DentaQuest
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DENTAQUEST NATIONAL INSURANCE COMPANY, INC.
(DENTAQUEST INSURANCE COMPANY, INC.)

DentaQuest PPO for Individuals and Families Policy

DentaQuest PPO Pediatric High Plan

January 1, 2024

DentaQuest National Insurance Company, Inc. (herein called "DentaQuest")

96 Worcester Street
Wellesley Hills, MA 02481

DentaQuest PPO for Individuals and Families Pediatric-Only Policy

DentaQuest National Insurance Company, Inc. (the Plan) certifies that you have the right to benefits for services according to the terms of this Policy. This Policy covers only individuals under the age of nineteen (19). This Policy is part of your Agreement.

This Policy was issued based on the information entered in your application, a copy of which is attached to this Policy. If you know of any misstatement in your application, or if any information concerning the medical history of any insured person has been omitted, you should advise the Plan within ten (10) days regarding the incorrect or omitted information; otherwise, your Policy may not be a valid contract.

RIGHT TO RETURN POLICY WITHIN 10 DAYS. If for any reason you are not satisfied with your Policy, you may return this Policy for cancellation to *the Plan*'s home office within ten days of the date you received it and the premium you paid, including any policy fees or other charges, will be promptly refunded and this Policy shall be deemed void from the beginning and the parties will be returned to their original position as if no Policy had been issued.

RENEWABILITY. This Policy renews annually on January 1 subject to our right to terminate coverage under Part IV, Section 11 (Termination of Policy). We reserve the right to change premium rates upon renewal of the Policy.

ATTEST: DENTAQUEST NATIONAL Insurance Company, Inc.

Brett A Bostrack

Brett Bostrack
President

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Introduction

This Policy, including the attached *Schedule of Benefits*, Application, and any applicable Riders, Endorsements and Supplemental Agreements is the Contract of Insurance. We urge you to read it carefully.

The dental services described in your *Schedule of Benefits* 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, which are found in your *Schedule of Benefits*. Please refer to the *Schedule of Benefits*, attached to this Policy, which outlines the specific services covered under this Policy and the extent of coverage for those services.

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

Subscriber's Rights and Responsibilities

As a DentaQuest Dental Plan *subscriber*, you have the right to:

• File a complaint about the dental services provided to you.

• Be provided with appropriate information about *the Plan* and its benefits, participating 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 at the telephone number listed at the end of this Policy.

Part I

Definitions

ACA: The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

Agreement: refers to this Policy, the *Schedule of Benefits*, the Application, and any applicable Riders, Endorsements and Supplemental Agreements.

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

Civil Union**:** a legal relationship between 2 persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Covered individual: a person who is eligible for and receives dental benefits. This Policy covers only children under the age of nineteen (19), including any natural children, adopted children, or step-children, including newborn children. Adopted children are covered from the date of adoption or placement for adoption, whichever comes first. A child who is in the custody of you or your spouse, pursuant to an interim court order of adoption or placement for adoption, vesting temporary care of the child in you or your spouse, is covered as an adopted child, regardless of whether a final order granting adoption is ultimately issued. Coverage will not be excluded for a child solely because the child does not reside with the *subscriber*.

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.

Effective Date: the date (at 12:00 A.M. Central Time), as shown on our records, on which your coverage begins under this Policy or an amendment to it.

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).

Fee Schedule: the payment amount for the services that may be provided by *Participating or Non-participating Dentists* under this Policy. Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* attached to this Policy and in effect at the time services are rendered.

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

Health care provider: any hospital or person that is licensed or otherwise authorized in Illinois to furnish health care services.

Health care service: the furnishing of a service to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

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

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

Out of Pocket Maximum: the maximum a *Covered Individual* will pay in deductibles, copays and coinsurance for allowable expenses in any *Benefit Year.*

Participating Dentist: a licensed dentist located in the *Plan's* service area that has entered into an agreement with the *Plan* or an affiliate to furnish services to its *covered individuals.*

Participating Dentist Contract: contract between the *Plan* and a *Participating Dentist*.

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.

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 NATIONAL Insurance Company, Inc.

You: the *subscriber* of the dental plan.

Part II Benefits

You have the right to benefits on a non-discriminatory basis for the services listed in the *Schedule of Benefits*, except as limited or excluded elsewhere in this Policy, including the *Schedule of Benefits*. The benefits may be limited to a maximum dollar payment for each *covered individual* for each *Benefit Year*. The extent of your benefits is explained in the *Schedule of Benefits* which is incorporated as a part of this Policy. Please refer to your *Schedule of Benefits* for benefits covered under this Policy.

