DentaQuest
a Sun Life company

DENTAQUEST OF FLORIDA INSURANCE COMPANY, INC.
(DENTAQUEST INSURANCE COMPANY, INC.)

DentaQuest EPO for Individuals and Families Policy

DentaQuest EPO Family Low Plan

January 1, 2026

DentaQuest of Florida, Inc.
96 Worcester Street
Wellesley Hills, MA 02481

DentaQuest EPO for Individuals and Families
Certificate of Coverage

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WELCOME

Dear Member:

You have joined the growing number of individuals who are enhancing their dental health by joining DentaQuest of Florida, Inc. (DentaQuest). We are proud to have you as our member.

We invite you to take full advantage of your dental benefits. DentaQuest is committed to giving you the widest range of high quality providers possible, so that you can obtain the best dental care.

Again, welcome to DentaQuest. This Certificate of Coverage explains how to use your dental benefits. Should you have questions at any time, our member services representatives, at our toll free number 877-453-8457 will be pleased to assist you.

Michele Blackwell

President

DENTAQUEST is in compliance with the Federal Patient Protection and Affordable Coverage Act of 2010 (PPACA). If any provision of PPACA conflicts with any of the provisions of this Certificate of Coverage, the Certificate will be interpreted to be compliant with PPACA.

Visit our website:

www.dentaquest.com

DentaQuest of Florida, Inc.
96 Worcester Street
Wellesley Hills, MA 02481

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Attachment: Benefit Schedule

DentaQuest of Florida, Inc. provides benefits as a Prepaid Limited Health Service Organization as described in Chapter 636 of the Florida Statutes.

HOW TO USE YOUR DENTAL BENEFITS

CUSTOMER SERVICES DEPARTMENT

DentaQuest's Member Services Representatives are available to assist you Our representatives are trained and educated on dental terminology and your plan benefits and can assist you with eligibility verification, finding a dentist, identification card replacements, explaining your benefits, understanding your treatment plan and providing information about dental specialists. English, Spanish, and Creole translation services are available.

DentaQuest of Florida, Inc.
96 Worcester Street.
Wellesley Hills, MA 02481
877-453-8457
Monday-Friday: 8 a.m.-7 p.m. EST

YOUR BENEFITS

Your plan benefit schedule lists all of the procedures that are covered, as well as the cost (if any) for each procedure and any limitations or exclusions. You are responsible for paying the cost for any procedures performed directly to the dental office at the time you receive the services. Payment for any services not listed on the applicable benefit schedule will be the sole responsibility of the member.

OBTAINING DENTAL SERVICES

DentaQuest contracts with dentists to provide dental services to our Members. You may schedule appointments by contacting a participating general dental office directly, at any time after your effective date of coverage. Please identify yourself as an DentaQuest Member. Make sure that you verify that the dental office is participating with DentaQuest before making each dental appointment and before receiving services. Pre-approval is required before obtaining covered services from a dental specialist.

INDEPENDENT DENTAL FACILITIES

DentaQuest contracts with independently owned dental offices. All participating dentists agree to perform their obligations in accordance with prevailing professional standards of the dental profession, to maintain in full force and effect professional liability (malpractice) insurance and to maintain general and premises liability insurance in reasonable amounts of coverage to cover damage to person or property of Members. DentaQuest is not liable for any damage or injury to person or property resulting directly or indirectly from the negligent act or omission of or malpractice of a participating dentist or any other dentist or auxiliary providing service to a Member, whether of an emergency nature or any otherwise, or for any other damage or injury to person or property resulting from, arising out of or in any way connected with any defective or dangerous conditions in, on, around or about a participating dental office or such other office or dental facility which may provide a service to a Member. DentaQuest will not be liable or responsible for any financial agreements made between a participating dentist and a Member.

MEMBER GRIEVANCE PROCEDURE

Members are encouraged to attempt to resolve any issues or grievances with the participating dentist without initiating a grievance with DentaQuest. If the grievance cannot be resolved satisfactorily, you may submit a grievance to DentaQuest, in writing, within 12 months of the incident. The written grievance must be specifically identified as a grievance, and must include a summary of the incident and a statement of the action requested of DentaQuest. The Member's name, address, identification number, signature, the current date and a copy of the paid receipt, if available, if the grievance involves a payment issue, must also be included. Formal grievances should be forwarded to:

DentaQuest of Florida, Inc.
P.O. Box 2906
Milwaukee, WI 53201-2906
1-877-453-8457
Monday-Friday: 8 a.m.-7 p.m. EST

The grievance will be reviewed by DentaQuest, and the decision will be communicated to the member, in writing. All grievances shall be processed within 60 days of receipt. If members are not satisfied with the grievance resolution, a second level appeal may be requested. The second level appeal includes presentation to and review by the Grievance Committee. The determination of the Grievance Committee is final. Members also have the right to submit grievances to the Department of Financial Services, Division of Consumer Services, 200 E. Gaines Street, Larson Building, Tallahassee, FL 32399, 1-877-693-5236.

THIRD PARTY INJURY

If the services rendered are required due to injury caused by the negligence of a third person, and if the Member receives a recovery against the negligent party, or if the Member receives Workers' Compensation or other insurance benefits, then any DentaQuest dentist shall be entitled to charge and collect from the Member, his/her usual, customary and reasonable fees for any dental services rendered up to the time and to the extent of recovery for such dental services.

