DENTAQUEST USA INSURANCE COMPANY,INC.
(DENTAQUEST INSURANCE COMPANY, INC)

DentaQuest for Individuals and Families Policy

DentaQuest Family Low Plan

January 1, 2024

[Logo]

96 Worcester Street
Wellesley Hills, MA 02481

DentaQuest for Individuals and Families
Dental Policy

We reserve the right to increase the premium for this policy at the time of renewal.

DentaQuest USA Insurance Company, Inc. certifies that you have the right to benefits for services according to the terms of your 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*.

Your Right to Examine This Policy - Your satisfaction is our number one priority. You have the right to examine this Policy for 10 business days from the date of delivery. Should this Policy not meet your needs please return to us, within 10 business days, the original Policy with a written letter informing us of your intent to cancel. You will receive a full refund of all premiums paid towards the cancelled Policy and your Policy will be void from its *effective date*. 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 premiums, we have the right to collect the excess from you.

This Policy is renewable. This Policy renews annually on January 1 subject to our right to terminate coverage under Part IV, Section 12 (Termination of a Policy). We reserve the right to change premium rates upon renewal of the Policy. If we do raise the premium rates, then at least 60 days prior to the renewal date, we will send written notice to the last known address shown on record.

ATTEST: DentaQuest USA Insurance Company, Inc.*

Brett A Bostrack
[1][Signature]
President & CEO

Colleen Louise Kallas
[1][Signature]
Corporate Clerk

*Incorporated under the laws of the State of Texas.

Contents

Introduction

This Policy, including the attached *Schedule of Benefits* Application and any applicable Riders, Endorsements and Supplemental Agreements is the Agreement between you and DentaQuest USA Insurance Company, Inc. (The Plan). We urge you to read it carefully.

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

Coverage under this Policy takes effect at 12:00 AM Central Time on the *effective date* and terminates at 11:59 PM Central Time on the date of termination.

Subscriber's Rights and Responsibilities

As a DentaQuest subscriber, you have the right to:

- File a grievance or *appeal* about the dental services provided to you.

- Be provided with appropriate information about the Plan and its benefits, *contracting dentists*, and policies.

You 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 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 (Pub. L. 111-148).

Adverse determination: a utilization review decision by the *Plan,* or a *health care provider* acting on behalf of the *Plan* that:

a) decides a proposed or delivered *health care service* which would otherwise be covered under the *covered individual's* Subscriber's Policy is not, or was not medically necessary or appropriate, or is experimental or investigational; and
b) may result in non-coverage of the *health care service*.

Adverse determination does not include a decision concerning a *subscriber's* status as a member.

Agreement: refers to the Subscriber's Policy, *Schedule of Benefits*, Enrollment Form, and any applicable Riders, Endorsements and Supplemental Agreements.

Appeal: a protest filed by a *covered individual,* a *covered individual's representative* or a *health care provider* acting on behalf of a *covered individual,* with *the Plan* through *the Plan's* internal grievance process regarding an *adverse determination* concerning the *covered individual*.

Appeal decision: a final determination by *the Plan* that arises from a grievance filed with *the Plan* under its internal grievance process regarding an *adverse determination* concerning a *covered individual*.

Benefit Period: the twelve (12) month period for which any applicable *deductibles* or maximums apply. This twelve (12) month period is the benefit year.

Benefit Year: a calendar year for which the *Plan* provides coverage for dental benefits.

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

Coinsurance: this means shared coverage. *Coinsurance* is the percent of covered dental expenses, after the *deductible* is satisfied, up to the maximum covered charge shown in the *Schedule of Benefits*.

Complaint: An oral or written expression of dissatisfaction with the Utilization Review Agent (URA), concerning the URA's process in conducting a utilization review.

Contracting Dentist: a licensed dentist who has entered into an agreement with *the Plan* to furnish services to its *covered individuals*.

Coverage decision: an initial determination by *the Plan,* or a representative of *the Plan*

that results in noncoverage of a *health care service*. *Coverage decision* includes nonpayment of all or any part of a claim, but does not include an *adverse determination* as defined above.

Covered dependents: See *Family Coverage* definition.

Covered individual: a person who is eligible for and receives dental benefits. This usually includes *subscribers* and their *covered dependents*.

Covered individual's representative: An individual who has been authorized by the *covered individual* to file a grievance, *appeal* or a *complaint* on the *covered individual's* behalf.

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: the portion of the covered dental expenses that the *covered individual* must pay before *the Plan's* payment begins. This deductible is shown in the *Schedule of Benefits*.

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 services which are within the scope of his or her license or certificate and covered by this Policy.

