DentaQuest 3 3 2) D P L O \ + L J K Plan

January 1, 202

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

Individuals and Families

Dental Policy

DentaQuest USA Insurance Company, Inc. (the *Plan*) certifies that you have the right to benefits for services according to the terms of this Policy. This Policy is part of your Agreement.

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

NOTICE OF INSURED'S RIGHT TO EXAMINE POLICY FOR TEN DAYS. If for any reason you are not satisfied with your Policy, you may return this Policy within ten days of the date of delivery and the premium you paid will be promptly refunded, and this Policy shall be deemed void from the beginning and the parties will be returned to their original position as if no Policy had been issued. This Policy may be returned to the *Plan* at 96 Worcester Street Wellesley Hills, MA 02481. If you have an existing policy, you are allowed 30 days to decide without cost whether you desire to keep the policy or will replace it.

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

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

THIS POLICY IS A NON-PARTICIPATING POLICY.

This is a Limited Policy - Read it Carefully

ATTEST: DentaQuest USA Insurance Company, Inc.

President Secretary

Brett Bostrack Colleen Kallas

Contents

Introduction

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

The dental services described in your *Schedule of Benefits* are covered as of your effective date, unless your benefits are subject to a waiting period. Additionally, there are some limitations and restrictions on your coverage, which are found in your *Schedule of Benefits*. Please refer to the Schedule of Benefits, attached to this Policy, which outlines the specific services covered under this Policy and the extent of coverage for those services.

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

Subscriber's Rights and Responsibilities

As a *subscriber*, you have the right to:

- File a complaint about the dental services provided to you.
- Be provided with appropriate information about the *Plan* and its benefits, participating dentists, and policies.

You have the responsibility to:

- Ask questions in order to understand your dental condition and treatment, and follow recommended treatment instructions given by your dentist.
- Provide information to your dentist that is necessary to render care to you.
- Be familiar with the *Plan* benefits, policies and procedures, by reading our written materials, or calling our Customer Service department at the telephone number listed at the end of this Policy.

Definitions

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

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

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

Covered dependents: See *Family Coverage* definition.

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

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

Date of service: the actual date that the service was completed. With multi-stage procedures, the date of service is the final completion date (the insertion date of a crown, for example).

Deductible: the portion of the covered dental expenses that the *covered individual* must pay before the *Plan's* payment begins.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule of Benefits: the part of this Policy which outlines the specific coverage in effect as well as the amount, if any, that you may be responsible for paying towards your dental care.

Subscriber: the Policy holder who is eligible to receive dental benefits. A parent or guardian enrolling a minor dependent, including under a child only plan, assumes all of the subscriber responsibilities on behalf of the minor dependent.

The Plan: refers to DentaQuest USA Insurance Company, Inc.

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

You: the *subscriber* of the dental plan.

Part II Benefits

You have the right to benefits on a non-discriminatory basis for the services listed in the *Schedule of Benefits*, except as limited or excluded elsewhere in this Policy, including the *Schedule of Benefits*. The extent of your benefits is explained in the *Schedule of Benefits* whichis incorporated as a part of this Policy. Please refer to your *Schedule of Benefits* for benefits covered under this Policy.

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

Part III
Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of this Policy. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist.

B. Who determines what is necessary and appropriate under the terms of the Policy: That decision is made based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the Policy even if your dentist has furnished, prescribed, ordered, recommended or approved the service. Such a determination is made by a licensed dental practitioner. Please see Part IV, Paragraph 40, Claim Appeal Procedures for additional details. Louisiana law requires additional considerations with regard to external review or adverse determinations involving individual claims in excess of two hundred fifty dollars. Claims over $250.00 are subject to additional considerations under Louisiana law.

2. WE DO NOT PROVIDE BENEFITS FOR:

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

Part IV Other Contract Provisions

1. BENEFIT PAYMENTS FOR SERVICES

IN-NETWORK SERVICES:
If a covered individual uses the services of a contracting dentist, the in-network benefit allowance is based on the schedule that the contracting dentist has agreed to accept as payment in full for the dental services listed in the benefits section, except as provided under item 2 below. The Plan pays the contracting dentist directly for covered services.

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

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

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

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

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

A. If you have received the maximum benefit allowed for services. For example, the maximum dollar amount for a *covered individual* in a calendar year, including the service that caused you to reach the maximum. There is no maximum benefit for covered individuals under age 19.

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

C. If, for some reason, you receive services from more than one dentist for the same dental procedure or receive services that are furnished in a series during a planned course of

treatment. In such a case the total amount of your benefit will not be more than the amount that would have been provided if only one dentist had furnished all the services.

3. PRE-TREATMENT ESTIMATES

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

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

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

4. WHEN YOUR COVERAGE BEGINS

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

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

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

Participating Dentists have agreed to give us all information necessary to determine your benefits under this Policy and have agreed not to charge for this service.