DENTAL RECORDS

Participating dentists are required to keep records and charts of all dental services rendered to Members in accordance with the Florida Dental Practice Act and Regulations. These records are the property of the participating dentist. Upon enrollment the member authorizes DentaQuest to request and obtain, for use exclusively by DentaQuest, Member records, radiographs or any other information from any dentist that has rendered treatment to the Member. Upon the request of the Member, the participating dentist will furnish copies of x-rays and service records. The participating dentist has the right to charge the Member an amount not to exceed the amount charged by the Clerk of Courts for the specific county in which the dental office is located for photocopies of dental records and copies of x-rays requested by the Member. Neither any participating dentist nor DentaQuest will be required to transfer any original records or x-rays, unless required by law.

SPECIALIST SERVICES

DentaQuest contracts with dental specialists in all fields. Oral surgeons for extractions, periodontists for treatment of the gums, endodontists who specialize in root canals, pedodontists for children and orthodontists for braces.

Members are urged to visit their participating general dentist to determine if specialty care is required. You may call DentaQuest for a list of participating

specialists and assistance in accessing specialty care.

EMERGENCY SERVICES
Members are covered for emergency dental services at participating dental offices. If you have a dental emergency, please call a participating dental office. Emergency office visits may be subject to additional charges as stipulated in the applicable benefit schedule. Members are also covered for emergency dental services while temporarily more than 50 miles from a participating dentist. Palliative treatment should be obtained from a licensed dentist and payment made for services rendered. DentaQuest will reimburse Members the usual and customary fees for covered dental services, subject to any applicable fees, not exceeding $100.00 per claim. To receive reimbursement, the Member must submit the following information to DentaQuest within ninety (90) days of the date of service:

1. Paid receipt;
2. Member's name, ID number, Address and Phone number;
3. Primary subscriber's name and ID number; and
4. Any other supporting documentation necessary to process the reimbursement.

ELIGIBILITY DETERMINATION

SUBSCRIBER ELEIGIBILITY IS LIMITED TO RESIDENTS OF FLORIDA.

The Health Insurance Marketplace must accept an individual's application and make an eligibility determination at any point in time during the year in a prompt and timely manner. The Marketplace will provide timely written notification to an applicant of the eligibility determination.

SUBSCRIBER ELIGIBLITY

To be eligible to be enrolled as the Primary Subscriber in this plan, an individual must apply to the Health Insurance Marketplace. The Marketplace will notify DentaQuest if the applicant is a Qualified Individual. You may also apply to enroll any eligible dependent(s) as defined below and the Marketplace will determine each dependent's eligibility as a Qualified Individual.

ELIGIBLE DEPENDENTS
The Primary Subscriber may elect coverage for the following eligible dependents:

- The legal spouse of the Primary Subscriber.
- The domestic partner of the Primary Subscriber with proper legal documentation.
- The dependent child of the Primary Subscriber or spouse or domestic partner who is under the age of twenty-six.
- Any unmarried child who is currently covered will be eligible for benefits beyond the age of 26 if he or she:
  a) is incapable of self-sustaining employment by reason of mental or physical handicap or disability
  b) is predominately dependent upon the Primary Subscriber for support and maintenance.

Proof of domestic partnership, or physical or mental handicap may be requested by DentaQuest for continued coverage.

ENROLLMENT PROCEDURES

All initial and subsequent applications for coverage under a Qualified Health Plan must be sent to the Health Insurance marketplace. The Marketplace will notify DentaQuest whether each individual applicant is a Qualified Individual.

Individuals who are at least 18 years of age and residents of the State of Florida are eligible for enrollment with DentaQuest. The Primary Subscriber and any eligible dependents will be covered as of midnight on the coverage effective date of the application between DentaQuest and the Individual. DentaQuest's eligibility requirements strictly comply with all applicable federal and state laws, rules and regulations.

CHILD-ONLY COVERAGE

A dependent child who is under age 19 may apply to the Health Insurance Marketplace to obtain a Child-Only Qualified Health Plan. The Marketplace will determine eligibility and will notify DentaQuest if the child is a Qualified Individual. If eligible, the benefits the child will receive through this plan are set forth in the Pediatric Benefit Schedule.

A dependent child who is under age 19 may apply to DentaQuest to obtain a Child-Only Qualified Health Plan. If eligible, the benefits the child will receive through this plan are set forth in the Pediatric Benefit Schedule.

ENROLLING DEPENDENTS
Eligible dependents must be included on the Primary Subscriber's initial application with DentaQuest sent to the Marketplace in order to be enrolled in the Plan. Other eligible dependents may be added to the Primary Subscriber's coverage only during the Annual Open Enrollment Period or if eligible, Special Enrollment Period.

Newly Eligible Dependents as defined above and acquired after initial enrollment may be added to the Primary Subscriber's coverage and enrollment must take place within thirty (30) days of the life change event (marriage, birth, etc.). If the newly acquired dependent is not enrolled during this time period, the dependent will not be eligible for coverage. Thirty (30) days prior to the Primary Subscriber's annual renewal date, the Primary Subscriber can enroll eligible dependents not previously covered. If an enrollment form and premium is received by us prior to renewal, coverage for the new enrollee will be effective at midnight on the Primary Subscriber's renewal date.

