DSM USA Insurance Company, Inc.

465 Medford Street
Boston, MA 02129

DentaQuest PPO for Individuals and Families Policy

DSM 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.

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 10 (Termination of Policy). We reserve the right to change premium rates upon renewal of the Policy.

ATTEST: DSM USA Insurance Company, Inc.

President

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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 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.

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*.

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. The deductible shall be applied to the allowable expenses covered under this Policy prior to applying any applicable coinsurance factor.

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).

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 and grandchildren in your court-ordered custody who are dependent upon *you* are also covered. Foster children are covered from the date of placement in foster care.

As long as this Policy remains in force, coverage for dependent children shall continue beyond age 26 while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the policyholder for support and maintenance. Proof of such incapacity and dependency must be furnished to *the Plan* by the policyholder within 31 days after the child's attainment of the limiting age. At reasonable intervals during the 2 years following the child's attainment of the limiting age, *the Plan* may require proof of the child's disability and dependency. After such two-year period, *the Plan* may require subsequent proof not more than once each year.

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 Missouri 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 of 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 DSM USA 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.

Part III
Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

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*

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.

5. WHEN YOUR COVERAGE BEGINS

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

6. 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.

7. 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.

8. 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.

9. 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 charge, to continue to receive such benefits as are available to *you* by means of the issuance of a separate subscription charge at a single rate under the *Plan*.

10. TERMINATION OF A POLICY

A. CANCELLATION BY INSURED

You may cancel your Policy for any reason.

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

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

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

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

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

B. CANCELLATION OR NONRENEWAL BY THE *PLAN*

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

1. *You* failed to pay premiums or contributions in accordance with the terms of this Policy or the *Plan* has not received timely premium payments.
2. *You* performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Policy.
3. The *Plan* is ceasing to offer coverage in the individual market in accordance with Missouri law.
4. If the *Plan* offers coverage in the market through a network plan, *you* no longer reside, live, or work in the service area, or in an area for which the *Plan* is authorized to do business; provided, however, that such coverage is terminated uniformly without regard to any health status-related factor of *covered individuals*.

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 Missouri. 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 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 10 shall take effect at 12:01 A.M. Eastern Time on the effective date of termination.

11. MISSTATEMENT OF AGE

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

12. 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.

13. BENEFITS AFTER TERMINATION

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

14. GRACE PERIOD

Unless not less than five days prior to the premium due date *the Plan* has delivered to the *subscriber* or has mailed to the *subscriber's* last address as shown by the records of *the Plan* written notice of its intention not to renew this Policy beyond the period for which the premium has been accepted, a grace period of 31 days shall be granted 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 *subscriber* 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.

15. 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 DSM USA Insurance Company, Inc., c/o DentaQuest Management, Inc., PO Box 2906, Milwaukee, WI 53201-2906
C. Always include your name and *subscriber* identification number.

16. CONTRACT CHANGES

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

Changes to the Policy may result in a change in your subscription charge. Except as provided in section 17, 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.

17. 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 s*ubscriber'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.

18. ENROLLMENT THROUGH THE *EXCHANGE* AND PREMIUM PAYMENTS

Notwithstanding the requirements of Sections 16 and 17 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.*

19. WHEN AND HOW BENEFITS ARE PROVIDED

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

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.

20. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

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

21. COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has dental coverage under more than one Plan. Plan is defined for purposes of this provision below.

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

DEFINITIONS

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

Plan includes: group and nongroup insurance contracts, health maintenance organization contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; hospital indemnity benefits in excess of $200 a day and Medicare or any other federal governmental plan, as permitted by law. A plan may also include 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: an individual or family insurance, or other individual coverage (except for group-type insurance), 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 the applicable state Coordination of Benefits law and this Policy.

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

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has dental coverage under more than one Plan.

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

D. Allowable expense is a dental expense, including *deductibles*, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

B.

