposed treatment plan. If treatment is to commence more than 90 days after the date we notify *you*, your covered *dependents* and the *dentist* of the benefits payable for the proposed treatment plan, a new treatment plan may be submitted.

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 applies 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. WHEN YOUR *CONTRACTING DENTIST* IS TERMINATED

If the *contracting dentist* is terminated for any reason other than fraud, patient abuse, incompetency or loss of license status, he/she shall continue to provide *dental services* to complete the procedure(s) in progress for at least 90 days from the date of notice of termination, as if his/her *contracting dentist* agreement with *the Plan* was still in effect. *The Plan* will compensate the *dentist* for such services in accordance to the terms set forth in the *contracting dentist* agreement.

If the *contracting dentist* terminates the *contracting dentist* agreement, the *contracting dentist* shall continue to provide, for at least 90 days after the date of notice of termination to *the Plan*, *dental services* to a *covered individual* of *the Plan* for whom the *contracting dentist* was responsible for the delivery of *dental services* prior to the notice of termination. The *contracting dentist* will provide orthodontic treatment begun when coverage was in effect, at the rates set forth in the *contracting dentist* agreement.

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

A. If *you* receive services from a *non-contracting dentist*, *you* may be required to pay more out of pocket than for services provided by most *contracting dentists*. Benefits for *covered services* provided by a *non-contracting dentist* are based on the lesser of the *dentist's* submitted fee or the payment amount for services that may be provided by a *contracting dentist* in accordance with the *fee schedule.* In addition, *you* will be responsible for paying any difference between *the Plan's* payment to a *non-contracting dentist,* after any *deductible* or *coinsurance* amounts are calculated based on the maximum allowable charge as indicated on the *fee schedule*, and the *non-contracting dentist's* total charge, if his/her total charge exceeds the *fee schedule* amount for that covered procedure(s). Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* in effect at the time services are rendered.

B. A *covered individual* may request a referral to a specialist who is a *non-contracting dentist* if (a) a *covered individual* is diagnosed with a condition or disease that requires specialized dental care; and (b) *the Plan* has not contracted with a specialist with the professional training and expertise to treat the condition or disease; and, (c) the specialist agrees to be reimbursed the same allowed benefit as would be provided to a specialist who is a *contracting dentist*.

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, visit our website, or check the directory of *contracting dentists*.

6. EMERGENCY CARE

All dental expenses for emergency services are paid as any other expense. Nothing in this *Policy* 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. If *you* utilize the *dental services* of a *non-contracting dentist*, benefits will be paid under the out-of-network *Plan* benefits described in item 5 above.

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.

8. PREMIUM

The amount of money that *you* are responsible for paying to *the Plan* for your benefits under this *Agreement* is called your premium. We will send *you* a notice at least 45 days before any change in your premium goes into effect. Your premium will not change more than once every 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.

The notice will tell *you* the *effective date* of the change and the benefits for *covered 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. MISSTATEMENT OF AGE

If the age of the *subscriber*, or any 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.

11. BENEFITS AFTER CANCELLATION

If this *Policy* is cancelled, no benefits will be provided for services that *you* receive after the effective date of the cancellation, except as set forth in this section.

Benefits will be provided for a course of treatment for 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.

12. NOTICES

A. To *you*: We will send notices and/or bills 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 premium or a change in the *Policy*. If your name or mailing address should change, *you* should notify *the Plan*. 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 Dental Care Plus, Inc., 10300 Springfield Pike, Cincinnati, OH 45215 . Always include your name and *subscriber* identification number.

13. WHEN AND HOW BENEFITS ARE OBTAINED AND PROVIDED

This *Policy* is designed to provide high quality dental care while controlling the cost of such care. To do this, this *Policy* encourages the *covered individual* to seek dental care from *contracting dentists*, however, *you* are free to select the *dentist* of your choice.

When application is made under this *Policy*, the *covered individual* receives a welcome packet which includes a dental plan identification card.

Benefits will be provided ONLY for those *covered services* that are furnished on or after the *effective date* of this *Policy*. If, before the *effective date*, *you* or a covered *dependent* started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure.

In order for *you* to receive any of the benefits for which *you* may have a right, *you* must inform your *dentist* that *you* are a *covered individual* and supply him or her with your *subscriber* identification number and any necessary information needed to file your claim. If *you* fail to inform your *dentist* within 12 months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

14. 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*.