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

6. PREMIUM

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

DentaQuest PPO

DentaQuest USA Insurance Company, Inc.

96 Worcester Street Wellesley Hills, MA 02481

SCHEDULE OF BENEFITS

Individuals and Families
Dental Family High Option

COVERAGE

In-Network Benefits		Out-of-Network Benefits
Diagnostic and Preventive Services		
The Plan pays 100% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		*The Plan* pays 100% of covered charges up to the *fee schedule* amounts for services by a *Non-participating Dentist*.
Restorative and other Basic Services		
The Plan pays 80% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		*The Plan* pays 80% of covered charges up to the *fee schedule* amounts for services by a *Non-Participating Dentist*
Complex and Major Restorative Dental Services		
The Plan pays 50% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		*The Plan* pays 50% of covered charges up to the *fee schedule* amounts for services by a *Non-Participating Dentist*
Orthodontic Services **(Under age 19 only)**		
The Plan pays 50% of covered charges up to the *fee schedule* amounts for medically necessary orthodontic services by a *Participating Dentist.*		*The Plan* pays 50% of covered charges up to the *fee schedule* amounts for medically necessary orthodontic services by a *Non-Participating Dentist.*

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 months.

Periodic exam; once every six (6) months.

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

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

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

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

Fluoride treatment Topical Fluoride - Varnish - 2 every 12 months,

Topical application of fluoride (excluding prophylaxis) - 2 every 12 months.

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

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

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

RESTORATIVE AND OTHER BASIC SERVICES

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

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

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

Protective restorations.

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

Simple tooth extractions.

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

Consultations.

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

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

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

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

Vital pulpotomy and pulpal therapy is limited to deciduous teeth.

COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES

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

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

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

Inlays are paid as an alternative benefit of amalgam.

Implants- once every 60 months.

Dentures and Bridges

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

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

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

ORTHODONTIC SERVICES

Orthodontic services for individuals who are under age nineteen (19) who achieve a minimum Salzmann Evaluation Criteria Index score of twenty-five (25) points. Other medically necessary qualifiers are considered. Orthodontic services require prior authorization.

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

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Schedule of Benefits.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Schedule of Benefits.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints), except for covered medically necessary orthodontics for individuals under age 19.
- Services that are meant primarily to change or to improve your appearance.
- Repair or reline of an occlusal guard.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Lab exams.
- Photographs.
- Duplicate dentures and bridges.
- Services related to congenital anomalies unless otherwise covered. However, this exclusion does not apply to covered orthodontic services.
- Occlusal adjustment.
- Dietary advice and instructions in dental hygiene including proper methods of toothbrushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- Service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Tooth bleach.
- Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
- Transitional implants.
- Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomies, root amps, ridge augmentations and dental implant placements.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
- Cone Beam Imaging and Cone Beam MRI procedures.
- Nitrous oxide.
- Oral sedation.

- Topical medicament center.

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.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 everycalendar 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, alveoloplasty 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; not to be combined with regular cleanings.

Endodontic services for root canal treatment once per permanent tooth 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.

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 DentalAssociation, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Schedule of Benefits.
- Services that are rendered 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 Schedule of Benefits.
- 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, apicoectomies, rootamps, 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.

DEDUCTIBLES

Restorative and other Basic Services, and Complex and Major Restorative Dental Services described above are subject to a $50 deductible for each *covered individual* every calendar year. In the case of a family contract, the total deductible payment for all *covered individuals* shall not exceed $150 for Restorative and other Basic Services, and Complex and Major Restorative Dental Services in a calendar year. This means the *covered individual(s)* must pay the first $50 of benefits provided every calendar year, not to exceed $150 per calendar year for families with three or more *covered individuals*.

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

Total benefits are limited to a maximum of $1500 for each *covered individual* every calendar year.

OUT OF POCKET MAXIMUM (applies only to Covered Individuals under age 19 and only to in-network benefits)

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

WAITING PERIOD

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

For *covered individuals* age 19 and older Restorative and other Basic Services are subject to a six (6) month waiting period and Complex and Major Restorative Dental Services are subject to a twelve (12) month waiting period.

DEPENDENT COVERAGE

Dependent children are covered up to and including age 26.

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

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

OUT-OF-NETWORK SERVICES:

For services performed by a *Non-participating Dentist*, *the Plan* will pay the dentist directly by applying the out-of-network benefit coinsurance payments for each type of service against the maximum allowable charge indicated on the negotiated *Plan* Fee Schedule, or the dentist's submitted fee if lower.
The *subscriber or covered individual* is responsible for paying the *Non-participating Dentist* the difference between the dentist's fee and the amount paid by *the Plan*, including the difference between *the Plan's* payments and any balances resulting from plan specific deductibles and coinsurance.

CLAIMS SUBMISSION:

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

NOTE: Italicized terms are defined in the Policy.

If you have questions about this coverage, please contact our Customer Service Department at 1-844-241-5611.

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

DentaQuest*

Foreign Language Assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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