DentaQuest Virginia, Inc. (the Plan) certifies that you have the right to benefits for services according to the terms of this Subscriber Certificate. This Subscriber Certificate is part of your Agreement.

THIS SUBSCRIBER CERTIFICATE MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ!

This Subscriber Certificate was issued based on the information entered in your application, a copy of which is attached to this Subscriber Certificate. 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 Subscriber Certificate may not be a valid contract.

RIGHT TO RETURN SUBSCRIBER CERTIFICATE WITHIN 10 DAYS. If for any reason you are not satisfied with your Subscriber Certificate, you may return this Subscriber Certificate to the Plan within ten days of the date you received it and the premium you paid will be promptly refunded.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare is available from us.

RENEWABILITY – Your Subscriber Certificate renews annually subject to our right to cancel under Part IV, Section 12 (Termination of Subscriber Certificate) for the following reasons:

1. If you make any fraudulent misstatements in your application.
2. If you have not paid your subscription charges.
3. If you commit any acts of physical or verbal abuse, which pose a threat to a dentist, his or her employees, or employees of the Plan, which are unrelated to your mental or physical condition.
4. If you have been guilty of fraudulent or unethical dealings with us.

LIMITED BENEFIT POLICY: THIS IS A LIMITED BENEFIT POLICY. IT DOES NOT PROVIDE COVERAGE FOR ANY MEDICAL BENEFITS AND SERVICES. THIS IS AN EXCHANGE CERTIFIED STAND-ALONE DENTAL POLICY THAT PROVIDES COVERAGE FOR CERTAIN DENTAL SERVICES ONLY.

ATTEST: DentaQuest Virginia, Inc.

Signature
President
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Introduction

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

The dental services described in this Subscriber Certificate (see Benefits section) 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 Parts II and III of this Subscriber Certificate. Please refer to the Schedule of Benefits, attached to this Subscriber Certificate, which outlines the specific coverage provided under this Subscriber Certificate.

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

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.
Part I
Definitions


Adverse determination: means a decision by the Plan or a representative of the Plan to deny, reduce, or modify the availability of any dental care services, because your condition failed to meet the requirements for coverage based on necessity, appropriateness of care, level of care, or effectiveness.

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

Appeal: a protest filed by a covered individual or a health care provider with the Plan under its internal appeal process regarding a coverage decision concerning a covered individual.

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

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

Covered dependents: See Family Coverage definition.

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

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.), as shown on our records, on which your coverage begins under this Subscriber Certificate or an amendment to it.

Emergency medical condition: a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B). Emergency dental care includes treatment to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm.
**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, 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. "Notwithstanding any limiting age stated in the contract, any unmarried child covered under the contract as a dependent of an enrollee who is chiefly dependent for support upon the enrollee, and who, at the time of reaching the limiting age, is incapable of self-support because of intellectual disability or physical handicap that commenced prior to the child's attaining the limiting age, shall continue to be covered under the contract while remaining so dependent, unmarried, and intellectually disabled or physically handicapped, until the coverage on the enrollee upon whom the child is dependent terminates." Upon the attainment of the limiting age, coverage as a Dependent shall be extended if the child is chiefly dependent upon you for support and maintenance, until such time as your coverage terminates. You must notify the Plan and provide medical documentation to support this continued coverage within seventy-two (72) days of the child’s qualifying birthday.

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

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

**Fracture**: the breaking off of rigid tooth structure not including crazing due to thermal changes or chipping due to attrition. **Health care provider**: any hospital or person that is licensed or otherwise authorized in the Commonwealth of Virginia 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.

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

**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 Area Emergency**: the sudden onset of dental pain, trauma, or bleeding while traveling outside the service area that could not have been predicted.
**Out of Pocket Maximum:** the maximum a Covered Individual will pay in deductibles, copays and coinsurance for allowable expenses in any Benefit Year.

**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 Subscriber Certificate which outlines the specific coverage in effect as well as the amount, if any, that you may be responsible for paying towards your dental care.