15. COORDINATION OF BENEFITS

The Coordination of Benefits ("COB") provision applies when a *covered individual* has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

DEFINITIONS

A. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    1. "Plan" includes: group and nongroup insurance contracts and subscriber contracts; health insuring corporation ("HIC") contracts; uninsured arrangements of group or group-type coverage; group or nongroup coverage through closed panel plans; medical care components of long-term care contracts, such as skilled nursing care; medical benefits in automobile "no fault" and traditional automobile "fault" type contracts; and Medicare or any other federal governmental plan, as permitted by law.

    2. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage; school accident type coverage covering grammar, high school, and college students for accidents only; benefits for non-medical components of long-term care policies; benefits in long-term policies that pay a fixed daily benefit without regard to expenses incurred or the receipt of service in long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
    3. "Health care coverage" includes coverage for *dental services*.

    4. "Health care services" includes *dental services*.

    Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. "This Plan" means, in a COB provision, the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

D. For purposes of this section, "allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a *dentist* by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

2. If a Subscriber is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

3. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

4. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the *dentist* has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the *dentist*'s contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. “Closed panel plan” is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of *dentists* that have contracted with or are employed by the plan, and that excludes coverage for services provided by other *dentists*, except in cases of emergency or referral by a panel member.

F. “Custodial parent” is the parent awarded custody of a child for more than one-half of the calendar year by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.

B. 1. Except as provided in Paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both plans state that the complying plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

1. Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

    a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

        i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

        ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

    b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

        i. If a court decree states that one of the parents is responsible for the dependent 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. If the parent with the responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has actual knowledge of the terms of the court decree;

        ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

        iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

        iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

            (1) The plan covering the custodial parent.

            (2) The plan covering the spouse of the custodial parent.

            (3) The plan covering the non-custodial parent.

(4) The plan covering the spouse of the non-custodial parent.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or shorter length of coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total

allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Missouri DentaTrust may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. Missouri DentaTrust need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If *you* believe that we have not paid a claim properly, *you* should first attempt to resolve the problem by contacting us at 800-439-7807 or www.dentaquest.com. If *you* are still not satisfied, *you* may call the Missouri Department of Insurance for instructions on filing a consumer complaint, (800) 726-7390.

RIGHT TO RECOVER OVERPAYMENTS

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 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 at 1-800-439-7807 .

17. CONFORMITY WITH STATE STATUTES

This *Policy* shall be construed according to the laws of the State of Missouri. Any provision of this *Policy* which, on its effective date, is in conflict with the statutes of the state of Missouri on such date is hereby amended to conform to the minimum requirements of such statutes.

18. ENTIRE CONTRACT; CHANGES

This *Policy*, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

19. TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period.

20. GRACE PERIOD

A. General Grace Period

A grace period of 31 days will be granted for payment of each premium payment due after the first premium payment. During the grace period, the *Agreement* shall continue in force. If premiums are not received by the 31st day of the grace period, *the Agreement* will automatically terminate as of the 31st day of the grace period.

B. Three Month Grace Period for a *Subscriber* Receiving Advance Payments of the Premium Tax Credit

If a *subscriber* is receiving advance payments of the premium tax credit, and the *subscriber* has previously paid at least one full month's premium during the *Benefit Year*, the grace period is extended to 3 consecutive months.

During the 3 month grace period, *the Plan* shall:

1. Pay all claims for *covered services* rendered to the s*ubscriber* during the first month of the grace period, but may pend claims for *covered services* rendered to the s*ubscriber* during the 2nd and 3rd months of the 3 month grace period.

2. Notify the HHS of the *subscriber's* non-payment of premium.

3. Notify *dentists* of the possibility for denied claims for *covered services* when a s*ubscriber* is in the 2nd and 3rd months of the 3 month grace period.

During the 3 month grace period, *the* Plan shall also:

4. Continue to collect the advance payments of the premium tax credit on behalf of the s*ubscriber* from the Department of Treasury.

5. Return the advance payment of the premium tax credit to the United States Department of Treasury that *the Plan* collected on behalf of the s*ubscriber* for the 2nd and 3rd months of the 3 month grace period if the s*ubscriber* exhausts the 3 month grace period.