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

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

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

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

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

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

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

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

(i) If a court decree states that one of the parents is responsible for the dependent child's dental expenses or dental coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

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

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

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

- The Plan covering the Custodial parent;

- The Plan covering the spouse of the Custodial parent;

- The Plan covering the non-custodial parent; and then

- The Plan covering the spouse of the non-custodial parent.

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

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

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

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that,

when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan *deductible* any amounts it would have credited to its *deductible* in the absence of other dental coverage.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. We may get the facts we needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give us any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

22. 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.

23. CHOICE OF LAW

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

24. LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Policy.

No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

25. 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.

No statement made by an applicant for the Policy not included in the application shall avoid the Policy or be used to deny a claim hereunder or be used in any legal proceeding hereunder.

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

DSM USA Insurance Company, Inc.
c/o DentaQuest PO Box 2906,
Milwaukee, WI 53201-2906
Telephone: 1- 844-241-5603

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

27. 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.

28. STATEMENTS AS REPRESENTATION; EFFECT OF MISREPRESENTATION UPON POLICY

All statements and descriptions in your application for insurance or in negotiations therefor, by or on your behalf, shall be deemed to be representations and not warranties. Misrepresentations, omissions,

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

29. 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.

30. UTILIZATION REVIEW AND GRIEVANCE PROCEDURES

Attached to this Policy is a Utilization Review and Grievance Procedures document that describes *the Plan's* utilization review and grievance procedures that are available to *covered individuals*. Please see the Utilization Review and Grievance Procedures document for additional information.

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. We will make benefit payments within thirty (30) days to them.

   B. *Non-participating Dentists*: When *you* receive covered services from a *Non-participating Dentist,* either *you* or the dentist may file a claim. Contact our Customer Service Department at 1- 844-241-5603 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. Notice given to *the Plan* at DSM USA Insurance Company, Inc., c/o DentaQuest Management, Inc., P.O. Box 2906, Milwaukee, WI 53201-206, 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 pay claims immediately upon receipt of due written proof of loss.

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.

DSM USA Insurance Company, Inc.
465 Medford Street
Boston, MA 02129
Customer Service Department
1-844-241-5603

DSM USA Insurance Company, Inc.
465 Medford Street, Boston, MA 02129

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 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 severe and handicapping malocclusion as defined by one or more autoqualifiers. Orthodontic services require prior authorization.

The following list of limitations and exclusions applies 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 tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- Service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Tooth bleach.
- Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
- Transitional implants.
- Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomies, root amps, ridge augmentations and dental implant placements.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
- Cone Beam Imaging and Cone Beam MRI procedures.
- Nitrous oxide.
- Oral sedation.
- Topical medicament center.

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 $350 per calendar year. The *out of pocket* maximum applies per *covered individual* under age 19. The *out of pocket* maximum shall not exceed $700 per calendar year for two or more *covered individuals*. The *out of pocket* maximum applies to in-network benefits only. No out of pocket maximum applies to out of network benefits.

WAITING PERIOD

No waiting periods apply.

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 1-844-241-5603.

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 1-844-241-5605.

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 1-844-241-5605。

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 1-844-241-5605.

Arabic: ذم ذود باة ةلكتة. ليتح حث عم ثمرمج ثاصل ب 1-844-241-5605 ذإ ناكدليك وأ لد د صخش دعسته ةلئسأ صو صخب ضلاررويةة كئغلب

Korean: 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-241-5605 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 1-844-241-5605.

Russian: то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-241-5605.

Spanish: tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-241-5605.

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 1-844-241-5605 an.

Tagalog: may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-241-5605.

Gujarati: વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. ૬ ભ વષર્ો િ ત કરિ મ ટે,આ 1-844-241-5605 પર કોલ કરો.

Hindi: के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषषए से बात करने के लिए , 1-844-241-5605 पर कॉि करें।

Italian: hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-241-5605.

*Products underwritten by DSM USA 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 Tennessee and Texas.

DQ.Foreign.Lang.Asst. (2016)

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、1-844-241-5605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 1-844-241-5605.

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 1-844-241-5605.

Polish: masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-241-5605.

Amharic: ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-241-5605 ይደውሉ።