ANNUAL OPEN ENROLLMENT PERIOD

If an individual did not enroll in the Initial Enrollment Period but wants to enroll during the next Annual Open Enrollment Period, the individual must apply to the Marketplace who will determine whether the individual is a Qualified Individual. The Annual Open Enrollment Period will occur annually on dates established by the Marketplace. The Annual Open Enrollment for 2016 will begin November 1, 2015 and end January 31, 2016. Qualified Individuals currently enrolled in a Qualified Health Plan may also change plans at this time and enrollees will be notified in writing about the Annual Open Enrollment Period in September of each Benefit Year.

AUTOMATIC ENROLLMENTS

The Marketplace may automatically enroll Qualified Individuals for good cause which will be determined by the Marketplace.

SPECIAL ENROLLMENT PERIOD
A Qualified Individual or Enrollee is allowed to enroll with DentaQuest or change from one Qualified Health Plan to another outside the Annual Open Enrollment Period if the individual qualifies as a Special Enrollee. Application for enrollment with DentaQuest must be made to the Marketplace within sixty (60) days from any of the following events:

a. Birth, adoption, or placement for adoption;
b. Marriage; or
c. Enrollee loses minimum essential coverage

If timely enrolled:
a. Coverage will be effective on the date of birth, adoption or placement for adoption;
b. Coverage will be effective no later than the first day of the following month or subsequent following month dependent on the time of the month the application is received by the Marketplace for marriage and loss of minimum essential coverage events.

Loss of minimum essential coverage is any event that triggers a loss of eligibility for other minimum essential coverage. Triggering events include:
a. End of dependent status;
b. Legal separation or divorce ending eligibility of a spouse or step-child as a dependent;
c. Death of the Primary Subscriber ending eligibility for covered dependents;
d. Relocation outside the DentaQuest Service Area;
e. Termination of employment or reduction in hours needed to maintain group coverage;
f. Termination of employer contributions who has coverage that is not COBRA or Florida Continuation of Coverage;
g. Exhaustion of COBRA continuation coverage;
h. Reaching a lifetime limit on all benefits in a grandfather plan;
i. Termination of Medicaid or CHIP
j. Decertification of Qualified Health Plan outside of the Annual Open Enrollment Period;
k. Addition of a dependent through marriage, birth, adoption or placement for adoption;
l. An individual who was not previously a citizen, national or lawfully present, gains such status;
m. Unintentional error in enrollment, non-enrollment or disenrollment through the Marketplace;
n. An enrollee's Qualified Health Plan violates a material provision of its contract;
o. Becoming newly eligible for premium tax credits or cost-sharing reductions due to an individual's employer-sponsored coverage becoming unaffordable or no longer provides minimum value;
p. New Qualified Health Plans offered in the Marketplace become available to an individual as a result of a permanent move;
q. Exceptional circumstances as determined by the4 Marketplace which prevents or impedes an individual's ability to enroll in a timely manner through no fault of his or her own (e.g. national disasters).

COVEAGE EFFECTIVE DATE
A Qualified Individual's enrollment in this plan during an Initial, Annual or Special Enrollment Period will be effective as of the date provided to Us by the Marketplace.

TERM OF AGREEMENT/ENROLLMENT
This contract shall be for a minimum period of 12 months, unless the Primary Subscriber requests, in writing, a shorter contract period. At the end of the initial contract term, the policy will automatically renew each Benefit Year unless terminated or non-renewed as provided for in this Certificate. Rates and plan design changes will occur on a Benefit Year basis.

RENEWAL OF COVERAGE
DentaQuest guarantees the Primary Subscriber the right to renew this plan each year. However, DentaQuest may refuse to renew this plan if one of the following circumstances has occurred:

a. Failure to timely pay premium in accordance with the terms of this plan;
b. DentaQuest discontinues a particular product or all coverage in the individual market in Florida in accordance with Florida law;
c. The Primary Subscriber has performed an act or practice constituting fraud or misrepresentation of a material fact;
d. The Primary Subscriber no longer lives in the DentaQuest Service Area;
e. DentaQuest elects to discontinue offering dental coverage through the Health Insurance Marketplace.

DentaQuest will send the Primary Subscriber a renewal packet 60 days prior to the plan renewal date which must be signed and returned within 30 days of the renewal date in order to renew this plan.

GRACE PERIOD
If the Primary Subscriber is receiving premium subsidies, the following provision applies:

This plan has a 90 day grace period. A grace period means that if any requirement premium is not paid on or before the date it is due, it may be paid during the grace period immediately following that premium due date. This plan will stay in force during the grace period. Premiums must be paid and received directly by DentaQuest no later than the end of the grace period. The grace period does not apply to the premium due on the premium due date if the Primary Subscriber gave DentaQuest timely written notice that this plan is to be terminated prior to such premium due date. If the premiums are not paid and received directly by DentaQuest by the end of the grace period, coverage will terminate at midnight on the last day of the first month of the 3 month grace period. We will pay all appropriate claims during the first month of the grace period, but may pend claims in the second and third months of the grace period. Claims received during the second and third months of the grace period will be denied if the premium is not received by the end of the grace period.

If the Primary Subscriber is not receiving premium subsidies, the following provision applies:

Premium payments are due in advance, on an annual or a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a ten (10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Certificate will stay in force.