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


**Subscriber:** the Subscriber Certificate 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.

**Plan:** refers to DentaQuest Virginia, Inc.

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

**You:** the subscriber of the dental plan.
Part II Benefits

You have the right to benefits on a non-discriminatory basis for the following services, EXCEPT as limited or excluded elsewhere in this Subscriber Certificate. 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 Subscriber Certificate.

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

DIAGNOSTIC AND PREVENTIVE SERVICES

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most Covered Individuals receive during a routine preventive dental visit. Examples of these services include:

Comprehensive oral examination (including the initial dental history and charting of teeth); once every six (6) months.

Periodic exam; twice every calendar year.

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

Bitewing x-rays (x-rays of the crowns of the teeth); once every twelve (12) months when oral conditions indicate need.

Single tooth x-rays; as needed.

Study models and casts used in planning treatment; for non-orthodontic services.

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

Fluoride treatment for individuals under age nineteen (19); twice every calendar year.

Space maintainers required due to the premature loss of teeth for individuals under age nineteen (19); once every calendar year per tooth and not for the replacement of primary or permanent anterior teeth.

Sealants on unrestored permanent molars; once per tooth for individuals under age nineteen (19). Sealants are not covered when placed over restorations.
RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth (note teeth must have a good prognosis to qualify for benefits); (b) repair dentures or bridges; (c) rebase or reline dentures; (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 synthetic tooth color fillings, but limited to one filling for each tooth surface every twelve (12) months. No benefits are provided for replacing a filling within twelve (12) months of the date that the prior filling was furnished.

Protective restorations.

Stainless steel crowns.

Simple tooth extractions.

General anesthesia only when necessary and appropriate and only when provided by a licensed, practicing dentist.

Repair of dentures or fixed bridges.

Recementing of fixed bridges.

Rebase or reline dentures; once per denture every twenty-four (24) months.

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

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

Local anesthesia

COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES

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

Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth. Additional oral and maxillofacial surgery services include tooth reimplantation, biopsy of oral tissue and alveoplasty.
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). Gingivectomy is covered once every twenty-four (24) months per quadrant. Osseous surgery is covered once per quadrant per sixty (60) months. Scaling and root planing once every quadrant every twenty-four (24) months.

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

Full mouth debridement; once every twelve (12) months.

Provision Splinting.

Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, pulp caps, pulpal regeneration and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.

Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every sixty (60) months.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.

Crowns and Onlays

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

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

Apicoectomy/periradicular surgery once per tooth per lifetime

Removable prosthesis for children under age nineteen (19); once per arch per sixty (60) months.

Veneers for individuals under age nineteen (19) (Medically Necessary); once per tooth every sixty (60) months when tooth qualifies for crown.

Temporary crowns; Limited to a fractured tooth. Not to be used as temporary crown during crown fabrication.
ORTHODONTIC SERVICES

Medically Necessary Orthodontics

- Medically necessary pediatric orthodontia exists when there is a severe, dysfunctional, handicapping malocclusion. Orthodontic services require prior authorization.

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

DIAGNOSTIC AND PREVENTIVE SERVICES

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most Covered Individuals receive during a routine preventive dental visit. Examples of these services include:

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

Periodic exam; twice every calendar year.

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

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

Single tooth x-rays; as needed.

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

RESTORATIVE AND OTHER BASIC SERVICES

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

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist’s charge. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.

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

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

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

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

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

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

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

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

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

**COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES**

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

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

Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery). One quadrant of periodontal surgery every thirty-six (36) months. Scaling and root planing once per quadrant every twenty-four (24) months. Periodontal benefits are determined according to our administrative “Periodontal Guidelines.”

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

Endodontic services for root canal treatment once per permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.

**Dentures and Bridges**

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every sixty (60) months.
  - Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months
before replacement.

- Temporary partial dentures as follows:

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

Crowns and Onlays

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

- Initial placement of crowns and onlays.