Domestic Partner: means an opposite or same sex partner who has met all of the following requirements for at least 12 months: (1) resides with the *covered individual*; (2) shares financial assets and obligations with the *covered individual*; (3) is not related by blood to the *covered individual* to a degree of closeness that would prohibit a legal marriage; (4) is at least the age of consent in the state in which they reside; and (5) neither the *covered individual* or Domestic Partner is married to anyone else, nor has any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Effective Date: the date, as shown on our records, on which your coverage begins under this Policy or an amendment to it.

Emergency medical condition: a medical condition, whether physical or mental, manifesting itself by symptoms of 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.

Exchange: the federal health benefit exchange established by the Secretary of the U.S.

Department of Health and Human Services pursuant to § 1321 of the ACA, codified as 42 U.S.C. § 18041(c).

Family coverage: coverage that includes you, your spouse or domestic partner and your or your spouse's natural dependent children from the moment of birth and grandchildren up to and including twenty-six (26) years of age. Your or your spouse's adopted children 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, children under testamentary or court appointed guardianship, grandchildren in your court-ordered custody who are dependent upon you, children who the court orders to be covered under a subscriber's dental coverage, and children under your care are also covered.

Fee Schedule: the payment amount for the 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.

Filing date: the earlier of a.) five (5) days after the date of mailing; or b.) the date of receipt.

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

Health care provider: a.) an individual who is licensed under the Health Occupations Article to provide *health care services* in the ordinary course of business or practice of a profession and is a treating provider of the *covered individual*; or b.) a hospital, means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code

Health care service: a health or medical care procedure or service rendered by a *health care provider* that: a.) provides testing, diagnosis, or treatment of a human disease or dysfunction; or b.) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Individual (or single) coverage: coverage that includes only the *subscriber*, or only a minor dependent in the case of child only coverage.

Injury: (1) all damage to the *covered individual's* mouth due to an accident which occurs while he or she is covered by this Policy; 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.

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

Non-Contracting Dentist: a licensed dentist who has not entered into an agreement with *the Plan* to furnish services to its *covered individuals*.

Benefit year deductible: this *deductible* must be satisfied each benefit year.

Out of Area Emergency: the sudden onset of dental pain, trauma, or bleeding while traveling outside the service area that could not have been predicted.

Out of Pocket Maximum: the maximum a *covered individual* will pay in *deductibles*, copays and *coinsurance* for allowable expenses in any benefit year.

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 your dental care.

Schedule of Maximum Covered Charges: see *Fee Schedule*.

Subscriber: the Policy holder who is eligible to receive dental benefits. A parent or guardian enrolling a minor dependent, including under a child only *plan*, assumes all of the subscriber responsibilities on behalf of the minor dependent.

The Plan: refers to DentaQuest USA Insurance Company, Inc.

Utilization Review: a system for reviewing the appropriate and efficient allocation of *health care services* given or proposed to be given to a patient or group of patients.

You: the *subscriber* of the dental *plan*.

Part II

Benefits

You have the right to benefits on a non-discriminatory basis for the following services, EXCEPT as limited or excluded elsewhere in this Policy. The benefits are limited to a maximum dollar payment 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.

The following list of benefits applies only to *covered individuals* under age nineteen (19).

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.

ORTHODONTIC SERVICES

Orthodontic services for members who have a severe handicapping malocclusion or special medical conditions including cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

The following list of benefits applies to *covered individuals* age 19 and over.

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.

Comprehensive oral examination (including the initial dental history and charting of teeth); once every sixty (60) months.

Periodic exam; twice every calendar year.

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

Bitewing x-rays (x-rays of the crowns of the teeth); one set twice every calendar year.

Single tooth x-rays; as needed.

Routine cleaning, scaling and polishing of teeth; twice every calendar year.

RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth (note: teeth must have a good prognosis to qualify for benefits); (b) repair dentures or bridges; (c) rebase or reline dentures; and (d) repair or recement bridges, crowns and onlays.

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. 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. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.

Protective restorations; once per tooth every sixty (60) months.

Simple tooth extractions.

General anesthesia only when necessary and appropriate for impacted wisdom teeth removal and only when provided by a licensed, practicing dentist.

Repair of dentures or fixed bridges; once every twelve (12) months. Recementing of fixed bridges; once each twelve (12) months.

Rebase or reline dentures; once every thirty-six (36) months.

Tissue conditioning; two treatments every thirty-six (36) months.

Repair or recement crowns and onlays. Recementing is limited to once every twelve (12) months per tooth.

Adding teeth to existing partial or full dentures; once per tooth every twelve (12) months.

Palliative (emergency) treatment of dental pain – minor procedures; three (3) times every calendar year.

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; remove diseased or damaged natural teeth; and restore severely decayed or fractured teeth.

Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth. Additional oral and maxillofacial surgery services include tooth reimplantation, biopsy of oral tissue, alveoplasty and vestibuloplasty.

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). One quadrant of periodontal surgery every thirty-six (36) months. Scaling and root planing once per quadrant every twenty-four (24) months. Periodontal benefits are determined according to our administrative "Periodontal Guidelines."

