DentaQuest
a Sun Life company

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

DentaQuest EPO for Individuals and Families Policy

DentaQuest EPO Pediatric High Plan

January 1, 2026

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DentaQuest USA Insurance Company, Inc.

96 Worcester Street, Wellesley Hills, MA 02481

DentaQuest EPO for Individuals and Families 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.

RIGHT TO RETURN POLICY WITHIN 10 DAYS. If for any reason you are not satisfied with your Policy, you may return this Policy for cancellation to *the Plan*'s home office within ten days of the date you received it and the premium you paid, including any policy fees or other charges, will be promptly refunded and this Policy shall be deemed void from the beginning and the parties will be returned to their original position as if no Policy had been issued.

POLICY MAY BE TERMINATED BY THE PLAN. This Policy renews annually on January 1 subject to our right to terminate coverage under Part IV, Section 10 (Termination of Policy). We reserve the right to change premium rates upon renewal of the Policy.

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

In order to receive benefits under this Policy you must receive services from a *Participating Dentist*. No benefits are provided under this Policy for services rendered by a *Non-participating Dentist*, except in the case of emergency medical conditions as set forth in this Policy.

ATTEST: DentaQuest USA Insurance Company, Inc.

Teresa Pecoraro

President

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Introduction

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

The dental services described in this Policy (see Benefits section) are covered as of your effective date, unless your benefits are subject to a waiting period. Additionally, there are some limitations and restrictions on your coverage, which are found in Parts II and III of this Policy. Please refer to the Schedule of Benefits, attached to this Policy, which outlines the specific coverage provided under this Policy.

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

Subscriber's Rights and Responsibilities

As a DentaQuest Dental Plan *subscriber,* you have the right to:

• File a complaint about the dental services provided to you.

• Be provided with appropriate information about *the Plan* and its benefits, participating dentists, and policies.

You have the responsibility to:

• Ask questions in order to understand your dental condition and treatment, and follow recommended treatment instructions given by your dentist.

• Provide information to your dentist that is necessary to render care to you.

• Be familiar with *the Plan* benefits, policies and procedures, by reading our written materials, or calling our Customer Service department at the telephone number listed at the end of this Policy.

Part I

Definitions

ACA: The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.

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

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

Covered dependents: See *Family Coverage* definition.

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

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

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

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.

Exchange: the federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the ACA, codified as 42 U.S.C. § 18041(c).

Family coverage: coverage that includes you, your spouse, children for whom coverage is ordered by a court of law or administrative order 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 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.

Attainment of the limiting age shall not operate to terminate coverage for a child while the child is and continues to be both: (i) incapable of self-sustaining employment by reason of intellectual or physical disability; and (ii) chiefly dependent upon the *subscriber* for support and maintenance, provided that proof of the incapacity and dependency is furnished to *the Plan* by the *subscriber* within thirty-one (31) days of the child's attainment of the limiting age and subsequently may be required by *the Plan*, but no more frequently than annually after the two-year period following the child's attainment of the limiting age.

Fee Schedule: the payment amount for the services that may be provided by *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 Tennessee to furnish health care services.

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

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

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

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

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

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

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

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

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

You: the *subscriber* of the dental plan.

Part II Benefits

The following list of services includes those services most commonly provided to *covered individuals*. It is not an all inclusive list of covered services. For *covered individuals* under age nineteen (19), *the Plan* will provide benefits for ADA codes not included on the following list, subject to the exclusions and limitations set forth in this *Agreement*. An expanded list of covered CDT codes for individuals under age nineteen (19) is attached to this *Agreement.* The benefits may be limited to a maximum dollar payment for each *covered individual* for each *Benefit Year*. The extent of your benefits is explained in the *Schedule of Benefits* which is incorporated as a part of this Policy.

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. Single tooth x-rays; as needed.

Study models and casts used in planning treatment.

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 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.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.