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

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of the Subscriber Certificate. 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 Subscriber Certificate: 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 Subscriber Certificate even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

2. WE DO NOT PROVIDE BENEFITS FOR:

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

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Subscriber Certificate.
- 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 Subscriber Certificate.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
• A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
• Appointments with your dentist that you fail to keep.
• A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
• Prescription drugs.
• A service to treat disorders of the joints of the jaw (temporomandibular joints), except for covered medically necessary orthodontics for individuals under age 19.
• Services that are meant primarily to change or to improve your appearance.
• Repair or reline of an occlusal guard.
• Transplants.
• Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
• Lab exams.
• Photographs.
• Duplicate dentures and bridges.
• Temporary, complete dentures and temporary fixed bridges or crowns, except temporary crowns for fractured teeth.
• 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.
• Tooth bleach.
• Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
• Transitional implants.
• Sinus lifts.
• Implants.
• Inlays.

The following list of limitations and exclusions apply to covered individuals age 19 and over.
• Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
• A service or procedure that is not described as a benefit in this Subscriber Certificate.
• Services that are rendered solely 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 Subscriber Certificate.
• An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare.
• A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
• A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
• Appointments with your dentist that you fail to keep.
• A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
• Prescription drugs.
• A service to treat disorders of the joints of the jaw (temporomandibular joints).
• Services that are meant primarily to change or to improve appearance.
• Implants.
• Transplants.
• Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
• Lab exams.
• Photographs.
• Duplicate dentures and bridges.
• Services related to congenital anomalies unless otherwise covered. However, this exclusion does not apply to any covered orthodontic services.
• Consultations.
• Tooth bleach.
• Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
• Transitional implants.
• Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomys, root amps, ridge augmentations and dental implant placements.
• Sinus lifts.
• Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
• Veneers.
• Occlusal guards.
Part IV Other Contract Provisions

1. BENEFIT PAYMENTS 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 from the Plan. No benefits are provided under this Subscriber Certificate for services rendered by a non-participating dentist, except that the Plan agrees to directly reimburse you up to a maximum of $50 for an Out of Area Emergency as defined in this Subscriber Certificate, less any applicable member fees.

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 applies at the time services are completed and a claim is submitted for payment. The pre-treatment estimate is NOT a guarantee of payment or a preauthorization.
4. WHEN YOUR PARTICIPATING DENTIST IS TERMINATED

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

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

If the **Participating Dentist** terminates the **Participating Dentist Contract**, the **Participating Dentist** shall continue to provide, for at least ninety (90) days after the date of notice of termination to the **Plan**, dental care services to a **covered individual** of the **Plan** for whom the **Participating Dentist** was responsible for the delivery of dental care services prior to the notice of termination.

5. REFERRALS TO SPECIALISTS

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

If a **Participating Dentist** refers the **covered individual** to a specialist who is not a **Participating Dentist** for dental services that are covered under the Subscriber Certificate, the **Plan** will be responsible for payment of the specialist’s charges that exceed the co-payment specified in the Subscriber Certificate.

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.

If during the term of this contract none of the Plan **Participating Dentists** can render necessary care and treatment to the enrollee due to circumstances not reasonably within the control of the Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the Plan **Participating Dentists**, then the enrollee may seek treatment from an independent licensed dentist of the enrollee’s own choosing. The Plan will pay the enrollee for the expenses incurred for the dental services with the following limitations: The Plan will pay the enrollee for services which are listed in the patient charge schedule as No Charge, to the extent that such fees are reasonable and customary for dentists in the same geographic area; the Plan will also pay the enrollee for those services listed in the contract for which there is a copayment, to the extent that the reasonable and customary fees for such services exceed the copayment for such services as set forth in the contract. The enrollee may be required to give written proof of loss. The Plan agrees to be subject to the jurisdiction of the Virginia Insurance Commissioner in any determination of the impossibility of providing services by Plan **Participating Dentists**.
6. EMERGENCY CARE

Nothing in this Subscriber Certificate of coverage will prohibit a covered individual from seeking emergency care whenever the individual is confronted with an emergency medical condition, which in the judgment of a prudent layperson would require pre-hospital emergency services. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent. Emergency dental care is defined in Part I of this Subscriber Certificate. Please refer to your Schedule of Benefits for specifics on emergency care benefits.