Periodontal maintenance, including cleaning and scaling and root planing procedures, following active periodontal therapy; once per three months when preceded by active periodontal therapy. Once every three (3) months; not to be combined with regular cleanings.

Endodontic services for root canal treatment once per 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 every 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.

- Temporary partial dentures as follows:

  - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.

Crowns and Onlays

Crowns and onlays as follows, but only when the teeth cannot be restored with the fillings due to severe decay or fractures (note teeth must have good prognosis to qualify for benefits):

- Initial placement of crowns and onlays.

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

Part III

Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

   We will not provide benefits for a dental service that is not covered under the terms of the Policy. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

   A. To be necessary and appropriate, a 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 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:

The following list of limitations and exclusions apply to covered individuals under age nineteen (19).

- 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.
- Travel time and related expenses.
- An illness or injury that 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.

The following list of limitations and exclusions apply to covered individuals age 19 and over.

- 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.
- Travel time and related expenses.
- An illness or injury that 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.
- An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include 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.
- 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).
- Services that are meant primarily to change or to improve appearance.
- Implants.
- 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 any covered orthodontic services.
- Consultations.
- 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.
- Veneers.
- Occlusal guards.

Part IV

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 schedule that the *contracting dentist* has agreed to accept as payment in full for the dental 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*, covered dental services are the percentage of maximum allowable charges for the dental services listed in the benefits section.

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

When your *Contracting Dentist* provides covered services, he or she must accept the fee 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 benefit 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 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 ninety (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 ninety (90) days after the date of notice of termination to *the Plan*, dental care services to a *covered individual* of the *Plan* for whom the *Contracting Dentist* was responsible for the delivery of dental care 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*. Coverage shall be provided for sixty (60) days after the date coverage terminates if the dentist has agreed to or is receiving monthly payments. If the dentist has agreed to accept or is receiving quarterly payments, the dentist shall provide orthodontic treatment for sixty (60) days after the coverage terminates or until the end of the quarter, whichever is later.

5. EMERGENCY CARE

All dental expenses for emergency services are paid as any other expense. 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*. 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 1 above.

6. WHEN YOUR COVERAGE BEGINS

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

7. SUBROGATION

Covered individuals may have a legal right to recover some costs of their dental care from another party because another person has caused the illness or injury. When a *covered individual* has this right, he or she must allow the Plan the right to recover any payments it has made for the illness or injury subject to the following rules.

When a *covered individual* is not represented by an attorney in obtaining a recovery, all payors' share of a *covered individual's* recovery is an amount that is equal to the lesser of: (1) one-half of the *covered individual's* gross recovery; or (2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party.

When a *covered individual* is represented by an attorney in obtaining a recovery, all payors' share of a *covered individual's* recovery is an amount that is equal to the lesser of: (1) one-half of the *covered individual's* gross recovery less attorney's fees and procurement costs as provided by § 140.007 of the Texas Civil Practice and Remedies Code; or (2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party less attorney's fees and procurement costs as provided by § 140.007 of the Texas Civil Practice and Remedies Code.

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The *covered individual* is obligated to provide the Plan with the written authorization, information and assistance necessary to help the Plan recover its payment, and must not do anything to prohibit the Plan from collecting its repayment.

8. 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.

9. PREMIUMS

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 sixty (60) days before any change in your premium goes into effect. Premiums will not change more than once every twelve (12) months.

10. 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.

11. WHEN YOUR COVERAGE ENDS

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

A. The *subscriber* is no longer enrolled.
B. Your dependent child under your *family coverage* attains the limiting age for coverage, however, your dependent child's coverage will not cease solely because of age if the dependent child is: (1) not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and (2) dependent on you for support. (please see Part 1 for the definition of *Family Coverage* and eligibility requirements for dependents).
C. If you become divorced, your spouse's coverage under existing *family coverage* will continue so long as you remain a *subscriber* of the *plan* and a court judgment provides for such coverage. This coverage will continue until either you or your spouse remarries, or until the date of coverage termination stated in the judgment of divorce or separation, whichever is earlier. If your spouse loses coverage due to a change in marital status, we will, upon request, issue without evidence of insurability coverage to your spouse that most nearly approximates the coverage under this Policy with the same effective date of this Policy.

Benefits will be provided in accordance with the Policy in effect at the time an 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.

12. TERMINATION OF A POLICY

A. You may cancel your *Policy*.

1. You may cancel your Policy for any reason. To do so, we request you give us notice in writing at least thirty (30) days prior to the termination date.
2. If you cancel your Policy, you must wait at least one year after your cancellation before you can enroll again as a *subscriber*.