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

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

ORTHODONTIC SERVICES

Orthodontic services for severe and handicapping malocclusion as defined by one or more autoqualifiers and/or a MSA score of 28. Orthodontic services require prior authorization.

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

DIAGNOSTIC AND PREVENTIVE SERVICES

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most *covered individuals* receive during a routine preventive dental visit.

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.

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 and 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.

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

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

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

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

Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every sixty (60) months.

- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.

- Temporary partial dentures as follows:

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

Crowns and Onlays

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

- Initial placement of crowns and onlays.

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

Part III
Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of 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.

2. WE DO NOT PROVIDE BENEFITS FOR:

Below is a summary of dental services or items for which coverage is not provided under this Policy.

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 Policy.
- 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 Policy.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- Any fee or charge for a service not submitted as a current dental terminology (CDT) code based on the most recent American Dental Association publication of CDT codes.
- Appointments with your dentist that you fail to keep.
- A service rendered by someone other than a licensed dentist or a hygienist who is under the supervision of 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.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Lab exams.
- Duplicate dentures and bridges.
- Services related to congenital anomalies unless otherwise covered. However, this exclusion does not apply to covered orthodontic services.
- Occlusal adjustment.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- Service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Tooth bleach.
- Surgical stents.
- Transitional implants.
- Bone grafts.
- Sinus lifts.
- Cone Beam Imaging.
- Nitrous oxide.
- Oral sedation.
- Topical medicament center.

The following list of limitations and exclusions apply to covered individuals age 19 and over.

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Policy.
- 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 Policy.
- 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 under the supervision of 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.
- 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, root amps, ridge augmentations and dental implant placements.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
- Veneers.
- Occlusal guards.

Part IV Other Contract Provisions

1. BENEFIT PAYMENTS FOR SERVICES BY A *PARTICIPATING DENTIST*

Benefits are provided under this Policy only for services provided by *Participating Dentists.* The amount if any, that you may be required to pay your *Participating Dentist* is explained in the *Schedule of Benefits*. Payments are made directly to *Participating Dentists*.

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.

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 unless the dentist initially performing the services is no longer a *Participating Dentist* or unable to complete the dental procedure.

3. PRE-TREATMENT ESTIMATES

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

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

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

4. BENEFIT PAYMENTS FOR SERVICES BY *NON-PARTICIPATING DENTISTS*

No benefits are provided under this Policy for services performed by *Non-participating Dentists*, except in the case of emergency services as set forth in paragraph 29 of this Part IV.

5. WHEN YOUR COVERAGE BEGINS

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

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

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

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

7. 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 will send you a notice at least thirty (30) days before any change in your premium goes into effect. Premiums will not change more than once every twelve (12) months. We may not change your premium until the present Schedule of Benefits under this Policy has been in effect for twelve (12) months.

8. WE MAY CHANGE YOUR POLICY

We will send a notice each time we change all or part of your Policy, describing the change(s) being made. Changes to the Policy may include the addition or deletion of riders as well as plan design changes. You can also call our Customer Service department to get information on your plan change. Our telephone number is listed at the end of this Policy.

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

9. WHEN YOUR COVERAGE ENDS

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

A. Your dependent child under your *family coverage* attains the limiting age for coverage (please

see Part 1 for the definition of Family Coverage and eligibility requirements for dependents). If *the Plan* has accepted premium for the dependent child, coverage will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted.

B. If you become divorced or legally separated, your spouse's coverage under existing *family coverage* will continue so long as you remain a *subscriber* of the *Plan* and a court judgment provides for such coverage. This coverage will continue until either you or your spouse remarries, or until the date of coverage termination stated in the judgment of divorce or separation, whichever is earlier. If you remarry and your divorce judgment so provides, your former spouse will have the right, for an additional subscription, to continue to receive such benefits as are available to you by means of the issuance of a separate subscription at a single rate under the plan.

10. TERMINATION OF A POLICY

A. CANCELLATION BY INSURED

You may cancel your Policy for any reason.