BILLING

In the event a monthly premium payment is not received by DentaQuest prior to the expiration of the grace period, DentaQuest may terminate all coverage effective as of the first day of the month following the month for which the premium was due. The Member's obligation to pay all premium due while coverage remains in effect, shall survive termination of this Certificate. DentaQuest may, at its discretion, reinstate coverage if, prior to reinstatement, the Member pays all premiums in arrears, all premiums due for the current period, and a reinstatement fee.

PREMIUM

The premium that began on the Primary Subscriber's coverage effective date will not change until January 1 of each Benefit Year. DentaQuest will give the Primary Subscriber, written notice of any change in premium at least 45 days prior to implementation.

TERMINATION OF THIS PLAN BY THE PRIMARY SUBSCRIBER

The Primary Subscriber may terminate this plan at any time with appropriate notice of at least 14 days to either DentaQuest or the Health Insurance Marketplace. Coverage will terminate on the date specified or 14 days after termination is requested, whichever is later.

Should the Primary Subscriber and/or any covered dependents terminate coverage because of eligibility for Medicaid, CHIP or a Basic Health Plan or termination is due to the Primary Subscriber moving from one Qualified Health Plan to another during an Annual or Special Enrollment Period, the termination effective date will be the day before the effective date of the new coverage.

TERMINATION OF THIS PLAN DUE TO NON-PAYMENT OF PREMIUM

If the Primary Subscriber is receiving premium subsidies, the following provision applies:

If the required monthly premium is not received by the end of the 90 day grace period, We will terminate coverage effective at midnight on the last day of the first month of the 3 month grace period.

If the Primary Subscriber is not receiving premium subsidies, the following provision applies:

If the required premium is not received by the end of the 10 day grace period, we will terminate this plan without prior notification, retroactive to the last date for which premium was received, subject to the grace period provision. Termination will be effective as of midnight of the date that the premium was due.

TERMINATION OF MEMBERSHIP BY DENTAQUEST

Coverage for Primary Subscriber and each Dependent will cease at midnight on the last day of the month prior to renewal if the Primary Subscriber fails to renew this plan. Coverage will also cease at midnight for a Subscriber or Member if coverage is terminated for any reason specified in this plan.

DentaQuest may also disenroll a Member at any time for any of the following reasons and will provide 45 days written notice:

a) A members' behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation would impair DentaQuest's or a Provider's ability to provide covered Dental Services to Member or to other Members. DentaQuest will make a reasonable effort to resolve any conflict through the use of the grievance procedures;
b) A Member commits fraud or makes a material misrepresentation in seeking Dental Services;
c) A Member willfully misuses any documents provided as evidence of benefits available under this Certificate;
d) A Member furnishes to DentaQuest incorrect or incomplete information for the purpose of fraudulently obtaining covered Dental Services;
e) A Member permanently relocates from the DentaQuest Service Area;
f) Dependent no longer meets eligibility requirements to continue enrollment as established by the Marketplace.

Coverage for Dependents shall automatically terminate in the event the Primary Subscriber is disenrolled. In the event the disenrolled Member is not the Primary Subscriber, DentaQuest shall have the option to disenroll any Member listed on the terminated Member's enrollment card if the member is found to have committed any of the acts for disenrollment set forth in this section.

TERMINATION OF COVERAGE BY THE HEALTH INSURANCE MARKETPLACE OR DENTAQUEST

The Marketplace may terminate coverage in a Qualified Health Plan and will also permit DentaQuest to terminate coverage for any of the following reasons:

a. Loss of eligibility to purchase a Qualified Health Plan through the Marketplace.
b. Nonpayment of premiums provided that the grace period has elapsed.
c. Coverage is rescinded.
d. DentaQuest terminates or is decertified by the Marketplace.
e. An enrollee switches to another Qualified Health Plan during an Annual Open Enrollment Period or a Special Enrollment Period.

RESCISSION

DentaQuest will rescind coverage due to an act or practice constituting fraud or an intentional misrepresentation of a material fact. We will provide the Primary Subscriber forty-five (45) days advance written notice before coverage is rescinded.

EXTENSION OF BENEFITS

Upon termination of the Certificate, the Member may be entitled to Extension of Benefits. Termination of the Certificate

by DentaQuest is without prejudice to any continuous loss which commenced while the Certificate was in force. Benefits will be extended until the specific covered treatment or procedure undertaken is completed or for ninety (90) days from the termination date, whichever is the lesser period of time.

DentaQuest Providers shall complete all treatments and procedures commenced on Members prior to the effective date of termination of the Certificate to the extent that such Members would have been entitled to receive such Dental Services had this Certificate continued in effect, subject to the following conditions: During the period required for completion of such procedures, each Member shall continue to pay co-payments, directly to the Participating Dentist, as required under the applicable Benefit Schedule and all exclusions and limitations in this Certificate will continue to apply during the extension;

The term "treatment or procedures commenced on such Member prior to the date of termination" shall be construed to mean only those treatments and/or operative dental procedures actually commenced but unfinished, such as prosthetic appliances which have been cast, and dentures commenced but unfinished, prior to the effective date of termination of the Certificate. It shall not include dental defects which may have been diagnosed, but on which treatment or operative work may not have been commenced, prior to the effective date of termination.