A stand-alone dental plan covering the pediatric dental EHB must demonstrate that it has a reasonable annual limitation on cost- sharing as determined by the Exchange. Such annual limit is calculated without regard to Essential Health Benefits provided by the Plan and without regard to out-of-network services. Annual cost-sharing amounts can be found on the *Schedule of Benefits*.

Part III
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 this 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 *Schedule of Benefits* provides a summary of dental services or items for which coverage is not provided under this Policy.

Part IV Other Contract Provisions

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

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

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

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

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

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

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

3. PRE-TREATMENT ESTIMATES

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

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

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

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

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING DENTISTS ARE USED. You should be aware that when you elect to utilize the services of a *Non-participating Dentist* in non-emergency situations, benefit payments to such *Non-participating Dentist* are not based upon the amount billed. The basis of your benefit payment will be based on the lesser of the dentist's fees, or the amounts indicated on the *Fee Schedule* for services that may be provided by *Participating and Non-participating Dentists* under this Policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section 356z.3a of the Illinois Insurance Code 215 ILCS 5/356z.3a. *Participating Dentists* have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of a dentist and information on out-of-pocket expenses by calling the toll free telephone number on your identification card or at the end of this Policy. The *Plan's* and any administrator's name and toll-free number will be included on the identification card. Only the *Plan* may assume any underwriting risk when that risk is part of the delivery of services.

To find out if your dentist participates with *the Plan* ask your dentist if he or she has an agreement with us, call our Customer Service department at 1(844) 876-3980 or visit our website at www.dentaquest.com.

5. MEDICALLY NECESSARY REFERRALS

Whenever a *Participating Dentist* finds it medically necessary to refer a *covered individual* to a *Non-participating Dentist*, the *Plan* shall ensure that the *covered individual* so referred shall incur no greater out of pocket liability than had the *covered individual* received services from a *Participating Dentist*. This provision does not apply to a *covered individual* who willfully chooses to access a *Non-participating Dentist* for health care services available through *Participating Dentists*. In these circumstances, the contractual requirements for *Non-participating Dentist* reimbursements will apply.

6. WHEN YOUR COVERAGE BEGINS

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

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

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

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

information, we may not be able to provide benefits for his or her services.

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

8. SUBSCRIPTION CHARGE

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

9. WE MAY CHANGE YOUR POLICY

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

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

10. WHEN YOUR COVERAGE ENDS

Coverage lasts under this Policy for a *covered individual* until the end of the month in which the *covered individual* turns 19 years of age.

11. TERMINATION OF A POLICY

A. CANCELLATION BY INSURED

You may cancel your Policy for any reason.

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

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

2. If you provide us with notice less than fourteen (14) days prior to the proposed effective date of termination, the last day of coverage is the date determined by us, if we are able to effectuate termination in fewer than fourteen (14) days and you request an earlier termination effective date. If we are unable to effectuate

termination in fewer than fourteen (14) days, termination will be effective fourteen (14) days from the date of notice. If you are newly eligible for a Children's Health Insurance Program, the last day of coverage is the day before such coverage begins.

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

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

B. CANCELLATION OR NONRENEWAL BY THE PLAN

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

1. Subject to the Time Limitation on Certain Defenses provision set forth in Section 13 of this Part IV, if you have performed an act or practice that constitutes fraud or make an intentional misrepresentation of material fact. In such a case, cancellation will be as of your *effective date*. We will refund you the subscription charge you have paid us. We will subtract from the refund any payments made for claims under this Policy. If we have paid more for claims under this Policy than you have paid us in subscription charges, we have the right to collect the excess from you.
2. If you have not paid your subscription charges, subject to the Grace Period provision under Section 15 under this Part IV.
3. If you have been guilty of fraudulent dealings with us.
4. If we discontinue a particular product or all coverage in the individual market in Illinois in accordance with Illinois law.