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

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

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

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

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

B. CANCELLATION OR NONRENEWAL BY THE PLAN

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

1. Subject to the Time Limit on Certain Defenses provision set forth in Section 12, if you make any fraudulent claim or a fraudulent misrepresentation or intentional misrepresentation of material fact to us or to any dentist, material misrepresentation to us or to any dentist, such as an incorrect or incomplete statement on your application, which led us to believe you were eligible for this coverage when in fact you were not. In such a case, cancellation will be as of your *effective date*. We will refund you the premium you have paid us. We will subtract from the refund any payments made for claims under this Policy. If we have paid more for claims under this Policy than you have paid us in premiums, we have the right to collect the excess from you.
2. If you have not paid your premiums, subject to the Grace Period provision under Section 14 under this Part IV.
3. If you have been guilty of fraudulent dealings with us.
4. If we discontinue a particular product or all coverage in the individual market in Tennessee in accordance with Tennessee law.

If coverage is obtained through the *Exchange*, terminations will be initiated by the *Exchange*, except for terminations for nonpayment of premium which will be initiated by the *Plan*.

C. CANCELLATION DUE TO LOSS OF ELIGIBILITY.

Your Policy will be canceled if you are no longer eligible because you no longer live, reside or work in Tennessee. The termination date of this coverage shall be the last day of the month, at 12:01 A.M. Eastern Time, in which we were notified of your move and for which the premium has been paid.

A Participating Dentist shall notify a *covered individual* of the termination of the *covered individual's* Policy if the covered individual visits the Participating Dentist's office when the Participating Dentist is aware that the *covered individual's* Policy has terminated. The Participating Dentist shall also inform the *covered individual* of the charge for any scheduled dental services before performing the dental services.

D. TIME AT WHICH TERMINATION TAKES EFFECT

Any termination of this Policy under paragraphs A., B. or C of this Section 11 shall take effect at 12:01 A.M. Eastern Time on the effective date of termination.

11. MISSTATEMENT OF AGE

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

12. TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period.

13. BENEFITS AFTER TERMINATION

No benefits will be provided for services received after termination of this Policy except that coverage will be provided for procedures started while this Policy is in force and which are completed within 30 days after termination of this Policy.

14. GRACE PERIOD

Unless not less than five days prior to the premium due date *the Plan* has delivered to the *subscriber* or has mailed to the *subscriber's* last address as shown by the records of *the Plan* written notice of its intention not to renew this Policy beyond the period for which the premium has been accepted, a grace period of 31 days shall be granted for the payment of any premium falling due after the first premium during which coverage remains in effect. If payment is not received within the 31 days, coverage may be cancelled after the thirty-first day and the *subscriber* may be held liable for the payment of the premium for the period of time coverage remained in effect during the grace period.

If a *subscriber* is receiving advance payments of the premium tax credit under the ACA, and the *subscriber* has previously paid at least one full month's premium during the *Benefit Year*, the grace period is extended to three (3) consecutive months. *The Plan* may pend claims made during the second and third months of the extended three (3) month grace period. If the premium is not paid by the end of the grace period, coverage will be terminated as of the end of the first month of the grace period and claims pended during the second and third months of the grace period will be denied.

15. NOTICES

A. To you: When we send a notice to you by first class mail, once we mail the notice, we are not responsible for its delivery. This applies to a notice of a change in the premium or a change in the Policy. If your name or mailing address should change, you should notify *the Plan* at once. Be sure to give *the Plan* your old name and address as well as your new name and address.

B. To us: Send letters to DentaQuest USA Insurance Company, Inc., c/o DentaQuest Management, Inc., P.O. Box 2906 Milwaukee, WI 53201-2906. Always include your name and subscriber identification number.

16. CONTRACT CHANGES

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

thirty-one (31) day period. A minor for whom guardianship is granted by court order or testamentary appointment shall be covered from the date of appointment. A child, who the court or governmental agency orders to be covered under a subscriber's dental coverage, shall be covered from the date of the order.