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

B. *The Plan* may cancel or nonrenew your Policy.

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

a) Subject to the Contestability of Coverage provision set forth in Item 15, 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 Policy. If we have paid more for claims under this Policy than you have paid us in premiums, we have the right to collect the excess from you.
b) If you have not paid your premiums, subject to the Grace Period provision under Section 17 under this Part IV.
c) If you have been guilty of fraudulent or unethical dealings with us.
d) If we discontinue a particular product or all coverage in the individual market in Texas in accordance with Texas law.

2. 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 reside in Texas. 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.

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.

For information regarding benefits after cancellation see Part IV, Section 16 of this Subscriber

Policy.

13. REINSTATEMENT

If any premium is not paid within the required time period, coverage for you and any of your covered dependents will lapse. If we later accept a premium without requiring an enrollment for reinstatement, this Policy will be reinstated with such payment. If enrollment for reinstatement is required, the coverage will be reinstated when we approve your enrollment for reinstatement.

If the coverage is reinstated, any losses resulting from an injury will be covered only if the injury is sustained on or after the date of reinstatement.

In all other respects, we as well as you and your covered dependents will have the same rights as existed under this Policy before the coverage lapsed, subject to any provisions included with or attached to this Policy in connection with the reinstatement.

14. 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.

15. CONTESTABILITY OF COVERAGE

1. The *Agreement* may not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue.

2. A statement made by you relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two (2) years during your lifetime.

3. Absent fraud, each statement made by an applicant, or you are considered to be a representation and not a warranty.

4. A statement made to effectuate insurance may not be used to void the insurance or reduce benefits under the Policy unless (a) the statement is contained in a written instrument signed by the *subscriber* or *covered individual*, and (b) a copy of the statement is given to the *subscriber* or covered beneficiary of the *covered individual*.

This provision does not preclude the assertion at any time of defenses based upon the person's eligibility for coverage under this *Agreement*.

16. BENEFITS AFTER CANCELLATION

If you cancel your Policy or if we cancel your Policy for any reason other than material misrepresentation, no benefits will be provided for services that you receive after the

cancellation date, 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.

17. GRACE PERIOD

A grace period of thirty-one (31) days will be granted for payment of each premium due after the first premium. During the grace period, the *Agreement* shall continue in force.

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.

18. 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 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 [3]DentaQuest USA Insurance Company, Inc., c/o DentaQuest, LLC, 96 Worcester Street, Wellesley Hills, MA 02481. Always include your name and *subscriber* identification number.

19. 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 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 adoption. The date of 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. 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 premium. If additional payments of premiums are required to provide coverage for the newly dependent spouse, children or grandchildren, you must notify the *Plan* within thirty-one (31) days after the date of marriage, birth, adoption or other court order or testamentary appointment. You may be

required to submit proof of the court order or relationship to the *Plan*.

If Child or *Individual coverage* becomes an Individual + 1 individual/child, Individual + Children or *Family coverage*, failure to notify the *Plan* of the new dependent(s) within thirty-one (31) days shall result in the *Plan* never recognizing coverage for the new dependent(s) during the thirty-one (31) days. If an Individual + 1 individual/child becomes *Family coverage*, the first thirty-one (31) days are automatically covered but coverage shall end on the thirty-second (32nd) day only if you fail to notify us within the thirty-one (31) days. If another family member is added to *Family coverage*, the *Plan* requests notification of the additional individual to facilitate claims payments.

20. 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, and your spouse's death. Under those circumstances, you must notify the *Plan* within thirty (30) days or six (6) months (only if specified below) 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 *Agreement* at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's Policy. You must notify the *Plan* Sponsor within six (6) months of this event.

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 health 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 members' 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

21. 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.*

22. 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* and in-network facilities, 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 *contract*. If before a *subscriber's effective date* he or she started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure. 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 twelve (12) months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

23. 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.

24. COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person 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 accord 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 equal 100 percent of the total allowable expense.

DEFINITIONS

(a) A "plan" as used in this COB provision 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, blanket, or franchise accident and health insurance policies; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts, such as skilled nursing care; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(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 this COB provision, the part of the contract providing the 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 like benefits, and may

apply other separate COB provisions to coordinate other benefits.

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 equal 100 percent of the total allowable expense.

(c) "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 health care provider or physician by law or in accord 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 one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, 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 two 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 does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician 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 health care provider's or physician's contract permits, the negotiated fee or payment must 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, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(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 health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, 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 under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

(c) 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 must 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.

(d) 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.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this provision, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with coordination benefits requirements.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent 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, 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. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(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, separated, or not living together, whether or not they have ever been married:

(i) if a court order 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. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order 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 (h)(2)(A) must determine the order of benefits.

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

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; and then

(IV) the plan covering the spouse of the noncustodial 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 (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, 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 that covers 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 plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under 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, 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 does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must 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 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 equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must 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 nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL 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. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

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 we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have 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.