7. WHEN YOUR COVERAGE BEGINS

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

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

You agree that when you claim benefits under this Subscriber Certificate, 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 Subscriber Certificate and have agreed not to charge for this service.

A complete record of the Subscriber Certificateholder’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 Subscriber Certificate may be amended.

9. 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 sixty (60) 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 Subscriber Certificate has been in effect for twelve (12) months.

10. WE MAY CHANGE YOUR SUBSCRIBER CERTIFICATE

We will send a notice each time we change all or part of your Subscriber Certificate, describing the change(s) being made. Changes to the Subscriber Certificate 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 Subscriber Certificate.

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

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

A. 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).

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.

12. TERMINATION OF A SUBSCRIBER CERTIFICATE

A. CANCELLATION BY INSURED

You may cancel your Subscriber Certificate 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 Subscriber Certificate 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 Subscriber Certificate, you must wait at least one year after your cancellation before you can enroll again as a subscriber.

B. CANCELLATION BY THE PLAN
We may, upon thirty (30) days notice to you, cancel your Subscriber Certificate under any of the following circumstances:

1. Subject to the Time Limitation on Certain Defenses provision set forth in Item 14, 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 subscription charge you have paid us. We will subtract from the refund any payments made for claims under this Subscriber Certificate. If we have paid more for claims under this Subscriber Certificate than you have paid us in subscription charges, we have the right to collect the excess from you.

2. If you have not paid your subscription charges, subject to the Grace Period provision under Section 17 under this Part IV.

3. If you commit any acts of physical or verbal abuse, which pose a threat to a dentist, his or her employees, or employees of the Plan, which are unrelated to your mental or physical condition.

4. If you have been guilty of fraudulent or unethical dealings with us.

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 Subscriber Certificate will be canceled if you are no longer eligible because you no longer reside in Virginia. The termination date of this coverage shall be the last day of the month, at 12:01 A.M., 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 Subscriber Certificate if the covered individual visits the Participating Dentist’s office when the Participating Dentist is aware that the covered individual’s Subscriber Certificate has terminated. The Participating Dentist shall also inform the covered individual of the charge for any scheduled dental services before performing the dental services.

For information regarding benefits after cancellation, see Part IV, Section 15 of this Subscriber Certificate.

D. TIME AT WHICH TERMINATION TAKES EFFECT

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

13. 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 Subscriber Certificate 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 Subscriber Certificate 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
14. TIME LIMIT ON CERTAIN DEFENSES

Misstatements in the application: After two years from the date of this Subscriber Certificate, only fraudulent misstatements in the application may be used to void the Subscriber Certificate or deny any claim for loss incurred (as defined in the policy) that starts after the two-year period.

15. BENEFITS AFTER CANCELLATION

If you cancel your Subscriber Certificate or if we cancel your Subscriber Certificate, no benefits will be provided for services that you receive after the cancellation date. An extension of benefits shall be provided until the completion of dental services in progress while coverage was in effect. An extension of benefits will be provided for any dental procedure begun while the covered individual is covered by the Plan if the treatment requires two (2) or more visits on separate days to the dentist’s office; this extension of benefits shall continue until completion of the procedure. Orthodontic treatment begun while coverage is in effect shall be provided for at least sixty (60) days after the date coverage terminates if the orthodontist has agreed to or is receiving monthly payments, or if the orthodontist has agreed to or is receiving quarterly payments, until the end of the quarter in progress or for sixty (60) days, whichever is longer. If termination of coverage is due solely to the failure to pay the subscription fee or premium, an extension of benefits is not required.