Any Dependent of a Primary Subscriber whose coverage with DentaQuest is terminated for any reason, may also elect to continue coverage with DentaQuest directly if he/she was enrolled in a DentaQuest plan at the time of termination and he/she meets DentaQuest's eligibility requirements.

A Member may elect to continue coverage under any of the individual plans offered by DentaQuest.

However, a person may not convert to individual coverage if the loss of coverage was due to the Member:

a) failing to pay Premium;
b) committing fraud or providing a material misrepresentation in applying for coverage;
c) willfully and knowingly misusing the Member ID card;
d) willfully and knowingly providing incorrect or incomplete information to fraudulently obtain coverage;
e) leaving the geographic service area for the purposes of relocation;
f) acting in a way that was so disruptive, unruly, abusive or uncooperative that continuing coverage would prevent DentaQuest from providing proper services to that person or any other patients and the grievance process was unable to resolve the problem.

PRE-EXISTING CONDITIONS
There are no exclusions for pre-existing conditions.

BENEFIT WAITING PERIODS
The benefit waiting period refers to the amount of time the Primary Subscriber or dependent must wait before receiving certain covered plan benefits. Please refer to the Benefit Schedule for any applicable waiting periods.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS
The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan as defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in 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.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) 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; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with 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 health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is

covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a 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 health care benefits to covered persons primarily in the form of services through a panel of providers which 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. 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 regulation 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 coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverage 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.

(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 health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Benefit 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 health care expenses or health care 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 health care expenses or health care 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 health care expenses or health care 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 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 Benefit 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 health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim 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 health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a 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 health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Organization responsibility for COB administration] may get the facts it 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. Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Organization responsibility for COB administration] any facts it needs 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, Organization responsibility for COB administration 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. Organization responsibility for COB administration 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 Organization responsibility for COB administration 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.

HELPFUL GUIDELINES

For Making the Most of Your Dental Plan

What to Do in Case of Dental Emergency
If you should have a dental emergency, don't panic. Call a DentaQuest participating dental office for an appointment. If the office is not available immediately, call the DentaQuest Member Services Department for assistance with

obtaining an emergency appointment. In case of an acute emergency, seek immediate hospital care.

How to Schedule an Appointment
Not everyone can get an appointment early in the morning or late in the afternoon. If you are flexible with your time, appointment availability will increase significantly. Make sure you are visiting a DentaQuest participating dentist

It is very important to keep your scheduled appointments. If you need to cancel, please contact the dental office within 24 hours before your scheduled visit. Your dental office may have a fee for broken or missed appointments, which will be your responsibility.

MEMBER RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS:

- ✓ To be treated with courtesy and respect with appreciation, dignity and protection of your privacy.
- ✓ To know what member services are available and to be assisted promptly and courteously.
- ✓ To know who the DentaQuest participating dentists are.
- ✓ To be given information by your participating dentist concerning diagnosis, planned course of treatment, alternatives, risks and expected outcomes.
- ✓ To refuse treatment and to ask the participating dentist about the consequences of refusing treatment.
- ✓ To be given access to dental services regardless of your race, national origin, religion or physical handicap.
- ✓ To receive information about the dental plan.
- ✓ To voice complaints or file a grievance about the dental plan or the dental services you receive.
- ✓ To participate in making decisions with the participating dentist about your dental care.
- ✓ To confidentiality of your dental records and all other information unless you allow it to be released, or unless the law requires it to be released.

YOUR RESPONSIBILITIES:

- ✓ To read the benefit schedules and familiarize yourself with all of the aspects of the dental plan.
- ✓ To cooperate and be respectful of the participating dentist and dental office staff.
- ✓ To give the participating dentist and the dental office staff accurate and complete information needed to care for you.
- ✓ To keep your scheduled appointments and be on time. To notify the participating dental office as soon as possible when you cannot make an appointment.
- ✓ To respect the rights of fellow patients.
- ✓ To follow the treatment plan and instructions for dental care that you have agreed to with your participating dentist and dental office staff.
- ✓ To carry your identification card and present it before you receive services.
- ✓ To pay all charges for missed appointments and services not covered by the dental plan.
- ✓ To pay all co-payments (if applicable) at the time services are rendered.
- ✓ To follow the participating dental office rules and regulations regarding patient care and conduct.
- ✓ To receive services only from participating general dentists and pre-approved participating specialists except for dental emergencies outside of the service area, or hospital care for acute emergencies.

PLAN DEFINITIONS

"Act" means the Patient Protection and Affordable Care Act (PPACA).

"Acute emergency" shall mean a situation where the provision of emergency medical services is necessary to evaluate or treat a medical condition manifesting itself by the sudden and/or at the time, unexpected onset of symptoms that require immediate medical attention and for which failure to provide medical attention would result in serious impairment to bodily function.

"Annual Maximum/Maximum Benefit" means the total amount DentaQuest will make per covered adult Member for covered dental services per Benefit Year.

"Applicant" means an individual who is seeking eligibility for him or herself through an application submitted or transmitted to the Marketplace for enrollment in this plan.

"Benefit Schedule" or "Benefit Schedules" shall mean those dental services to which a Member is entitled, subject to all provisions, definitions, and limitations outlined in the Certificate of Coverage.