Changes to the Policy may result in a change in your premium. Except as provided in section 18, below, *the Plan* must be notified of new covered dependents within thirty-one (31) days. Failure to notify the *Plan* of new dependents within thirty-one (31) days shall result in the *Plan* never recognizing coverage for the new dependent(s) during the thirty-one (31) days.

17. ENROLLING DEPENDENTS

Under certain situations, dependents may be added to your coverage at any time. Qualifying events could be a result of court or administrative order and your spouse's death. Under those circumstances, you must notify *the Plan* within thirty-one (31) days or six (6) months (only if specified below) of the qualifying event.

a. Death of Spouse – If your spouse dies, you may add your dependent child(ren) to the coverage provided under this Policy at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's Policy or contract. You must notify *the Plan* within six (6) months of this event.

b. Court or Administrative Order – If you are required under a court or administrative order (whether from this state or another state that recognizes the right of the child to receive benefits under the subscriber's health coverage) to provide health coverage for a child, *the Plan* shall allow you to enroll the child under the following circumstances:

1. You shall be allowed to enroll in family members' coverage and include the child in that coverage regardless of any enrollment period restrictions.

2. If you are enrolled but do not include the child in the enrollment, we shall allow the noninsuring parent of the child, child support enforcement agency, or any other agency with authority over the welfare of the child to apply for enrollment on behalf of the child.

3. You may not terminate coverage for the child unless written evidence is provided to us that the order is no longer in effect, or the child is or will be enrolled under other comparable dental coverage that will take effect on or before the effective date of termination.

18. ENROLLMENT THROUGH THE EXCHANGE AND PREMIUM PAYMENTS

Notwithstanding the requirements of Sections 17 and 18 of this Policy, if coverage is obtained through the *Exchange*, the *Exchange* will enroll qualified individuals and enrollees and terminate coverage in accordance with the requirements of the ACA, the rules promulgated under the ACA, including Parts 155 and 156 of Title 45 of the Code of Federal Regulations, and the requirements of the *Exchange*. The annual open enrollment and special enrollment periods and effective dates of coverage in 45 C.F.R. §§ 155.410 and 155.420 will apply with respect to enrollment through the *Exchange*. Special enrollment periods include when a qualified individual gains a dependent or

becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care or a child support order or other court order.

The *Plan* is required to process enrollments in accordance with 45 CFR 156.265, which requires the *Plan* to enroll an individual only if the *Exchange* notifies the *Plan* that the individual is a qualified individual as determined by the *Exchange*.

For coverage obtained through the *Exchange*, premium payments will be required to be made directly to the *Plan* in accordance with the *Plan's* available methods for payment. The first premium payment will be due prior to the effective date of coverage, and premiums will be due monthly thereafter unless a different payment interval is permitted by the *Plan.*

19. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after the *effective date* of this Policy.

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

20. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

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

21. CONFORMITY WITH STATE STATUTES:

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

22. CHOICE OF LAW

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

23. LEGAL ACTIONS

No action at law or in equity shall be brought to recover under this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished as required by this Policy. No legal action may be brought after the expiration of two years after the time written proof of loss is required to be

furnished.

24. ENTIRE CONTRACT; CHANGES

This Policy, including the application and any amendments and riders, including the *Schedule of Benefits*, constitutes the entire contract of insurance and no change in this Policy shall be valid until approved by an executive officer of the *Plan* and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Policy or to waive any of its provisions.