25. CHOICE OF LAW

This Policy shall be construed according to the laws of the State of Texas. This Policy may be automatically revised in order to conform to statutory requirements of the laws of the State of Texas.

26. LEGAL ACTIONS

An action at law or in equity may not be brought to recover under this *contract* before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this *contract*. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

27. ENTIRE AGREEMENT; CHANGES

This Policy, including the attached *Schedule of Benefits*, Enrollment Form, and any applicable Riders, Endorsements and Supplemental Agreements constitutes the entire *contract*. 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.

28. GRIEVANCE AND APPEAL PROCEDURES FOR USE IN NON-EMERGENCY CASES

NOTE: *The Plan*, as used in these grievance and *appeals* procedures shall mean DentaQuest Mid-Atlantic to which *the Plan* has delegated its internal grievance and *appeals* process.

COVERAGE DECISION REQUESTS FOR RECONSIDERATION

1. Written notice of a *coverage decision* shall be sent to the *covered individual*, *the covered individual's representative* within thirty (30) calendar days after a *coverage decision* is made.

2. A *covered individual*, the *covered individual's representative*, or a *health care provider* acting on the member's behalf, may file a request for reconsideration orally or in written form within one hundred and eighty (180) days after receipt of an *coverage decision*.

3. An request for reconsideration regarding a *coverage decision*, along with any supporting documentation, should be sent to:

[3]DentaQuest USA Insurance Company, Inc.
C/O DentaQuest
96 Worcester Street, Wellesley Hills, MA 02481
Tel. (877) 453-8456

4. The *Plan* must acknowledge receipt of the request for reconsideration within (5) five working days from receipt of the oral or written request for reconsideration. Upon receipt of an oral request for reconsideration, the *Plan* must send a one-page appeal form to the requesting party. This acknowledgement letter must also include procedures and a list of the documents that the requesting party must submit for review.

5. A final decision will be rendered in writing to a *covered individual, the covered individual's representative* and *health care provider* acting on behalf of a *covered individual* within thirty (30) working days after the date on which a request for reconsideration is filed.

6. Written notice containing the details of the decision on reconsideration and information concerning the *covered individual, the covered individual's representative* or a *health care provider* acting on behalf of the *covered individual's* right to file a *complaint* with the Texas Department of Insurance will be sent to a *covered individual*, the *covered individual's representative* and *health care provider* acting on behalf of a *covered individual* within thirty (30) calendar days after the reconsideration decision is made.

APPEALS

1. Except in emergency cases, *the Plan* shall document an *adverse determination* after the determination has been orally communicated to the *covered individual*, *the covered individual's representative* or *health care provider* acting on behalf of the *covered individual*, and send notice of the *adverse determination* within:

- one (1) working day by either telephone or electronic transmission with respect to a *covered individual* who is hospitalized at the time of the *adverse determination*, followed by a letter within three (3) working days notifying the *covered individual's representative* or *health care provider* acting on behalf of the *covered individual* of the *adverse determination.*
- with respect to a *covered individual* who is not hospitalized at the time of the *adverse determination*, within three (3) working days in writing; or
- within the time appropriate to the circumstances relating to the delivery of the services to the *covered individual* and condition, provided that when denying

post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

2. A *covered individual,* the *covered individual's representative,* or a *health care provider* acting on the member's behalf, may file an *appeal* orally or in written form within one hundred and eighty (180) days after receipt of an *adverse determination.*

3. An *appeal* regarding an *adverse determination,* along with any supporting documentation, should be sent to:

[3]DentaQuest
11100 W. Liberty Drive
Milwaukee, WI 53224

4. The *Plan* must acknowledge receipt of the *appeal* within (5) five working days from receipt of the oral or written *appeal*. Upon receipt of an oral *appeal*, the *Plan* must send a one-page *appeal* form to the appealing party. This acknowledgement letter must also include procedures and a list of the documents that the appealing party must submit for review.

5. If there is insufficient information to complete the internal grievance process, *the Plan* will notify the *covered individual, the covered individual's representative* or *health care provider* acting on the *covered individual's* behalf within five (5) working days of the *filing date* that review of the *appeal* may not proceed unless additional information is provided. *The Plan* will assist the *covered individual, the covered individual's representative* or *health care provider* in gathering the necessary information.

6. A final *appeal decision* will be rendered in writing to a *covered individual, the covered individual's representative* and *health care provider* acting on behalf of a *covered individual* within thirty (30) working days of the *filing date* of an *appeal.*

   If the *appeal decision* is denied, the written notice must include a clear and concise statement of:
   - the clinical basis for the denial;
   - the specialty of the physician or other health care provider making the denial; and
   - the appealing party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review.