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

"Certificate of Coverage or Certificate" means this written document which is the agreement between the individual and DentaQuest whereby coverage and benefits specified herein will be provided to Members. The Certificate, Plan Information Page, enrollment applications, addenda exhibits, riders, schedules of benefits and any amendments which may be incorporated in this Certificate from time to time constitutes the entire agreement between the Primary Subscriber and DentaQuest.

"Deductible" is the total amount a Member must pay toward covered treatment per Benefit Year before dental benefits are paid by DentaQuest. Please refer to the Benefit Schedule for applicable Deductibles.

"Dental Office", "Dental Facility", "Participating Dental Office", or "Participating Dental Facility" shall mean the location of a Participating General Dentist's or Participating Specialist's office where Member may obtain Dental Services.

"Dental Services" shall mean those dental services set forth in the applicable Benefit Schedule and determined by the Dentist to be required to establish and maintain the Member's good oral health.

"Effective Date of Coverage" or "Effective Date" shall mean, as to an individual Member, the first (1st) day of the month after such Member has enrolled, has satisfied any applicable waiting period or is a Dependent or a Primary Subscriber. Coverage is effective at 12:00 a.m., local standard time on the date so specified on the Plan Information Page.

"Emergency Dental Services" shall mean those services which are required immediately due to an injury or unforeseen condition, and which provide for the relief of pain or prevent worsening of any condition that would be caused by delay. Refer also to the definition of Acute Emergency.

"Enrollee" means a Qualified Individual enrolled in a Qualified Health Plan.

"Experimental" shall mean any evaluation, treatment or therapy which involves the application, administration or use of procedures, techniques, equipment, supplies, products or remedies that are considered experimental by DentaQuest based on reports, articles or written assessments published by the American Dental Association or in other authoritative medical and scientific literature published in the United States.

"Fees" shall mean the specific dollar amount or percentage discount, as specified in the applicable Benefit Schedule, payable by the Member directly to the Provider upon receipt of covered Dental Services. A Member is not responsible for paying contracted fees owed by DentaQuest to its Participating Providers.

"Health Insurance Marketplace (Marketplace)" means a governmental agency or non-profit entity that makes Qualified Health Plans available to Qualified Individuals. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges and a Federally-qualified Exchange.

"Identification Card" shall mean, a card issued by DentaQuest to Members enrolled in this Plan. The Identification Card is the property of DentaQuest and is not transferable to another person. Possession of such card in no way verifies eligibility to receive benefits under this Agreement.

"Member" shall mean the Primary Subscriber, including a Dependent, for whom all premiums have been paid to DentaQuest when due and who is enrolled and entitled to receive Dental Services pursuant to this Certificate.

"Out-of-Pocket Maximum" means the maximum amount a Member will pay in deductible and coinsurance for allowable expenses in any Benefit Year. Please refer to the Benefit Schedule for applicable Out-of-Pocket amounts.

"Palliative Treatment" shall mean only those procedures which alleviate pain or discomfort.

"Premium" shall mean the advance payments due to DentaQuest on behalf of Members to receive Dental Services as set forth in this Certificate.

"Primary Subscriber" shall mean the Qualified Individual who is eligible to enroll on behalf of himself/herself and his/her Dependents with DentaQuest for Dental Services through the Marketplace.

"Provider" or "Participating Dentist" shall mean a participating general dentist or specialist who has executed an agreement with DentaQuest to provide Dental Services to Members.

"Qualified Health Plan (QHP)" means a health benefit plan that has in effect a certification that it meets the standards described in the Act, or recognized by each Marketplace through which the plan is offered.

"Qualified Individual" means an individual who has been determined eligible to enroll in a Qualified Health Plan through the Marketplace.

"Service Area" means the geographic area in Florida in which DentaQuest has contracted with a network of dental providers as set forth in the Dental Provider Directory.

GLOSSARY OF DENTAL TERMS

Amalgam "Silver" Filling: A metal restoration that has a silver-like color used to fill cavities in teeth caused by decay.

Anesthesia (local): A drug used by a dentist to put your mouth to sleep so that you don't feel any pain during dental procedures.

Bridge: A prosthetic replacement of one or more missing teeth.

Cavity: A hole in one of your teeth caused by decay.

Crown: Also called a cap, a lab fabricated false tooth used to restore a tooth that has heavy decay, a fracture or a root canal.

Examination/Oral Evaluation: A thorough examination of the hard and soft tissues of the oral cavity and surrounding structures.

Extraction: Removal of a tooth.

Fluoride: A substance applied to teeth after a cleaning is performed. Fluoride helps prevent tooth decay by stopping the breakdown of enamel.

Gingivitis: The inflammation of your gums. The first sign of gum disease.

Impacted Tooth: A tooth that is unable to break through the gums.

Malocclusion: Improper alignment of biting or chewing surfaces of upper and lower teeth.

Medically Necessary Orthodonture means for enrollees under the age of 19, a severe handicapping malocclusion as defined by an IAF Score of 26 and/or one or more auto qualifier.

Plaque: A sticky, white film of bacteria that forms on teeth, causing tooth decay, inflammation of the gums, periodontal disease and bad breath.

Prophylaxis/Cleaning: Cleaning, scaling and polishing procedure performed to remove plaque, tartar and stains from teeth above the gum line.