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

25. IMPORTANT INFORMATION ABOUT YOUR INSURANCE

In the event that you need to contact someone about this coverage for any reason, you should contact your agent. If no agent was involved in the sale of this coverage, or if you have additional questions, you may contact DentaQuest USA Insurance Company, Inc. at the following address and telephone number:

DentaQuest USA Insurance Company, Inc.
c/o DentaQuest P.O. Box 2906
Milwaukee, WI 53201-2906
Telephone: 1-844-876-3978

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

26. REINSTATEMENT

If the renewal premium is not paid before the grace period ends, the Policy will lapse. Later acceptance of the premium by *the Plan* or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the Policy. If *the Plan* or its agent requires an application for reinstatement, the Subscriber will be given a conditional receipt for the premium. If the application is approved the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Plan has previously written the Subscriber of its disapproval. The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than 10 days after such date. In all other respects the rights of the Subscriber and *the Plan* will remain the same, subject to any provisions noted or attached to the reinstated Policy. Any premiums *the Plan* accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

27. STATEMENTS AS REPRESENTATION; EFFECT OF MISREPRESENTATION UPON POLICY

All statements and descriptions in your application for insurance or in negotiations therefor, by or on your behalf, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under this Policy unless: (i) fraudulent; (ii) material either to the acceptance of the risk, or to the hazard assumed by *the Plan*; or (iii)

the Plan in good faith would either not have issued this Policy, or would not have issued this Policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to *the Plan* as required either by the application for this Policy or otherwise.

28. ADMINISTRATION OF CLAIM AGAINST *THE PLAN* NOT DEEMED WAIVER OF DEFENSE

Without limitation of any right or defense of *the Plan* otherwise, none of the following acts by or on behalf of *the Plan* shall be deemed to constitute a waiver of any provision of this Policy or of any defense of *the Plan* hereunder: (i) acknowledgement of the receipt of notice of loss or claim; (ii) furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted; or (iii) investigating any loss or claim or engaging in negotiations looking toward a possible settlement of any such loss or claim.

29. EMERGENCY MEDICAL CONDITIONS

Nothing in this *Policy* will prohibit a *covered individual* from seeking emergency care whenever the individual is confronted with an *emergency medical condition*, which in the judgment of a prudent layperson would require pre-hospital emergency services. For purposes of this provision, an "*emergency medical condition*" is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B).

If a *covered individual* requires services for an *emergency medical condition*, and cannot reasonably be attended to by a *Participating Dentist*, the *Plan* shall pay for the emergency services so that the *covered individual* is not liable for a greater out-of-pocket expense than if the *covered individual* were attended to by a *Participating Dentist*.

Part V Filing a Claim

1. EXPLANATION OF BENEFITS (EOB) Each time we process a claim for you under this Policy, a written notice will be sent to you explaining your benefits for that claim. This notice will tell you how we paid the claim or the reasons it was denied. The notice is called an Explanation ofBenefits or "EOB."

2. WHO FILES A CLAIM

   Participating Dentists: *Participating Dentists* will file claims directly to us for the services covered by this Policy. We will make benefit payments within thirty (30) days to them.

3. PROOF OF LOSS

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

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

4. NOTICE OF CLAIM. Written notice of claim must be given to the *Plan* within twenty (20) days after the occurrence or commencement of any loss covered by the Policy or as soon thereafter as reasonably possible. Notice given by or on behalf of the *covered person* to the *Plan* at DentaQuest USA Insurance Company, Inc., c/o DentaQuest Management, Inc., P.O. Box 2906 Milwaukee, WI 53201-2906, or to any authorized agent of the *Plan*, with information sufficient to identify the *subscriber*, shall be deemed notice to the *Plan*. Please include in the notice the name of the claimant if other than the *subscriber* and the policy number.

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

   (b) If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss.

6. TIME OF PAYMENT OF CLAIMS. Indemnities payable under this Policy will be paid immediately upon receipt of due written proof of such loss.

7. PAYMENT OF CLAIMS. Benefits for covered services will be paid directly to the *Participating Dentist*.

8. UNPAID PREMIUM. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

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

Customer Service Department
1-844-876-3978

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

SCHEDULE OF BENEFITS
DentaQuest EPO for Individuals and Families
Pediatric High Option

This Schedule applies only to individuals under age nineteen (19).