21. REINSTATEMENT

A. Reinstatement of coverage obtained through the *FFM*. If any renewal premium is not paid within the required time period and expiration of the grace period stated in Part V, Section 20, this *Policy* and its coverage for you and any of your covered *dependents* will lapse. You must contact the *FFM* for information on reinstatement. You and your covered *dependents* may not be eligible to re-enroll in coverage through the *FFM* until the next open enrollment period or qualification for a special enrollment period.

B. Reinstatement of coverage not obtained through the *FFM*. If any renewal premium is not paid within the required time period and expiration of the grace period stated in Part V, Section 20, this *Policy* and its coverage for you and any of your covered *dependents* will lapse. A subsequent acceptance of premium by us or an agent authorized by us to accept your premium payment, without requiring in connection therewith an application for reinstatement, shall reinstate the *Policy*. However, we may ask for a new application to accept your premium and reinstate your policy. If we require an application for reinstatement and issue a conditional receipt for the premium tendered, the *Policy* will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt unless we previously notified you in writing of our disapproval of the application.

22. REFUND OF PREMIUM

In the event of your death, the amount of premium refund shall be prorated from the date following the date of your death to the end of the *benefit period* for which the premium has been paid. If someone other than *you* paid the premium, the refund will be paid to that person upon proof of payment. If *you* paid the premium, the refund will be paid to your surviving spouse. If there is no surviving spouse, the premium will be paid in the same manner as distribution of a person who dies intestate under Missouri law.

23. APPEALS, UTILIZATION REVIEW AND GRIEVANCE PROCEDURES

NOTE: *The Plan*, as used in these procedures shall mean Dental Care Plus, Inc. c/o DentaQuest, LLC, at PO Box 2906 Milwaukee, WI 53201 . *The Plan* has delegated its utilization review and grievance procedures to DentaQuest.

The Plan recognizes its responsibility to provide *covered individuals* with adequate methods to

make inquiries and express concerns about *the Plan*. *The Plan* has established procedures to allow *you* to file appeals and grievances and seek a review of *the Plan*'s decisions.

You also have the right to file a complaint, appeal or grievance with the Missouri Department of Insurance at any time:

Missouri Department of Insurance
Room 530 Truman Building
301 West High Street
Jefferson City, MO 65101; or

P.O. Box 690
Jefferson City, MO 65102;

Insurance Consumer Hotline, toll free—(800) 726-7390

You may also file a complaint electronically with the Department of Insurance:

https://www.insurance.mo.gov/consumers/complaints/consumerComplaint.php

A. Definitions

The following definitions apply to these Appeals, *Utilization Review* and Grievance Procedures:

Adverse determination: a determination by *The Plan* or its designee *utilization review* organization that a health care service has been reviewed and, based upon the information provided, does not meet *The Plan's* requirements for medical necessity or appropriateness and the payment for the requested service is therefore denied, reduced or terminated.

Concurrent review means *utilization review* conducted during a patient's course of treatment.

Enrollee means a policyholder, *subscriber*, or other *covered individual* under a *policy* or *subscriber* certificate issued by *the Plan*.

Retrospective review means *utilization review* of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, *concurrent review*, case management, discharge planning or *retrospective review*. *Utilization review* shall not include elective requests for clarification of coverage.

B. Appeal Procedures

An *appeal* is a request to change a previous decision by *the Plan* on a claim or pretreatment estimate to deny, reduce or terminate benefits. An *appeal* must be filed in writing within 180 days following your initial receipt of notice that benefits for a claim or pretreatment estimate have been denied, reduced or terminated. *Appeals* filed later than 180 days following your initial receipt of such notice, will be denied. All *appeals* must be submitted in writing.

An *appeal* may be filed by *you*, your *dentist* or by an *authorized representative* acting on your behalf.

In order to file an *appeal*, send a letter to:

Missouri DentaTrust Dental Plan
c/o DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201
800-439-7807

Include in your letter of appeal the following information:

- Your name.
- If applicable, the name of your *authorized representative*.
- Your identification number, address, and telephone number. Please include the best time to reach *you*.
- The decision that *you* are appealing. Include all the facts and issues related to your *appeal*, the names of any *dentists* involved with your treatment, and medical records, if applicable.
- The resolution *you* are requesting.