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

C. CANCELLATION DUE TO LOSS OF ELIGIBILITY.

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

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

D. TIME AT WHICH TERMINATION TAKES EFFECT

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

12. MISSTATEMENT OF AGE

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

13. TIME LIMIT ON CERTAIN DEFENSES

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

14. BENEFITS AFTER TERMINATION

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

15. GRACE PERIOD

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

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

16. NOTICES

A. To you: When we send a notice to you by first class mail. Once we mail the notice or bill, we are not responsible for its delivery. This applies to a notice of a change in the subscription charge or a change in the Policy. If your name or mailing address should change, you should notify *the Plan* at once. Be sure to give *the Plan* your old name and address as well as your new name and address.
B. To us: Send letters to DENTAQUEST NATIONAL Insurance Company, Inc., c/o DentaQuest Management, Inc., P.O. Box 2906 Milwaukee, WI 53201. Always include your name and subscriber identification number.

17. CONTRACT CHANGES

Any additions or changes to the Policy are allowed ONLY when they conform to our underwriting guidelines. Changes to the Policy may result in a change in your subscription charge.

18. ENROLLING DEPENDENTS

Under certain situations, dependents may be added to your coverage at any time. Qualifying events could be a result of court order and your spouse's death. Under those circumstances, you must notify *the Plan* within thirty-one (31) 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 Policy at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's Policy or contract. You must notify *the Plan* 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.

19. 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 annual open enrollment 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*. Special enrollment periods include when a qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption or placement in foster care.

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.*

20. WHEN AND HOW BENEFITS ARE PROVIDED

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

21. 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.

22. COORDINATION OF BENEFITS AND RIGHT TO RECOVER OVERPAYMENTS

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

A. Definitions:

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

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

3. The plan that provides benefits first under the COB rules is known as the **primary plan**. The primary plan is responsible for providing benefits in accordance with its terms and conditions of coverage without regard to coverage under any other plan.

4. The plan that provides benefits next is the **secondary plan**. It provides benefits toward any remaining balance for covered services in accordance with its terms and conditions of coverage, including its COB provision.

B. Secondary Plan's Benefits:

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

C. Order of Benefit Determination Rules:

1. The coverage from both plans shall be coordinated so that the *covered individual* receives the maximum allowable benefit from each plan.
2. A plan that does not contain a COB provision is always primary. An exception to this rule is coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits. An example of this type of coverage is a point-of-service benefit written in connection to a closed (capitation) panel.
3. In determining which plan is the primary and which is the secondary, the following rules shall apply and in this order:
    a. The plan that covers the c*overed individual* other than as a dependent is the primary plan. The secondary plan is the one that covers that c*overed individual* as a dependent. However, if federal law requires Medicare to be a secondary plan, then this rule may be reversed.
    b. When both plans cover the c*overed individual* as a dependent child, the plan of the parent whose birthday occurs first in a Benefit Year should be considered as primary. The parents should be married, not separated (whether or not they ever have been married), or a court decree awards

joint custody without specifying that one party has the responsibility to provide health care coverage.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits shall be: 1) the plan of the custodial parent 2) the plan of the spouse of the custodial parent 3) the plan of the noncustodial parent.
d. If a determination cannot be made with the rules as set out above, the plan that has covered either of the parents for a longer time should be considered as primary. This rule shall apply if the parents have the same birthday.
e. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule shall apply to claim determination periods or Benefit Years commencing after the plan is given notice of the court decree.

4. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
5. If one of the plans is a medical plan and the other is a dental plan, the medical plan will always be the primary plan.
6. Whichever plan that covered the c*overed individual* as an employee, member, *subscriber* or retiree longer is the primary plan.

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

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

23. CONFORMITY WITH STATE STATUTES:

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

24. CHOICE OF LAW

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

25. LEGAL ACTIONS

No action at law or in equity shall be brought to recover under this Policy prior to the expiration of sixty (60)

days after written proof of loss has been furnished as required by this Policy. No legal action may be brought after the expiration of two years after the time written proof of loss is required to be furnished.

26. ENTIRE CONTRACT; CHANGES

This Policy, including the application and any amendments and riders, including the *Schedule of Benefits*, constitutes the entire contract of insurance and no change in this Policy shall be valid until approved by an executive officer of the *Plan* and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Policy or to waive any of its provisions.

27. IMPORTANT INFORMATION ABOUT YOUR INSURANCE

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

DENTAQUEST NATIONAL
Insurance Company, Inc. c/o
DentaQuest P.O. Box 2906
Milwaukee, WI 53201
Telephone: 1(844) 876-3980

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting the agent, or DENTAQUEST NATIONAL Insurance Company, Inc., you should have your Policy number available.