COVERAGE

In-Network Benefits		Out-of-Network Benefits
Diagnostic and Preventive Services		
The Plan pays 100% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		No benefits are provided for services performed by a *Non-participating Dentist*.
Restorative and other Basic Services		
The Plan pays to 80% of covered charges up to the *fee schedule* amounts for services by a *Participating Dentist.*		No benefits are provided for services performed 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.*		No benefits are provided for services performed by a *Non-participating Dentist*.
Orthodontic Services		
The Plan pays 50% of covered charges up to the *fee schedule* amounts for medically necessary orthodontic services by a *Participating Dentist.*		No benefits are provided for services performed by a *Non-participating Dentist*.

DIAGNOSTIC AND PREVENTIVE SERVICES

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

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

Periodic exam; once every six (6) months.

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

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

Study models and casts used in planning treatment.

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 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.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.

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

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

ORTHODONTIC SERVICES

Orthodontic services for severe and handicapping malocclusion as defined by one or more autoqualifiers and/or a MSA score of 28. Orthodontic services require prior authorization.

DEDUCTIBLES

Restorative and other Basic Services, and Complex and Major Restorative Dental Services described above are subject to a $50 deductible for each *covered individual* under age 19 every calendar year. This means the *covered individual(s)* must pay the first $50 of benefits provided every calendar year.

ANNUAL MAXIMUM BENEFIT

No annual maximum benefit applies to this coverage.

OUT OF POCKET MAXIMUM (in-network benefits only)

The *out of pocket maximum* is $400 per calendar year. The *out of pocket* maximum applies per *covered individual* under age 19. The *out of pocket* maximum applies to in-network benefits only. No out of pocket maximum applies to out of network benefits.

WAITING PERIOD

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

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

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

OUT-OF-NETWORK SERVICES:

No benefits are provided for services performed by a *Non-participating Dentist*.

CLAIMS SUBMISSION:

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

NOTE: Italicized terms are defined in the Policy.

If you have questions about this coverage, please contact our Customer Service Department at 1- 844-876-3978

DentaQuest*

Foreign Language Assistance

English: you have the right to get help and information in your language at no cost. To talk to an interpreter, call [1-844-876-3981].

Chinese: 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 [1-844-876-3981]。

Vietnamese: quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi [1-844-876-3981].

Arabic: ن---م ن---ود ي---اة فلك---------تة. ل---لتدحث عم ت---مرمج ت---اصل ب [1-844-876-3981] ن--إ ن--اك دليك وأ لب---د ص---خش دعاس---ته ةلئس---------أ صوص-----خب ض الرروية كتغل---------ب

Korean: 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 [1-844-876-3981] 로 전화하십시오.

French: vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez [1-844-876-3981].

Russian: то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону [1-844-876-3981].

Spanish: tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al [1-844-876-3981].

German: haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer [1-844-876-3981] an.

Tagalog: may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa [1-844-876-3981].

Gujarati: િવશે પ્રĕ◌ હ◌ર્ ત◌ તમને મદદ અને મ હહતી મેિળિ◌ ન◌ અિવક ર છે. તે ખય◌્િવન તમ રી ભ ષમ ◌ાં પ્ર ɯત કરી શક ર્ છે. દ ભ વષ◌ોિ◌ ત કિર મ ટે,આ [1-844-876-3981] પર ક◌લ કર◌.

Hindi: के बारे मʌ प्रæन हɛ ,तो आपकेपास अपनी भाषा मʌ मुÝत मʌ सहायता और सूचना प्राÜत केसका अिधकार है। ककसी◌ ◌ुभाषषए से बात करने के◌ िलए [1-844-876-3981] पर कॉ◌ि◌ करʌ।

Italian: hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare [1-844-876-3981].

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

Japanese：についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、[1-844-876-3981]までお電話ください。

Portuguese: você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para [1-844-876-3981].

French Creole: se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan [1-844-876-3981].

Polish: masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer [1-844-876-3981].

Amharic: ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ [1- 844-876-3981] ይደውሉ።

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