You or your *dentist* may submit written comments, records and other information when *you* file an appeal. *You* may also request, free of charge, copies of all records and other information which were relied on or created by *the Plan* in the process of reviewing a claim or pretreatment review request. If benefits for a claim or pretreatment estimate were denied, reduced or terminated based on the professional judgment of a *dentist* that the treatment is experimental, investigational or not medically necessary or appropriate, *the Plan* will notify *you* of the identity of the *dentist* who initially reviewed the claim or pretreatment review request. Your *appeal* and all relevant information, including information *you* submitted, will be re-reviewed by a different *dentist* prior to deciding your *appeal*.

C. Utilization Review and Grievance Procedures

Initial Utilization Review Decisions

Proposed Services

With regard to proposed procedures or services requiring a review determination, *the Plan* shall make initial determinations within 36 hours, which shall include 1 working day, of obtaining

all necessary information.

In the case of a determination to certify a procedure or service, *the Plan* shall notify the *dentist* rendering the service by telephone or electronically within 24 hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to the *enrollee* and the *dentist* within 2 working days of making the initial certification. In the case of an *adverse determination*, *the Plan* shall notify the *dentist* rendering the service by telephone or electronically within 24 hours of making the *adverse determination* and shall provide written or electronic confirmation of a telephone or electronic notification to the *enrollee* and the *dentist* within 1 working day of making the *adverse determination*.

Concurrent Reviews

For *concurrent review* determinations, *the Plan* shall make the determination within 1 working day of obtaining all necessary information.

In the case of a determination to certify additional services, *the Plan* shall notify by telephone or electronically the *dentist* rendering the service within 1 working day of making the certification, and provide written or electronic confirmation to the *enrollee* and the *dentist* within 1 working day after telephone or electronic notification. The written notification shall include the next review date, the new total number of days or services approved, and the date of initiation of services.

In the case of an *adverse determination*, *the Plan* shall notify by telephone or electronically the *dentist* rendering the service within 24 hours of making the *adverse determination*, and provide written or electronic notification to the *enrollee* and the *dentist* within 1 working day of a telephone or electronic notification. The service shall be continued without liability to the *enrollee* until the *enrollee* has been notified of the determination.

Retrospective Reviews

For *retrospective review* determinations, *the Plan* shall make the determination within 30 working days of receiving all necessary information. *The Plan* shall provide notice in writing of *the Plan*'s determination to an *enrollee* within 10 working days of making the determination. A written notification of an *adverse determination* shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. *The Plan* shall provide the clinical rationale in writing for an *adverse determination*, including the clinical review criteria used to make that determination, to any party who received notice of the *adverse determination* and who requests such information.

Emergency Services Review

Emergency services are covered as any other expense. Nothing in this *Agreement* shall prevent any person from obtaining emergency services. Emergency services include services necessary to screen and stabilize and do not require prior authorization. If an emergency service requires immediate post evaluation or stabilization, authorization shall be provided within sixty minutes otherwise will be deemed approved.

Retraction of Authorization

If an authorized representative of *the Plan* authorizes the provision of health care services, *the Plan* shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless (1) such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or (2) the policy terminates before the health care services are provided; or (3) the covered person's coverage under the policy terminates before the health care services are provided.

Levels of Review

First Level - A request for a first-level grievance review shall be made within 180 days of the date notice was sent to *you* informing *you* of the *adverse determination* or other decision giving rise to the grievance. Any grievance should be accompanied by documents or records in support of the grievance.

The Plan will acknowledge receipt in writing within 10 working days and will investigate the grievance within 20 working days after receipt of a grievance. If additional time is needed to complete the investigation, *the Plan* will notify the *enrollee* in writing on or before the 20th working day with the investigation completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation. *The Plan* will notify the *enrollee* in writing of the decision within 5 working days following completion of the investigation. The notice will include the right to file an appeal for a second-level review and explain the resolution of the grievance. Within 15 working days after the investigation is completed, *the Plan* will notify the person who submitted the grievance (if other than an *enrollee* who already received notice) of *the Plan*'s resolution of the grievance.

Second Level - *You* have the right to request a second-level review. A request for a second-level grievance review shall be made within 180 days of the date notice was sent to *you* informing *you* of *the Plan*'s resolution of the first-level grievance.