If the Plan or the Participating Dentist terminates the Participating Dentist Contract, the Participating Dentist will provide orthodontic treatment begun when coverage was in effect, at the rates set forth in the Participating Dentist Contract and subject to the time limits set out above.

16. GRACE PERIOD

The certificate holder shall be given a 31-day grace period for the payment of any premium falling due after the first premium during which coverage remains in effect. If payment is not received within the 31 days, coverage may be cancelled after the thirty-first day and the certificate holder may be held liable for the payment of the premium for the period of time coverage remained in effect during the grace period. If a subscriber is receiving advance payments of the premium tax credit under the ACA, and the subscriber has previously paid at least one full month’s premium during the Benefit Year, the grace period is extended to three (3) consecutive months.

17. 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 Subscriber Certificate. 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 Virginia, Inc., c/o DentaQuest Management, Inc., P.O. Box 9708
18. CONTRACT CHANGES

Any additions or changes to the Subscriber Certificate 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. A minor for whom guardianship is granted by court or testamentary appointment shall be covered from the date of appointment. A child, who the court orders to be covered under a subscriber’s dental coverage, shall be covered from the date of the order. The Plan must be notified of new covered dependents within thirty-one (31) days. For newborn children, 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. Failure to notify the Plan of new dependents, including newborn children, within thirty-one (31) days shall result in the Plan never recognizing coverage for the new dependent(s) during the thirty-one (31) days; provided that if you already have family coverage and another family member is added, the Plan requests timely notification of the additional individual to facilitate claims payments but the thirty-one (31) day deadline shall not apply.

Changes to the Subscriber Certificate may result in a change in your subscription charge. If additional payments of subscription charges are required to provide coverage for the newly dependent spouse, children or grandchildren, you must notify the Plan within thirty-one (31) days after the date of marriage, birth, adoption or other court order or testamentary appointment. You may be required to submit proof of the court order or relationship to the Plan.

19. ENROLLING DEPENDENTS

Under certain situations, dependents may be added to your coverage at anytime. Qualifying events could be a result of court order and your spouse’s death. Under those circumstances, you must notify the Plan within seventy-two (72) 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 Subscriber Certificate at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse’s Subscriber Certificate 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.

20. ENROLLMENT THROUGH THE EXCHANGE AND PREMIUM PAYMENTS

Notwithstanding the requirements of Sections 18 and 19 of this Subscriber Certificate, 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.

21. 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 contract. If before a subscriber’s effective date he or she started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure.

In order for you to receive, any of the benefits for which you may have a right, you must inform your dentist that you are a covered individual and supply him or her with your subscriber identification number and any necessary information needed to file your claim. If you fail to inform your dentist within fifteen (15) months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

22. 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.

23. CONFORMITY WITH STATE STATUTES:

Any provision of this Subscriber Certificate that on its effective date is in conflict with the laws of the state in which the Subscriber resides on that date is hereby amended to conform to the minimum requirements of the laws.
24. CHOICE OF LAW
This Subscriber Certificate shall be construed according to the laws of the Commonwealth of Virginia. This Subscriber Certificate will be automatically revised in order to conform to statutory requirements of the laws of the Commonwealth of Virginia.

25. LEGAL ACTIONS
No legal action may be brought to recover under this Subscriber Certificate within sixty (60) days after written proof of loss has been given as required by this Subscriber Certificate. No legal action may be brought after three years from the time written proof of loss is required to be given.

26. ENTIRE CONTRACT; CHANGES
This Subscriber Certificate, 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 Subscriber Certificate shall be valid until approved by an officer of the Plan and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Subscriber Certificate or to waive any of its provisions.