   Should the *covered individual* have a life-threatening condition, the written notice must include a description of the *covered individual's* right to an immediate review by an independent review organization and of the procedures to obtain that review. The *covered individual* is not required to comply with procedures for an internal review of the *adverse determination.*

   Once the independent review organization is in receipt of a request to seek review of a denial, the independent review organization must mail or otherwise transmit the notice

of determination no later than the second working day after the date of the request the agent receives all information necessary to complete the review to *covered individual, the covered individual's representative* or *health care provider*.

The *Plan* shall comply with the independent review organization's determination regarding the medical necessity or appropriateness of health care items and services for a *covered individual*.

The *Plan* shall comply with the independent review organization's determination regarding the experimental or investigational nature of health care items and services for a *covered individual*.

Not later than the third working day after the date the *Plan* receives a request for independent review, the *Plan* shall provide to the appropriate independent review organization a copy of:

- any medical records of the *covered individual* that are relevant to the review;
- any documents used by the *Plan* in making the determination to be reviewed;
- the written notification described by Section 4201.359; and
- any documents and other written information submitted to the *Plan* in support of the *appeal*; and

- a list of each physician or other health care provider who:
  - has provided care to the *covered individual*; and
  - may have medical records relevant to the *appeal*.
  - the *Plan* may provide confidential information in the custody of the *Plan* to an independent review organization, subject to rules and standards adopted by the commissioner under Chapter 4202.

The *Plan* shall pay for an independent review conducted.

7. Except in emergency cases, *the Plan* shall document an *appeal decision* in writing after the decision has been orally communicated to the *covered individual , the covered individual's representative* or *health care provider* acting on behalf of the *covered individual*, and send notice of the *appeal decision* within three (3) working days after the oral communication of the decision to the *covered individual, the covered individual's representative* and any *health care provider* acting on behalf of the *covered individual.*

8. *The Plan* may extend, by no longer than 30 working days, the thirty (30) day period required for making a final *appeal decision* with written consent of the *covered individual, the covered individual's representative* or *health care provider* who filed the *appeal* on the *covered individual's* behalf.

9. A *complaint* may be filed with the Commissioner if an *appeal decision* is not received on or before the 30th working day after the *filing date* for prospective denials, and if an *appeal decision* is not received on or before the 45th working day after the *filing date* for retrospective denials. When filing a *complaint* with the Commissioner, *the covered individual* or the *covered individual's representative* will be required to authorize the release of any medical records of the covered individual that may be required to be

reviewed for the purpose of reaching a decision on the *complaint*.

10. Adverse and *appeal decisions* are made under the direction of:

[4]DentaQuest
11100 W. Liberty Drive
Milwaukee, WI 53224

Specialty Review

1. If not later than the 10th working day after the date an *appeal* is denied the *covered individual's* health care provider states in writing good cause for having a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the decision denying the *appeal*. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received.

29. EXPEDITED APPEAL PROCEDURE FOR USE IN EMERGENCY CASES

1. An expedited review is available when an *adverse determination* involves an *emergency* case. An *emergency* case exists only when an *adverse determination* has been rendered for proposed *health care services* that have not been delivered, and the services are necessary to treat a condition or illness that, without immediate attention, would:

a.) Seriously jeopardize the life or health of the *covered individual* or the *covered individual's* ability to regain maximum function; or
b.) Cause the *covered individual* to be in danger to self or others.

2. In an *emergency* case, a decision will be rendered within twenty-four (24) hours after the *filing date* of an *appeal* by a *covered individual, the covered individual's representative* or a *health care provider* acting on the *covered individual's* behalf. The *covered individual, the covered individual's representative* or a *health care provider* acting on the *covered individual's* behalf will be orally notified of the decision on the day the decision is rendered. Written notice of the *appeal decision* will be provided to the *covered individual, the covered individual's representative* and *health care provider* acting on the *covered individual's* behalf within one (1) day after the decision has been orally communicated to the *covered individual* or *health care provider*.

3. In an emergency case, the *covered individual, the covered individual's representative* or *health care provider* acting on the *covered individual's* behalf may file a *complaint* with the Texas Department of Insurance if an *appeal decision* is not received with twenty-four (24) hours after the *filing date*.

30. FILING COMPLAINTS

With *the Plan*:

If you are dissatisfied with any aspect of your dental plan coverage, dental care or *Contracting Dentist*, you may file a *complaint* within ninety (90) days of the *date of service* or occurrence by contacting our Customer Service department at:

[5]DentaQuest USA Insurance Company, Inc.
C/O DentaQuest
96 Worcester Street, Wellesley Hills, MA 02481
Tel. (877) 453-8456

We shall initially respond to the *complaint* within twenty (20) days from the date the *complaint* is filed. The disposition of the *complaint* shall be communicated orally or in writing to you within thirty (30) to sixty (60) days of receipt of the *complaint*. This period may be extended by mutual agreement.