Periodontal Scaling/Deep Cleaning: The removal of plaque and tartar from the crowns and root surfaces above and under the gum in Members with periodontal disease. A routine prophylaxis/cleaning cannot be performed on a Member with untreated periodontal disease.

Resin "White" Filling: A plastic-like filling that is tooth colored and is used to fill cavities in teeth caused by decay. These fillings can be used on both front

and back teeth enhancing a cosmetic effect.

Root Canal: Removal of the pulp inside a tooth and its roots due to infection or fracture.

Sealant: Protective plastic coating that covers grooves in healthy teeth to prevent decay. Sealants are usually applied to permanent back teeth.

Space Maintainer: An appliance inserted in the mouth to prevent drifting and crowding of teeth after removal of a baby tooth.

TYPES OF SPECIALISTS

Endodontist: Specializes in root canal therapy.

Oral Surgeon: Specializes in extractions and surgery.

Orthodontist: Specializes in adjustment of bite and braces.

Pedodontist: Specializes in the care of children.

Periodontist: Specializes in the care of gums.

Prosthodontist: Specializes in the replacement of missing teeth (dentures and bridges).

HIPAA POLICY/NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to make payments for services provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Member Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up dental payment records, dental records, study models, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain

circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or member under certain circumstances.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

COVERED DENTAL SERVICES
The benefits provided under this plan are specified in the Dental Benefit Schedule(s) attached to this Certificate

EXCLUSIONS & LIMITATIONS

- The cost to an enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the participating orthodontist's usual and customary fees for the treatment plan. The participating orthodontist will prorate the amount for the number of months remaining to complete treatment. The enrollee makes payment directly to the participating orthodontic as arranged.
- Orthodontic treatment in progress is limited to new DentaQuest enrollees who, at the time of their original effective date, are in active treatment started under their previous employer-sponsored dental plan as long as they continue to be eligible under the DentaQuest program. Active treatment means tooth movement has begun. Enrollees are responsible for all co-payments and fees subject to the provisions of their prior dental plan. The administrator is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

EXCLUSIONS (The following services are not covered or offered by DentaQuest):

- Oral Surgery requiring the setting of fractures or dislocations.
- Any treatment, which cannot be performed because of the general health and physical limits of the Member, as indicated by said Member's personal physician, a participating DentaQuest dentist/specialist or DentaQuest Dental Professionals
- Any dental procedure considered experimental by a participating DentaQuest dentist/specialist or the DentaQuest Dental Professionals.
- Dispensing of prescription drugs.
- Any treatment paid for by Workers' Compensation or employer's liability laws, by a federal or state government agency or other insurance coverage carried by the Member. Any treatment provided without cost by any municipality, county or other political subdivision.
- Dental services received from any dental facility other than a participating dentist, including the services of an out-of-network dentist who provides specialized services are excluded unless expressly authorized by DentaQuest, or as covered under Emergency Services as described in this Certificate of Coverage.
- Dental services received from any dental facility other than a participating dentist, a pre-authorized dental specialist, or a participating orthodontist are excluded, except for Emergency Services as described in this Certificate of Coverage.
- Services resulting from any act of war, declared or not, or resulting from military services.
- The participating dentist shall have the right to refuse treatment to a Member who fails to follow a prescribed course of treatment.
- Any dental expenses incurred in connection with any dental treatment started prior to the Member's effective date for eligibility of benefits with DentaQuest, including but not limited to teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken, and orthodontics, unless qualified for orthodontic treatment in progress provision.
- All related fees for admission, use, or stays in a hospital, outpatient surgery center or other similar care facility.
- Any procedure that in the professional opinion of the participating general dentist, specialist or one of DentaQuest's dental professionals,
  - has poor probability for success based on the condition of the tooth or teeth or surrounding structures.
  - is inconsistent with generally accepted standards for dentistry.
- Consultations for non-covered benefits.
- Accidental injury defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth.
- Services solely for cosmetic purposes.
- Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
- Lost, stolen or broken orthodontic appliances.
- Changes in orthodontic treatment necessitated by accident of any kind.
- Myofunctional or parafunctional appliances and/or therapies.
- Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
- Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.
- Procedures, appliances or restoration to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint.
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) personalization and characterization of complete and partial dentures.
- Cone Beam Imaging and Cone Beam MRI procedures.

- Internal and external bleaching.
- Nitrous oxide.
- Oral sedation.
- Topical medicament center.
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non-eligible implants.

LIMITATIONS:

- Please refer to the Benefit Schedule for any applicable limitations in addition to those specified in this Certificate of Coverage.

(BACK COVER)

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DentaQuest
a Sun Life company

DentaQuest of Florida, Inc.

96 Worcester Street
Wellesley Hills, MA 02481

BENEFIT SCHEDULE

DentaQuest EPO for Individuals and Families - Family Low Option

Coverage Type	Deductible	DentaQuest Pays
Class I - **Diagnostic & Preventive Services**	Per Member: None	100%
Class II - **Restorative and Other Basic Services**	Per Member: $50.00	40% under age 19, 50% age 19 and older
Class III – **Complex and Major Restorative Dental Services**	Per Member: $50.00	40% under age 19, 50% age 19 and older
Class IV – **Orthodontics (medically necessary)**	Per Member None	40% under age 19, No Coverage age 19 and older

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

DIAGNOSTIC AND PREVENTIVE SERVICES

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

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

Periodic exam; once every six (6) months.

