DentaQuest
a Sun Life company

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

DentaQuest EPO for Individuals and Families Policy

DentaQuest EPO Pediatric High Plan

January 1, 2024

DentaQuest PPO

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

Individuals and Families
Dental Policy

DentaQuest USA Insurance Company, Inc. (the *Plan*) certifies that you have the right to benefits for services according to the terms of this Policy. 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* immediately regarding the incorrect or omitted information; otherwise, your Policy may not be a valid contract.

NOTICE OF INSURED'S RIGHT TO EXAMINE POLICY FOR TEN DAYS. If for any reason you are not satisfied with your Policy, you may return this Policy within ten days of the date of delivery and the premium you paid 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. This Policy may be returned to the *Plan* at 96 Worcester Street Wellesley Hills, MA 02481. If you have an existing policy, you are allowed 30 days to decide without cost whether you desire to keep the policy or will replace it.

QUALIFIED RIGHT OF RENEWAL. This Policy renews annually on January 1 subject to our right to cancel or nonrenew coverage in accordance with Part IV, Section 23 of this Policy. We shall notify you in writing at least forty-five (45) days before any increase of twenty percent of more in the policy rates.

We may increase your premiums at renewal. We will send you a notice at least thirty (30) days before any increase in your premium goes into effect. Premiums will not change more than once every twelve (12) months.

THIS POLICY IS A NON-PARTICIPATING POLICY.

This is a Limited Policy - Read it Carefully

ATTEST: DentaQuest USA Insurance Company, Inc.

Brett A Bostrack
President

Colleen Louise Kallas
Secretary

Contents

Introduction

This Policy, including the attached Schedule of Benefits, Application, and any applicable Riders, Endorsements and Supplemental Agreements is the *Agreement*. 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 *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.

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.

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*.

Customary Fee: the fee level determined by the administrator of the dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

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. Eastern Time), as shown on our records, on which your coverage begins under this Policy or an amendment to it.

Family coverage: coverage that includes you, your spouse and dependent children up to and including twenty-six (26) years of age. Your or your spouse's adopted children are covered from the date of adoptive or parental placement with an insured subscriber or plan enrollee for the purpose of adoption. Children under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, and grandchildren in your court-ordered custody who are dependent upon you are also covered.

With respect to an unmarried child covered by this Policy prior to the attainment of the age of twenty-six (26) who is incapable of self-sustaining employment by reason of intellectual or physical disability and who became so incapable prior to attainment of age twenty-six (26) and who is chiefly dependent upon such policyholder for support and maintenance, coverage shall not terminate while this Policy remains in force and the dependent remains in such condition, if the *subscriber* has within thirty-one (31) days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein and subsequently may be required by the insurer not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

An unmarried dependent child or grandchild who is a full-time student and who develops a mental or nervous condition, problem, or disorder which renders the dependent, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by the issuer,

unable to attend school as a full-time student and from holding self-sustaining employment, until the age of twenty-four. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

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 Louisiana 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* 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 USA Insurance Company, Inc.

Usual Fee: the fee which an individual dentist most frequently charges for a specific dental procedure.

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 extent of your benefits is explained in the *Schedule of Benefits* whichis incorporated as a part of this Policy. Please refer to your *Schedule of Benefits* for benefits covered under this Policy.

This is not an all inclusive list of benefits and all required FEDVIP dental benefits are being provided for children under age 19. The FEDVIP benchmark plan can be found at the following link: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf.

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. Such a determination is made by a licensed dental practitioner. Please see Part IV, Paragraph 40, Claim Appeal Procedures for additional details. Louisiana law requires additional considerations with regard to external review or adverse determinations involving individual claims in excess of two hundred fifty dollars. Claims over $250.00 are subject to additional considerations under Louisiana law.

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

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:
Benefits for covered services provided by a *Non-participating Dentist* are based on the lesser of the dentist's fees, or the amounts indicated on the *Fee Schedule* for services that may be provided by *participating and non-participating dentists* under this Policy. The *Plan's* payment for services provided by a *Non-participating Dentist* will be the same as the *Plan's* payment for services provided by a *Participating Dentist*, except that the payment for services for *a Non-participating Dentist* will not exceed the actual fee charged by the *Non-participating Dentist* for the dental services rendered.

Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* attached to this Policy and in effect at the time services are rendered. You will be responsible for paying the dentist any deductible, copayment or coinsurance amount applicable to the covered service and the difference between the dentist's fee and the amount paid by the *Plan* after any deductible or coinsurance amounts are calculated.

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

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. There is no maximum benefit for covered individuals under age 19.

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. WHEN YOUR COVERAGE BEGINS

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

5. 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.

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.

6. PREMIUM

The amount of money that you are responsible for paying to *the Plan* for your benefits under this *Agreement* is called your premium. We may not change your premium until the present Schedule of Benefits under this Policy has been in effect for twelve (12) months.

7. 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.

8. WHEN YOUR COVERAGE ENDS

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

A. Your dependent child under your *family coverage* attains the limiting age for coverage (please see Part 1 for the definition of Family Coverage and eligibility requirements for dependents). If the *Plan* has accepted premium for the dependent child, coverage will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted.

B. If you become divorced or legally separated, 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 you remarry and your divorce judgment so provides, your former spouse will have the right, for an additional subscription, to continue to receive such benefits as are available to you by means of the issuance of a separate subscription at a single rate under the plan.

9. SUBROGATION

You may have a legal right to recover some costs of your dental care from someone else because another person has caused your illness or injury. When you have this right, you must let us use it if we decide to recover any payments we have made for the illness or injury. However, if you use this right to recover money from someone else, you must repay us for the payments we have made. You must give us information and assistance and sign necessary documents to help us receive our repayment. You must not do anything that might limit our repayment. Any right we have of recovery from third parties is subordinate to your right to be fully compensated for your damages. We are obligated to share in legal expenses incurred.

10. ENTIRE CONTRACT; CHANGES

This Policy, including the *Schedule of Benefits*, and any applicable rider(s) or attachments, and the Application constitute the entire contract of insurance. No change in this Policy shall be valid until approved by an 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.

11. TIME LIMIT ON CERTAIN DEFENSES

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

(b) No claim for loss incurred after three years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

12. GRACE PERIOD

A grace period of thirty (30) days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force. The Policy will terminate at the end of the grace period if the premium is not received. If we have not received the premium payment fifteen days prior to the end of the grace period, we will mail you a notice stating that: (i) if the premium has not been paid by the end of the grace period, the Policy will lapse as provided by its provisions; and (ii) the Policy will be reinstated with no penalties if the full premium payment is received within the period allowed for reinstatement.

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.

13. REINSTATEMENT

If any renewal premium be not paid within the time granted the *subscriber* for payment, a subsequent acceptance of premium by the *Plan* or by any agent duly authorized by the *Plan* to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy: Provided, however, That if the *Plan* or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the *Plan* or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the *Plan* has previously notified the *subscriber* in writing of its disapproval of such application. The reinstatement of the Policy following default in payment of premium shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten days after the date of such acceptance. In all other respects the subscriber and the *Plan* shall have the same rights hereunder as they had immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than

sixty days prior to the date of reinstatement.

14. NOTICE OF CLAIM.

Written notice of claim for injury or for sickness must be given to the *Plan* within twenty (20) days after the date of the accident causing such injury or the commencement of the disability from such sickness, except that in case of industrial policies such notice of claim must be given to the insurer within ten (10) days in such cases. In the event of accidental death, immediate notice thereof must be given to the Plan. Such notice given by or on behalf of the *covered person* or the beneficiary to the *Plan* at DentaQuest USA Insurance Company, Inc., c/o DentaQuest, P.O. Box 2906, Milwaukee, WI 53201-2906, or to any authorized agent of the *Plan*, with information sufficient to identify the *subscriber*, shall be deemed notice to the *Plan*. Failure to give such notice within such time shall not invalidate nor reduce any claim if it was not reasonably possible to give such notice within the time required, provided written notice of claim is given as soon as reasonably possible. Please include in the notice the name of the claimant if other than the subscriber and the policy number.

15. CLAIM FORMS.

(a) The *Plan*, upon receipt of notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss.