With the Texas Department of Insurance:

To file a *complaint* with the Texas Department of Insurance, the *covered individual, the covered individual's representative* or *health care provider* acting on the *covered individual's* behalf must contact:

Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030
1-800-252-3439
FAX # (512) 475-1771

When filing a *complaint* with the Texas Department of Insurance, the *covered individual* or the *covered individual's representative* will be required to authorize the release of any medical records of the *covered individual* that may be required to be reviewed for the purpose of reaching a decision on the *complaint*.

31. CONFORMITY WITH STATE STATUTES

Any provision of this policy that, on its effective date, conflicts with the statutes of the state in which the insured resides on the effective date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

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

Contracting Dentists: *Contracting Dentists* will file claims directly to us for the services covered by this *contract*. We will make benefit payments immediately upon due written proof of loss.

3. TIME LIMIT

All claims for benefits under the *Agreement* 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

If you file a claim, the following rules apply. Obtain an Attending Dentist's Statement claim form from *the Plan*. As the Plan does not require a written request for a claims form, the *covered individual* may also call the Customer Service Department at 1-(800) 334-6277 to request a form. A *covered individual* may request a claims form at any time after services are rendered keeping in mind that completed claims forms must be submitted to the Plan no more than ninety (90) days after services are rendered, except under circumstances set out in Section 3 above.

Within fifteen (15) days of receipt of notice, the Plan will provide the *covered individual* claims forms. If the *covered individual* does not receive a claims form within those fifteen (15) days, the *covered individual* will be deemed to have complied with the Plan's

requirements of this *contract* for filing a completed claims form, if within the Time Limit under Section 3, the *covered individual* submits written proof covering the service, the character and the extent of the service for which the claim is made.

After we receive your completed forms, we will immediately send you a check for your claim to the extent of your benefits under this Policy.

Within (15) days after we receive the claim and all items needed to secure the proof we will notify you in writing of why we are not paying your claim or of the acceptance of such claim.

You may direct us, in writing, to pay benefits to the recognized *health care provider* who provided the service for which benefits became payable.

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

5. PAYMENT FOR EXPENSES INCURRED BY THE TEXAS DEPARTMENT OF HUMAN SERVICES

If the Texas Department of Human Services pays through medical assistance for a *covered individual* expenses for which the *covered individual* is entitled to payment under this Policy, we will repay the actual costs of those expenses to the Texas Department of Human Services.

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.

DentaQuest USA Insurance Company, Inc.
96 Worcester Street
Wellesley Hills, MA 02481

DentaQuest*

Foreign Language Assistance

English: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

Español (Spanish): si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

Tagalog (Tagalog – Filipino): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

Tiếng Việt (Vietnamese): Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

Français (French): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-278-7310 (TTY: 1-800-466-7566 or 711)번으로 전화해 주십시오.

Deutsch (German): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-278-7310 (TTY: 1-800-466-7566 or 711) an.

[*Products underwritten by DentaQuest National Insurance Company, Inc. in Arizona, Georgia, Illinois, Missouri, Ohio, Pennsylvania, and Virginia,] by DentaQuest of Florida, Inc. in Florida, and [byDentaQuest USA Insurance Company, Inc. in Indiana, Louisiana, Tennessee and Texas.]

Р у с с к и й (Russian): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

م لحوظة :إذا ك نت ت تحدث اذك ر ال ل غة، ف إن خدمات ال م ساعدة ال ل غوي ة ت تواف :(Arabic) ال عرب ة
7566-466-800-1: ر ل ك ب ال مجان .ات صل ب رق م 1-888-278-7310)رق م هات ف ال صم وال ب كم
711).

*Products underwritten by DentaQuest National Insurance Company, Inc. in Arizona, Georgia, Illinois, Missouri, Ohio, Pennsylvania, and Virginia, by DentaQuest of Florida, Inc. in Florida, and by DentaQuest USA Insurance Company, Inc. in Indiana, Louisiana,Tennessee and Texas.

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Kreyòl Ayisyen (French Creole): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratispou ou. Rele 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

ह िंदी (Hindi): ध्यान द: यदद आप द िंदी बोलते हैं तो आपके ललए मफ्ु त भाषा स ायता सेवाएिंउपल ध हैं। 1-888-278-7310 (TTY: 1-800-466-7566 or 711) पर कॉल कर।

Italiano (Italian): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenzalinguistica gratuiti. Chiamare il numero 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

Polski (Polish): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.Zadzwoń pod numer 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

Português (Portuguese): Se fala português, encontram-se disponíveis serviços linguísticos,grátis. Ligue para 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-278-7310 (TTY: 1-800-466-7566 or 711)まで、お電話にてご連絡ください。

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschteebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

*Products underwritten by DentaQuest National Insurance Company, Inc. in Arizona, Georgia, Illinois, Missouri, Ohio, Pennsylvania, and Virginia, by DentaQuest of Florida, Inc. in Florida, and by DentaQuest USA Insurance Company, Inc. in Indiana, Louisiana,Tennessee and Texas.