28. REINSTATEMENT

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

29. STATEMENTS AS REPRESENTATION; EFFECT OF MISREPRESENTATION UPON POLICY

All statements and descriptions in your application for insurance or in negotiations therefor, by or on your behalf, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under this Policy unless they are material either to the acceptance of the risk, or to the hazard assumed by *the Plan*, which were either deemed to be fraudulent or

were intentionally perpetrated.

30. ADMINISTRATION OF CLAIM AGAINST *THE PLAN* NOT DEEMED WAIVER OF DEFENSE

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

31. GRIEVANCE PROCEDURES

You may file a grievance concerning the provision of dental care services or other matters relating to your coverage under this Policy. A grievance may be filed by phone, in person, by mail or by electronic means. All grievances should be submitted to:

DentaQuest
Attention: Grievances & Complaints
PO Box 2906
Milwaukee, WI 53201-2906
By telephone: 1(844) 876-3980
Website: www.dentaquest.com

If an oral grievance has been presented, we will request your grievance be sent to us in writing within ten (10) business days, unless this timeframe has been waived or extended by mutual written agreement between both you and *the Plan.*

We will provide you a written resolution of the grievance within thirty (30) days of receipt of the written grievance.

32. ASSIGNMENT

No provision of the Illinois Insurance Code, or any other law, prohibits a Subscriber from making an assignment of all or any part of his/her rights and privileges under the policy.

Part V Filing a Claim

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

2. WHO FILES A CLAIM

   A. *Participating Dentists*: *Participating Dentists* will file claims directly to us for the services covered by this Policy.

   B. *Non-participating Dentists*: When you receive covered services from a *Nonparticipating Dentist,* either you or the dentist may file a claim. Contact our Customer Service Department at 1-(844) 876-3980 for claim forms.

3. PROOF OF LOSS

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

   If benefits are denied because a *Participating 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 *Participating 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

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

   B. CLAIM FORMS. When *the Plan* receives a request for a claim form for the services of a *Non-participating Dentist*, it will send the claimant an Attending Dentist's Statement form for filing proof of loss. If the form is not given to the claimant within fifteen (15) days after receipt of a request from the claimant, the claimant will be deemed to have complied with *the Plan's* requirements of this Policy for filing a completed claims form, if within the time limit under Section 3, the *covered individual* submits a written statement of the nature of the service, and the character and the extent of the service for which the claim is made.

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

All claims payable under this Policy shall be paid within 30 days following receipt by us of due proof of loss. Failure to pay within such period shall entitle the *subscriber* to interest at a rate of 9% per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

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

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

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

DENTAQUEST NATIONAL
Insurance Company, Inc.
96 Worcester Street
Wellesley, MA 02481
Customer Service Department
1(844) 876-3980

DentaQuest National Insurance Company, Inc.
(herein called "DentaQuest")

96 Worcester Street, Wellesley Hills, MA 02481

SCHEDULE OF BENEFITS
DentaQuest PPO for Individuals and Families
Pediatric High Option

This Schedule applies only to individuals under age nineteen (19).

COVERAGE

In-Network Benefits		Out-of-Network Benefits
Diagnostic and Preventive Services		
The Plan pays 100% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		*The Plan* pays 100% of covered charges up to the *fee schedule* amounts for services by a *Non-participating Dentist.*
Restorative and other Basic Services		
The Plan pays to 80% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		*The Plan* pays 80% of covered charges up to the *fee schedule* amounts for services by a *Non-participating Dentist.*
Complex and Major Restorative Dental Services		
The Plan pays 50% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		*The Plan* pays 50% of charges up to the *fee schedule* amounts for services by a *Non-participating Dentist.*
Orthodontic Services		
The Plan pays 50% of covered charges up to the *fee schedule* amounts for medically necessary orthodontic services by a *Participating Dentist.*		*The Plan* pays 50% of covered charges up to the *fee schedule* amounts for medically necessary orthodontic services by a *Non-participating Dentist.*

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 (6) months.

Periodic exam; once every six (6) months per dentist in an office setting and once every twelve (12) months in a school setting.

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.

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

Fluoride treatment Topical Fluoride - Varnish - 1 every 12 months, Topical application of fluoride (excluding prophylaxis) - 1 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 4 years.

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 (resin-based) tooth color fillings; once every twelve (12) months per tooth. 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.

Protective restorations (sedative fillings).

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

Simple tooth extractions.

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

Nitrous oxide when medically necessary.

Non-intravenous conscious sedation when medically necessary.

Therapeutic drug injection when medically necessary.

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.

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

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:

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

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.

Inlays are paid as an alternative benefit of amalgam.