Upon receipt of a request for second-level review, *the Plan* will submit the grievance to a grievance advisory panel. Review by the grievance advisory panel shall follow the same time frames as a first-level review, except in the case of a grievance involving a situation where the time frame of the standard grievance procedures would seriously jeopardize the life or health of an *enrollee* or would jeopardize the *enrollee*'s ability to regain maximum function. Any decision of the grievance advisory panel shall include notice of the *enrollee*'s or the health carrier's or plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office.

Expedited Review

If the time frame of the standard grievance procedures would seriously jeopardize the life or health of an *enrollee*, an expedited review may be requested. A request for an expedited review may be submitted orally or in writing. However, the request shall not be considered a grievance

unless the request is submitted in writing. *The Plan* will notify an *enrollee* orally within 72 hours after receiving a request for an expedited review of our determination. *The Plan* will provide written confirmation of our decision covering an expedited review within 3 working days of providing notification of the determination.

Reconsideration

A treating *dentist* has the opportunity to request, on behalf of an *enrollee*, reconsideration of an *adverse determination*. The reconsideration shall occur within 1 working day of the receipt of the request and shall be conducted between the *dentist* rendering the service and the reviewer who made the *adverse determination* or a clinical peer designated by the reviewer if the reviewer who made the *adverse determination* is not available within 1 working day. If the reconsideration process does not resolve the difference of opinion, the *adverse determination* may be appealed by the *enrollee* or the *dentist* on behalf of the *enrollee*. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an *adverse determination*.

24. CONVERSION

Under the circumstances set forth below, *covered individuals* have the option to convert to another dental plan offered by *the Plan*.

Conversion shall be available without evidence of insurability. Upon receipt of a written application and upon payment of at least the first monthly premium not later than 31 days after the termination of coverage under this *Policy*, *the Plan* shall issue a converted policy.

The option for conversion is available to the following individuals:

6. Upon the death of the *subscriber*, to the surviving spouse with respect to such of the *dependents* as are then covered by the *Policy*;

7. To a child solely with respect to the child upon attaining the limiting age of 26;

8. Upon the divorce, dissolution, or annulment of the marriage of the *subscriber*, to the divorced spouse, or former spouse in the event of annulment, of such *subscriber*..

Part VI

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

Contracting Dentists: *Contracting dentists* will file claims directly with us for the services covered by this *Policy*.

Non-Contracting Dentists: *Non-contracting dentists* may file claims directly with us or *you* may need to submit claims.

3. NOTICE OF CLAIM

Written notice of claim must be given to us within twenty (20) days after the occurrence or commencement of any loss covered by the *Policy*, or as soon thereafter as is reasonably possible. Notice given by *you* or on your behalf or your beneficiary to us at DentaTrust c/o DentaQuest, LLC PO Box 2906 Milwaukee, WI 53201 , or to any agent authorized by us, with information sufficient to identify *you*, shall be deemed notice to us.

4. CLAIM FORMS

We, upon receipt of a notice of a claim, will furnish *you* with such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, *you* shall be deemed to have complied with the requirements of this *Policy* as to proof of loss upon submitting, within the time fixed by this *Policy* for filing proofs of loss, written proof covering the occurrence, character, and the extent of the loss for which the claim is made.

5. PROOFS OF LOSS

Written proof of loss must be furnished to us at DentaTrust c/o DentaQuest, LLC PO Box 2906 Milwaukee, WI 53201 in case of claim for loss for which the *Policy* provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

If *you* have any questions, contact our Customer Service department.

800-439-7807

6. TIME OF PAYMENT OF CLAIMS

We will pay claims immediately upon receipt of due written proof of loss.

7. PAYMENT OF CLAIMS

Any amounts due for *covered services* at the time of your death will be paid to the beneficiary designated by *you* or to your estate

8. PHYSICAL EXAMINATIONS AND AUTOPSY

We, at our own expense, will have the right and opportunity to examine a *covered individual* when as and often as we 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.

9. LEGAL ACTIONS

No action at law or equity shall be brought to recover on this *Policy* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *Policy*. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

10. CHANGE OF BENEFICIARY

The right to change of beneficiary is reserved to *you* and the consent of the beneficiary of beneficiaries shall not be requisite to surrender or assignment of this *Policy* or to change of beneficiary or beneficiaries or to any other changes in this *Policy*.

Part VII

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 the *Policy*.

SCHEDULE OF BENEFITS

Missouri 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 Missouri 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: $14.79 per month
Two or More Children Rate: $24.41 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 800-439-7807.