27. COMPLAINT PROCEDURES
All dental procedures listed herein and under the attached Schedule of Benefits will be provided if, in the opinion of the Participating Dentist, they are necessary for the patient’s dental health. If a subscriber or dependent refuses to accept procedures or treatment recommended by his/her Participating Dentist, the Participating Dentist may regard such refusal as incompatible with the maintenance of the dentist-patient relationship and as obstructing the provision of proper dental care. If the Participating Dentist believes that no professionally acceptable alternative exists, then the subscriber or dependent shall be so advised and the subscriber or dependent may then select another Participating Dentist for treatment. If the subscriber or dependent refuses to use this option or refuses to accept the procedures or treatment recommended by the second dentist, then the subscriber or dependent shall use the Complaint Procedure set forth in subparagraphs B, C, and D hereof. The Plan may refuse to provide any further benefits for a particular condition if the subscriber or dependent refuses to accept a recommended course of treatment.

If a satisfactory dentist-patient relationship cannot be established or maintained with the Participating Dentist, then the subscriber or dependent may select another Participating Dentist from the list on Exhibit B, and shall notify the Plan and Group. If a satisfactory dentist-patient relationship with the subscriber and/or his/her dependent(s) cannot be established or maintained after the selection of three Participating Dentists, during the term of the contract, then coverage of the subscriber and his/her dependents will terminate after the Plan gives the subscriber written notice at least thirty (30) days before termination. A pro rata refund of the unearned portion of the subscription dues will be made.

Complaints may be directed to the Quality Assurance Department of DentaQuest Virginia, Inc., c/o DentaQuest Management, Inc., at P.O. Box 9708, Boston, MA 02114-9708, within ninety (90) days of the date of service or occurrence. The Quality Assurance Department will handle the Complaint and attempt to resolve it in an equitable and fair manner. If the Complaint is of an administrative nature, the Quality Assurance Department may resolve it alone or may assign its disposition to the Member Services or Provider Relations Departments. If the Complaint relates to the performance or nonperformance of dental services, the Quality Assurance Department will attempt to resolve it through discussions with the members’ Participating Dentist, the member, and if necessary, a consulting dentist. The Plan will initially respond to the Complaint.
within twenty (20) days from the date the Complaint is filed. The disposition of the Complaint shall be communicated orally or in writing to the Complainant within thirty (30) to sixty (60) days of receipt of the Complaint. This time period may be extended by mutual agreement. The date and disposition of the Complaint shall be recorded.

The disposition of the Complaint may be appealed by the Complainant to the Dental Advisory Board (the "Board") of DentaQuest Virginia, Inc., c/o DentaQuest Management, Inc., at P.O. Box 9708, Boston, MA 02114-9708. The appeal shall be initiated by the Complainant by written request to the Board within fourteen (14) days following receipt of the Resolution decision. This fourteen (14) day period may be extended by mutual agreement of the parties. The Board shall have thirty (30) to sixty (60) days to review the case and to reach a consensus. The Board may call members of the Quality Assurance department and consultants and the patient in its review. The Board will then have ten (10) working days to notify the Complainant in writing of its decision. If the Complainant is dissatisfied with the result, the Complainant may appeal to the President of DentaQuest Virginia, Inc., within fourteen (14) days following receipt of the Board's decision. The President shall have thirty (30) days to review the record and may call members of the Quality Assurance Department, the Board, consultants, and the patient in this process. The decision of the President shall be sent in writing to the Complainant and shall be considered final. All records concerning a Complaint shall be kept on file for five (5) years.

If a Complaint involves the competency of a Participating Dentist, then the Board on appeal of the Complaint may consult an independent third party to be chosen by DentaQuest Virginia, Inc. The Plan shall abide by the decision of such third party. The Plan shall pay the fees and expenses (if any) charged by the third party.