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[LOGO]

96 Worcester Street
Wellesley Hills, MA 02481

DentaQuest Individual Dental Plan
OUTLINE OF COVERAGE

This Outline of Coverage provides a brief description of some important features of the individual dental policy. This is not the insurance policy and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both the covered individual and the insurance company. It is, therefore, important to **READ THE POLICY CAREFULLY**.

This is not a Medicare Supplement policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

BENEFITS: The individual dental policy is designed to provide coverage for covered dental services, subject to all conditions, limitations, exclusions and maximums set forth in the policy.

COVERED DENTAL SERVICES

The following list of benefits applies only to Members under age nineteen (19).

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 Members 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.

ORTHODONTIC SERVICES

Orthodontic services for members who have a severe handicapping malocclusion or special medical conditions including cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

The following list of benefits applies to Members age 19 and over.

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 Members 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 sixty (60) months.

Periodic exam; twice every calendar year.

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

Bitewing x-rays (x-rays of the crowns of the teeth); one set twice every calendar year.

Single tooth x-rays; as needed.

Routine cleaning, scaling and polishing of teeth; twice every calendar year.

RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth (note: teeth must have a good prognosis to qualify for benefits); (b) repair dentures or bridges; (c) rebase or reline dentures; and (d) repair or recement bridges, crowns and onlays. Examples of these services include:

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. 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. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.

Protective restorations; once per tooth every sixty (60) months.

Simple tooth extractions.

General anesthesia only when necessary and appropriate for impacted wisdom teeth removal only when provided by a licensed, practicing dentist.

Repair of dentures or fixed bridges; once every twelve (12) months.

Recementing of fixed bridges; once each twelve (12) months.

Rebase or reline dentures; once every thirty-six (36) months.

Tissue conditioning; two treatments every thirty-six (36) months.

Repair or recement crowns and onlays. Recementing is limited to once every twelve (12) months per tooth.

Adding teeth to existing partial or full dentures; once per tooth every twelve (12) months.

Palliative (emergency) treatment of dental pain – minor procedures; three (3) times every calendar year.

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; 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. Additional oral and maxillofacial surgery services include tooth reimplantation, biopsy of oral tissue, alveoplasty and vestibuloplasty.

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). One quadrant of periodontal surgery every thirty-six (36) months. Scaling and root planing once per quadrant every twenty-four (24) months. Periodontal benefits are determined according to our administrative "Periodontal Guidelines."

Periodontal maintenance, including cleaning and scaling and root planing procedures, following active periodontal therapy; once per three months when preceded by active periodontal therapy; not to be combined with regular cleanings.

Endodontic services for root canal treatment once per permanent tooth 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 every 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.
- Temporary partial dentures as follows:
  - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.

Crowns and Onlays

Crowns and onlays as follows, but only when the teeth cannot be restored with the fillings due to severe decay or fractures (note teeth must have good prognosis to qualify for benefits):

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

Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

   We will not provide benefits for a dental service that is not covered under the terms of the Policy. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

   A. To be necessary and appropriate, a 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 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:

The following list of limitations and exclusions apply to covered individuals under age nineteen (19).

- 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 Subscriber Certificate.
- Travel time and related expenses.
- An illness or injury that 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 Subscriber Certificate.
- 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.

The following list of limitations and exclusions apply to covered individuals age 19 and over.

- 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 Subscriber Certificate.
- Travel time and related expenses.
- An illness or injury that 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 Subscriber Certificate.
- An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include 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.
- 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).
- Services that are meant primarily to change or to improve appearance.
- Implants.
- 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 any covered orthodontic services.
- Consultations.
- 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.
- Veneers.
- Occlusal guards.

RENEWABILITY

The Policy is renewable. The Policy renews January 1 of each year subject to our right to cancel or nonrenew the policy for the following reasons as further described in the Policy: (a) fraudulent claims or material misrepresentations to us or to any dentist; (b) nonpayment of your subscription charges; (c) fraudulent or unethical dealings with us; or (d) if we discontinue a particular product or all coverage in the individual market in Texas in accordance with Texas law.

PREMIUM

We reserve the right to change premium rates upon renewal of the Policy. If we do raise the premium rates, than at least 60 days prior to the renewal date, we will send written notice to the last known address shown on record.

The initial premium for the Policy is [1]

Monthly Pay [1]

Texas 2024	Pediatric Only		Individual and Family	
	High Option		High Option	Low Option
Marketing Plan Name	DentaQuest PPO Pediatric High		DentaQuest PPO Family High	DentaQuest PPO Family Low
Per person Under Age 19 * Max of 2X	$ 28.94		$ 28.94	$ 20.15
Per person 19 and Over	N/A		$ 18.84	$ 14.08