(b) If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, affirmative written proof covering the occurrence, the character and the extent of the loss for which claim is made.

16. PROOF OF LOSS

All claims for benefits under this Policy 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.

Affirmative written proof of loss must be furnished to the insurer at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as

reasonably possible and in no event later than one year from the time proof is otherwise required. Any such policy may also provide, at the insurer's option that written notice or proof of continuance of disability must be furnished not less frequently than each ninety days during the continuance of disability.

17. TIME OF PAYMENT OF CLAIMS.

Indemnities payable under this Policy for will be paid immediately upon receipt of due written proof of such loss. All claims shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court.

18. PAYMENT OF CLAIMS.

Indemnities will be payable to the *subscriber*. However, at our option, all or any portion of any indemnities provided by this Policy may be paid directly to the person rendering the dental services covered by this Policy. It is not required that the dental services be rendered by a particular person.

19. PHYSICAL EXAMINATIONS.

The *Plan* at its own expense shall have the right and opportunity to examine a *covered individual* when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

20. 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 in accordance with the requirements of this Policy. No action shall be brought after the expiration of one (1) years after the time proofs of loss are required to be filed.

21. MISSTATEMENT OF AGE

If the age of a *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.

22. 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.

23. TERMINATION OF POLICY

A. CANCELLATION BY INSURED

You may cancel your Policy for any reason.

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

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

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

1. You may cancel this Policy at any time by written notice delivered or mailed to us at least 30 days prior to the proposed effective date of cancellation. The effective date of cancellation will be the date stated in the notice or 30 days after our receipt of notice of cancellation, whichever is later. 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 sixty (60) 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 11 of this Part IV, if you make any fraudulent claim or a fraudulent misrepresentation or intentional misrepresentation of material fact to us or to any dentist, 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.
2. If you have been guilty of fraudulent dealings with us.
3. If we discontinue a particular product or all coverage in the individual market in Louisiana in accordance with Louisiana law.

We may, upon thirty (30) days' notice to *you*, cancel or nonrenew your Policy if you have not paid your premiums, subject to the Grace Period provision under Section 12 of this Part IV.

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*.

Termination of this Policy by the *Plan* shall be without prejudice to any continuous loss which commenced while this Policy was in force provided that the *covered individual* who suffered the loss while this Policy was in force was and remains continuously disabled, and provided further that coverage for the loss that commenced while this Policy was in force will not extend beyond the duration of any benefit period in the Policy, nor shall the payment exceed the maximum benefits under this Policy.

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 Louisiana. The termination date of this coverage shall be the last day of the month, at 12:01 A.M. Eastern Time, in which we were notified of your move and for which the premium has been paid.

We will notify a *covered individual* of the termination of the *covered individual's* Policy.

D. TIME AT WHICH TERMINATION TAKES EFFECT.

Any termination of this Policy under paragraphs A., B. or C of this Section 23 shall take effect at 12:01 A.M. Eastern Time on the effective date of termination.

E. EFFECT OF TERMINATION ON SPOUSE

Your spouse will not be terminated solely because of the occurrence of an event that results in termination of your coverage, other than nonpayment of premium. In the event of the Subscriber's death, the spouse of the Subscriber, if covered under this Policy, shall become the Subscriber.

24. CONFORMITY WITH STATE STATUTES

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

Any provision of the policy which, on the date of issue, is in conflict with the statutes of the state in which the insured resides at the date of issue is understood to be amended to conform to such statutes.

25. BENEFITS AFTER TERMINATION

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

26. 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* 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 USA Insurance Company, Inc., c/o DentaQuest, P.O. Box 2906 Milwaukee, WI 53201-2906. Always include your name and subscriber identification number.

27. CONTRACT CHANGES

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

Changes to the Policy may result in a change in your premium. Except as provided in section 28, below, the *Plan* must be notified of new covered dependents within thirty-one (31) days. Failure to notify the *Plan* of new dependents within thirty-one (31) days shall result in the *Plan* never recognizing coverage for the new dependent(s) during the thirty-one (31) days.

28. 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.