Implants- once every 60 months.

Prosthodontic services including 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.

Maxillofacial prosthetics

ORTHODONTIC SERVICES

Orthodontic services for individuals who are under age nineteen (19) who achieve a minimum Salzmann Evaluation Criteria Index score of forty-two (42) points. Other medically necessary qualifiers are considered. Orthodontic services require prior authorization.

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

DEDUCTIBLES

Restorative and other Basic Services, and Complex and Major Restorative Dental Services described above are subject to a $50 deductible for each *covered individual* under age 19 every calendar year. This means the *covered individual(s)* must pay the first $50 of benefits provided every calendar

year.

ANNUAL MAXIMUM BENEFIT

No annual maximum benefit applies to this coverage.

OUT OF POCKET MAXIMUM (in-network benefits only)

The *out of pocket maximum* is $400 per calendar year. The *out of pocket* maximum applies per *covered individual* under age 19. The *out of pocket* maximum applies to in-network benefits only. No out of pocket maximum applies to out of network benefits. A family with 2 or more covered individuals under age 19 will have an aggregate out-of-pocket maximum of $800 for individuals under age 19 for the calendar year.

WAITING PERIOD

There are no waiting periods for *covered individuals* under age 19.

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

For services performed by a *Participating Dentist*, the in-network benefit allowance is based on the dentist's fee, up to the maximum allowable charge indicated on the negotiated *Plan* Fee Schedule. *The Plan* pays the *Participating Dentist* directly for covered services. The *Participating Dentist* may collect from the *subscriber* or *covered individuals* any difference between the *Plan* payment and his/her actual submitted charge or the maximum Fee Schedule amount, whichever is lower, as well as any plan specific deductibles.

OUT-OF-NETWORK SERVICES:

For services performed by a *Non-participating Dentist*, *the Plan* will pay the dentist directly by applying the out-of-network benefit coinsurance payments for each type of service against the maximum allowable charge indicated on the negotiated *Plan* Fee Schedule, or the dentist's submitted fee if lower.

The *subscriber or covered individual* is responsible for paying the *Non-participating Dentist* the difference between the dentist's fee and the amount paid by *the Plan*, including the difference between *the Plan's* payments and any balances resulting from plan specific deductibles and coinsurance.

CLAIMS SUBMISSION:

All claims for benefits under this *Agreement* must be submitted within ninety (90) days of the date that the *covered individual* received 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.

NOTE: Italicized terms are defined in the Policy.

If you have questions about this coverage, please contact our Customer Service Department at 1(844) 876-3980.

DentaQuest*

Foreign Language Assistance

English: you have the right to get help and information in your language at no cost. To talk to an interpreter, call [1-844-876-3981].

Chinese: 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 [1-844-876-3981]。

Vietnamese: quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi [1-844-876-3981].

Arabic: ض الررويةن---م ن---ود ي---اة قلك--------تة. ل--لكدحث عم ت----مرمج ت----اصل ب [1-844-876-3981] ن--إ ن---اك دليك وأ لـ---د ص---خش دعاس---ته ظلس--------أ صوص-----خب كتفل----------ب

Korean: 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 [1-844-876-3981] 로 전화하십시오.

French: vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez [1-844-876-3981].

Russian: то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону [1-844-876-3981].

Spanish: tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al [1-844-876-3981].

German: haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer [1-844-876-3981] an.

Tagalog: may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa [1-844-876-3981].

Gujarati: િવશે પ્રĕો હોર્ તો તમને મદદ અને મ હહતી મેિળિ નો અિવક ર છે. તે ખચ્ િવન તમ રી ભ ષમ ાં પ્ ાપ્ત કરી શક ર્ છે. ૬ ભ વષ્ો િ ત કિર મ ટે,આ [1-844-876-3981] પર કોલ કરો.

Hindi: के बारे मΛ प्रæन ह ,तो आपके पास अपनी भाषा मΛ मुŕत मΛ सहायता और सूचना प्राŏत केका अिधकार है। ककसी ि ुभाषषए से बात करने के िलए , [1-844-876-3981] पर कॉि करΛ।

Italian: hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare [1-844-876-3981].

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

Japanese：についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、[1-844-876-3981]までお電話ください。

Portuguese: você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para [1-844-876-3981].

French Creole: se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan [1-844-876-3981].

Polish: masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer [1-844-876-3981].

Amharic: ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ [1- 844-876-3981] ይደውሉ።