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

Bitewing x-rays (x-rays of the crowns of the teeth); once every six (6) months when oral conditions indicate need. Single tooth

x-rays; as needed.

Study models and casts used in planning treatment; once every sixty (60) months.

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

Fluoride treatment Topical Fluoride - Varnish - 2 every 12 months, Topical application of fluoride (excluding prophylaxis) - 2 every 12 months.

Space maintainers required due to the premature loss of teeth; not for the replacement of primary or permanent anterior teeth.

Sealants on unrestored permanent molars. 1 sealant per tooth every 36 months.

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

RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth; (b) repair dentures or bridges; (c) rebase or reline dentures; (d) repair or recement bridges, crowns and onlays; and (e) remove diseased or damaged natural teeth. Examples of these services include:

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist's charge.

Periodontal maintenance, including cleaning and scaling and root planing procedures, following active periodontal therapy; 4 in 12 months. Periodontal scaling and root planing; once every twenty-four (24) months per quadrant.

Protective restorations.

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

Simple tooth extractions.

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

Consultations.

Repair of dentures or fixed bridges. Recementing of fixed bridges.

Rebase or reline dentures; once every thirty-six (36) months. 6 months after initial installation.

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

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

Vital pulpotomy and pulpal therapy is limited to deciduous teeth.

COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES

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

Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery). Periodontal benefits are determined according to our administrative "Periodontal Guidelines."

Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, and the removal of dental pulp.

Inlays are paid as an alternative benefit of amalgam.

Implants- once every 60 months.

Dentures and Bridges

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

Crowns and Onlays. Once per tooth per sixty (60) months, but only when the teeth cannot be restored with the fillings due to severe decay or fractures:

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

ORTHODONTIC SERVICES

Medically Necessary Orthodonture means for enrollees under the age of 19, a severe handicapping malocclusion as defined by an IAF Score of 26 and/or one or more auto qualifier.

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

DIAGNOSTIC AND PREVENTIVE SERVICES

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

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

Periodic exam; twice every calendar year.

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

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

Single tooth x-rays; as needed.

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

RESTORATIVE AND OTHER BASIC SERVICES

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

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

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

Simple tooth extractions.

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

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

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

Rebase or reline dentures; once every thirty-six (36) months. Tissue conditioning; two treatments every thirty-six (36) months.

Repair or recement crowns and onlays. Recementing is limited to once every twelve (12) months per tooth. Adding teeth to existing partial or full dentures; once per tooth every twelve (12) months.

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

COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES

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

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

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

months. Periodontal benefits are determined according to our administrative "Periodontal Guidelines." Periodontal maintenance, including cleaning and scaling and root planing procedures, following active periodontal therapy; once per three months when preceded by active periodontal therapy. 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.

DEDUCTIBLES

Restorative and other Basic Services, and Complex and Major Restorative Dental Services described above are subject to a deductible for each Member in each calendar year. In the case of a family contract, the total deductible payment for all Members shall not exceed 3 times the individual deductible for Restorative and other Basic Services, and Complex and Major Restorative Dental Services.

ANNUAL MAXIMUM BENEFIT (applies only to Members age 19 and older)

Total benefits are limited to a maximum of $1000 for each Member for each calendar year.

OUT OF POCKET MAXIMUM (applies only to Members under age 19)

The maximum out of pocket expense (a combination of deductibles and co-insurance) is $400 per calendar year. The maximum out of pocket expense applies per Member under age 19. A family with 2 or more Members under age 19 will have an aggregate maximum out of pocket expense of $800 per calendar year for Members under age 19. Adult coverage has no limit on the out of pocket expense.

WAITING PERIOD

There are no waiting periods for Members under age 19.

For Members age 19 and older, Restorative and other Basic Services are subject to a three (3) month waiting period. Complex and Major Restorative Dental Services are subject to a twelve (12) month waiting period

DEPENDENT COVERAGE

Dependent children are covered up to age 26.

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

For services performed by a Participating Dentist, the in-network benefit allowance is based on the fee schedule shown in the Benefit Schedule that the Participating Dentist has agreed to accept as payment in full. The Plan pays the Participating Dentist directly for covered services.

OUT-OF-NETWORK SERVICES:

No benefits are provided for dental services provided by Non-Participating Dentists, except in the case of an emergency dental condition.

CLAIMS SUBMISSION:

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

If you have questions about this coverage, please contact our Customer Service Department at

1- 877-453-8457.

DentaQuest of Florida, Inc., provides benefits as a Prepaid Limited Health Service Organization as described in Chapter 636 of the Florida Statutes.

DentaQuest*

Foreign Language Assistance

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

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

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

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

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

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

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

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

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

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

م لحوظة :إذا ك نت ت تحدث اذك ر ال ل غة، ف إن خدمات ال م ساعدة ال ل غوي ة ت تواف :(Arabic) ال عرب ة
7566-466-800-1: ر ل ك ب ال مجان .ات صل ب رق م 1-888-278-7310)رق م هات ف ال صم وال ب كم
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Kreyòl Ayisyen (French Creole): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratispou ou. Rele 1-888-278-7310 (TTY: 1-800-466-7566 or 711).

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

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

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

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

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

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

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