29. ENROLLMENT THROUGH THE EXCHANGE AND PREMIUM PAYMENTS

Notwithstanding the requirements of Sections 27 and 28 of this Part IV, 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.*

30. 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.

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 fifteen (15) months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

31. 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.

32. 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 USA Insurance Company, Inc. at the following address and telephone number:

DentaQuest USA Insurance Company,
Inc.[c/o DentaQuest P.O. Box 2906
Milwaukee, WI 53201
Telephone: 1-844-241-5611

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

33. 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.

34. PRE-EXISTING CONDITIONS

This Policy does not exclude coverage for pre-existing conditions.

35. IMPROPER UTILIZATION CAUSED BY PARTICIPATING DENTISTS

If a *covered person* receives a service from a *Participating Dentist* that would otherwise be a covered service under this Policy but is not covered due to improper utilization caused by a *Participating Dentist,* the *covered person* will be held harmless for any payment denial for such services.

36. EMERGENCY MEDICAL CONDITIONS

Nothing in this *Policy* will prohibit a *covered individual* from seeking emergency care whenever the individual is confronted with an *emergency medical condition,* which in the judgment of a prudent layperson would require pre-hospital emergency services. For purposes of this provision, an "*emergency medical condition*" is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy,

serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B).

37. NON-DISCRIMINATION

The *Plan* complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage for dental services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. The *Plan* will not deny or limit coverage to any dental service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such dental service is ordinarily available. The *Plan* will not deny or limit coverage for a specific dental service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

38. 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."

39. WHO FILES A CLAIM

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

40. CLAIM APPEAL PROCEDURES

The Plan has implemented processes for appeals of coverage determinations and claims which comply with any applicable federal law or regulation, including both internal and external claims appeal processes. the Plan will provide you with notice, where applicable and in a culturally and linguistically appropriate manner, of available internal and external appeals processes.

A. INTERNAL APPEALS

If you or the *Participating Dentist* providing dental services to you believes we have incorrectly denied all or part of the claim, you or the *Participating Dentist* may file a request for review within 180 days of the date on which you receive notice of the adverse determination. To request a formal review of your claim, send the request in writing to the address set forth in Section 32 of this Part IV.

You may request copies of all documents relevant to the claim for benefits, which will be sent to you free of charge. You may also submit comments and documents relating to the appeal claim, without regard to whether that information was submitted or considered in the initial benefit determination. You may also to receive continued coverage pending the outcome of the appeals process where required by applicable law or the Plan document or policy.

B. STANDARD EXTERNAL APPEALS

For purposes of claims related to a dental insurance policy, this section applies only to external review or adverse determinations involving individual claims in excess of two hundred fifty dollars ($250.00). Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to R.S. 22:2433, you or your authorized representative may file a request for an external review with the Plan.

If a claim is denied based on lack of medical necessity, the decision will be based upon a determination by a dentist who holds a non-restricted license issued in the United States in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review. Any denial on appeal of a claim based on lack of medical necessity shall be made by a dentist who is not an employee of the Plan.

Within five (5) business days following the date of receipt of the external review request from you or your authorized representative pursuant to Subsection A of this Section, the Plan shall complete a preliminary review of the request to determine whether all of the following have been met:

1) You are or were a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, you were a covered person in the health benefit plan at the time the health care service was provided.
2) The health care service is the subject of an adverse determination or a final adverse determination.
3) You have exhausted the Plan's claims and appeals process as provided pursuant to R.S. 22:2401 unless the you are not required to exhaust the Plan's claims and appeals process pursuant to R.S. 22:2435.
4) You have provided all the information and forms required to process an external review, including the authorization form provided for in R.S. 22:2433(B).

Any written communication to you or a dentist that includes or pertains to a denial of benefits for all or part of a claim based on lack of medical necessity shall include the name, applicable specialty designation, license number together with state of issuance, and the direct telephone number of the licensed dentist making the adverse determination. The Office of Consumer Advocacy of the Louisiana Department of Insurance is available at 800-259-5300 if you need assistance with the appeals process. The Plan shall notify the commissioner that a request is eligible for external review pursuant to Louisiana statute by submitting a request for assignment of an independent review organization through the Department of Insurance's website. Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination.