IMPORTANT INFORMATION ABOUT YOUR INSURANCE

In the event that you need to contact someone about this coverage or 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 Virginia, Inc. at the following address and telephone number:

DentaQuest Virginia, Inc.
c/o DentaQuest P.O. Box 9708
Boston, MA 02114-9708
Telephone: 1-800-334-6277

We recommend that you familiarize yourself with DentaQuest Virginia Inc.’s complaint procedure, and make use of it before taking any other action. If you are unable to contact or obtain satisfaction from DentaQuest Virginia, Inc. or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
Telephone: 804-371-9741
Toll Free: 1-800-552-7945
National Toll Free: 1-877-310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting the agent, DentaQuest Virginia, Inc. or the Bureau of Insurance, you should have your Subscriber Certificate number.
available. If there are any questions regarding an appeal or complaint concerning the health care services provided which have not been satisfactorily addressed by the Plan, you may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
Telephone: Toll-Free: 1-877-310-6560
Metropolitan Richmond: 804-371-9032
E-Mail: ombudsman@scc.state.va.us

Web Page: Information regarding the Ombudsman may be found by accessing the State Corporation Commission's web page at: www.scc.virginia.gov.

If you have any questions or concerns related to the quality of care, contact the Office of Licensure and Certification (OLC) at:

Office of Licensure and Certification (OLC)
Virginia Department of Health
9960 Maryland Drive, Suite 401
Richmond, VA 23233
Phone: 804-367-2104 -ask for MCHIP
Fax Line: 804-527-4503

The Plan is subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to the Title 38.2 of the Code of Virginia and the Virginia Department of Health pursuant to Title 32.1 of the Code of Virginia.

28. DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Enrollment will not be denied to an individual and the making of any payment for benefits to the individual or on the individual's behalf for health care will not be denied because the individual is eligible for medical assistance. The Department of Medical Assistance Services shall be the payor of last resort to any insurer, including a group health plan as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a health services plan, a service benefit plan, a health maintenance organization, a managed care organization, a pharmacy benefits manager, or other party that is, by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service for persons eligible for medical assistance in the Commonwealth of Virginia.

29. REINSTATEMENT

If the renewal premium is not paid before the grace period ends, the Subscriber Certificate 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 Subscriber Certificate. 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 Subscriber Certificate will be reinstated as of the approval date. Lacking such
approval, the Subscriber Certificate 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 Subscriber Certificate 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 Subscriber Certificate. 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.
Part V Filing a Claim

1. EXPLANATION OF BENEFITS (EOB) Each time we process a claim for you under this Subscriber Certificate, 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 contract. We will make benefit payments within sixty (60) days to them.

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

   If benefits are denied because a Participating Dentist fails to submit a claim on time, you will not be responsible for paying the dentist for the portion of the dentist’s charge that would have been a benefit under the dental plan. This applies only if the covered individual properly informed the Participating Dentist that he or she was a covered individual by presenting his or her dental plan identification card. The covered individual will be responsible for his or her patient liability, if any.

4. WHEN YOU FILE A CLAIM
   
   A. NOTICE OF CLAIM: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to the Plan at DentaQuest Virginia, Inc., c/o DentaQuest Management, Inc., P.O. Box 9708 Boston, MA 02114-9708, or to the Plan’s agent. Notice should include the name of the Subscriber, and claimant if other than the Subscriber, and the policy number.

   The Plan does not require a written request for a claims form. The covered individual may call the Customer Service Department at 1-(800) 334-6277 to request a form. A covered individual may request a claims form at any time after services are rendered keeping in mind that completed claims forms must be submitted to the Plan no more than ninety (90) days after services are rendered, except under circumstances set out in Section 3 above.

   B. CLAIM FORMS. When the Plan receives a request for a claim form, 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 contract 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. After we receive your completed forms, we will no later than thirty (30) days after we receive the claim (a) send you a check for your claim to the extent of your benefits under this Subscriber Certificate; or (b) send you a notice in writing of why we are not paying your claim; or (c) send you a notice in writing that the legitimacy of the claim is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary to pay your claim. If you have any questions, contact our Customer Service department. Our telephone number is listed at the end of this Subscriber Certificate.

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.
This index lists the major benefits and limitations of your Subscriber Certificate. Of course, it does not list everything that is covered in your Subscriber Certificate. To understand fully all benefits and limitations you must read carefully through your Subscriber Certificate.

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