C. EXPEDITED EXTERNAL APPEALS

Your or your authorized representative may make a request for an expedited external review with the *Plan* at the time that you receive:

1. An adverse determination if both of the following apply:
   a. The adverse determination involves a medical condition of you for which the time frame for completion of an expedited internal review of a grievance involving an adverse determination made pursuant to R.S. 22:2401 would seriously jeopardize the life or health of the covered person or would jeopardize your ability to regain maximum function.
   b. You or your authorized representative has filed a request for an expedited review of a grievance involving an adverse determination made pursuant to R.S. 22:2401.
2. A final adverse determination if either of the following applies:
   a. You have a medical condition in which the time frame for completion of a standard external review pursuant to R.S. 22:2436 would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.
   b. The final adverse determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request of an expedited external review, the *Plan* shall determine whether the request meets the reviewability requirements specified in R.S. 22:2436(B). The *Plan* will notify you, and if applicable, your authorized representative, of our eligibility determination. Immediately upon the *Plan's* determination that a request is eligible for an expedited external review or upon the determination by the commissioner that a request is eligible or an expedited external review, the *Plan* issuer shall determine whether the request meets the reviewability requirements specified in R.S. 22:2436(B). The *Plan* will submit a request for assignment of an independent review organization through the Department of Insurance's website.

As expeditiously as your medical condition or circumstances requires, but in no event more than seventy-two hours after the date that the *Plan* receives the request for an expedited external review, the assigned independent review organization shall do both of the following:

   a. Make a decision to uphold or reverse the adverse determination or final adverse determination.
   b. Notify you, your authorized representative (if applicable), the *Plan,* and the commissioner, of the decision.

41. FALSE OR FRAUDULENT CLAIM

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

42. EXTENSION OF TIME LIMITATIONS

If any limitation of this Policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this Policy is less than that permitted by law of the state, district, or territory in

which the insured resides at the time this Policy is issued, such limitation is extended to agree with the minimum period permitted by such law.

43. UNIFORM CLAIM FORMS

Notwithstanding any other law to the contrary, all claims shall be processed in conformity with the uniform claim form issued by the Louisiana Department of Insurance pursuant to Louisiana Revised Statute 22:1824.

Part V
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
Customer Service Department
1 844-241-5611

DentaQuest PPO

DentaQuest USA Insurance Company, Inc.

96 Worcester Street

Wellesley Hills, MA 02481

SCHEDULE OF BENEFITS

Individuals and Families
Dental 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 to 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 covered 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 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 individuals who are under age nineteen (19) who achieve a minimum Salzmann Evaluation Criteria Index score of twenty-five (25) 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 Schedule of Benefits.
- 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 Schedule of Benefits.
- 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 toothbrushing, 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.

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.

WAITING PERIOD

There are no waiting periods for covered services.

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 datethat 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 inthe 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 1-844-241-5611.

This is not an all inclusive list of benefits and all required FEDVIP dental benefits are being provided for children under age 19. The FEDVIP benchmark plan can be found at the followinglink: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan- codes/2014/brochures/MetLife.pdf.

DentaQuest PPO

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIMITED BENEFIT INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing limited benefit insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(I) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(4) ___ By checking this blank, I agree to receive this notice exclusively by electronic means only.

The above "Notice to Applicant" was delivered to me on:

_____ _____

Applicant's Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LIMITED BENEFIT INSURANCE

According to [your application] [information you have furnished), you intend to lapse or otherwise terminate existing limited benefit insurance and replace it with a policy to be issued by [insert company name] Insurance Company. Your new policy provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(I) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and lo refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

[DentaQuest USA Insurance Company, Inc.]

_____

DATE MAILED OR PROVIDED TO APPLICANT

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 by DentaQuest 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).

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

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

ह िंदी (Hindi): ध्यान दें: यदद आप द िंदी बोलते िं तो आपके ललए मुफ्त में भाषा स िंबिंधी सेवाएिं उपलब्ध िं। 1-888-278-7310 (TTY: 1-800-466-7566 or 711) पर कॉल करें।

Italiano (Italian): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica 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 Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

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