DentaQuest
a Sun Life company

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

DentaQuest PPO for Individuals and Families Policy

DentaQuest PPO Family Basic Plan

January 1, 2026

7198(1.26)Prev.PolicyEN

DentaQuest National Insurance Company, Inc.

Policy Declarations

Named Insured: [Name]

Coverage Effective Date: January 1, 2026, 12:00 A.M., Eastern Time

Coverage End Date: December 31. 2026, 11:59 P.M., Eastern Time

Premium: $19.76 per month, per *covered individual* under age 19

$11.81 per month, per *covered individual* age 19 or older

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

PPO Dental Insurance Policy for Individuals and Families

DentaQuest National 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 MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ!
This Policy is issued in consideration of your application for insurance and the payment of the first premium. A copy of the application is attached to this Policy. This Policy is a legal contract between you and the Plan. 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 to *the Plan* within ten days of the date you received it and the premium you paid will be promptly refunded.

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

CONDITIONAL RENEWABILITY. Your Policy renews annually on January 1 subject to our right, upon thirty (30) days' notice to you, to nonrenew coverage for the following reasons: (1) You fail to pay the Premium when due, subject to the grace period provisions in this Policy; (2) We discontinue this Policy; (3) You or a Covered Dependent commits fraud or intentional material misrepresentation of a material fact, as determined by the Plan; (4) You or a Covered Dependent permits a person not authorized to use Your/his/her ID card, which shall be considered fraudulent conduct; (5) You obtain coverage under another plan; or (6) You or a Covered Dependent fail(s) to comply with the Policy provisions, as determined by the Plan.

Preferred Provider Organization (PPO)Policy Disclosure: This Policy provides the same benefits for covered services provided by Participating Dentists and Non-participating Dentists, as defined herein. You are responsible for paying your portion of any coinsurance or deductible for covered services as specified in your Schedule of Benefits. Non-participating Dentists may also charge you for the difference between the amount paid by the Plan and the dentist's actual charge.
LIMITED BENEFIT POLICY: THIS IS A LIMITED BENEFIT POLICY. IT DOES NOT PROVIDE COVERAGE FOR ANY MEDICAL BENEFITS AND SERVICES. THIS IS AN EXCHANGE CERTIFIED STAND-ALONE DENTAL POLICY THAT PROVIDES COVERAGE FOR CERTAIN DENTAL BENEFITS AND SERVICES ONLY.

DentaQuest National Insurance Company, Inc.

Teresa Decoraro

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 *Agreement*. 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. The contact information for the Customer Service department is on the last page of this Policy.

Subscriber's Rights and Responsibilities

As a 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.

• File a complaint/appeal without fear of disenrollment by the *Plan*.

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. The contact information for the Customer Service department is on the last page of this Policy.

Part I

Definitions

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

Adverse benefit determination: means a decision by *the Plan* or a representative of *the Plan* to deny, reduce, terminate or modify the availability of any dental care services because you are not eligible for coverage, including a decision that your condition failed to meet the requirements for coverage based on necessity, appropriateness of care, level of care, or effectiveness.

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.), as shown on our records, on which your coverage begins under this Policy or an amendment to it. The *effective date* is stated on the first page of your Policy Declarations

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

Family coverage: coverage that includes you, your spouse and dependent children up to and including twenty-six (26) years of age. Your or your spouse's adopted children are covered from the date of adoptive or parental placement with an insured *subscriber* or plan enrollee for the purpose of adoption. Children under testamentary or court appointed guardianship, placement in foster care, other than temporary guardianship of less than 12 months duration, and grandchildren in your court-ordered custody who are dependent upon you are also covered. Notwithstanding any limiting age stated in this Policy, any child covered under this Policy as a dependent of a *covered individual* who is chiefly dependent for support upon the *covered individual*, and who, at the time of reaching the limiting age, is incapable of self-support because of intellectual disability or physical impaired that commenced prior to the child's attaining the limiting age, shall continue to be covered under this Policy while remaining so dependent and intellectually disabled or physically impaired , until

the coverage on the *covered individual* upon whom the child is dependent terminates. You must notify the *Plan* and provide medical documentation to support this continued coverage within seventy-two (72) days of the child's qualifying birthday.

Fee Schedule: the schedule of fees that *Participating Dentists* must accept as full payment for services provided to *covered individuals*.

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

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.

Medically necessary: or words of similar meaning, means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. .

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.

Service Area: The Service Area is comprised of the following counties and independent cities. Counties: Albemarle, Amelia, Amherst, Appomattox, Arlington, Bedford, Botetourt, Campbell, Caroline, Charles City, Chesterfield, Clarke, Craig, Cumberland, Dunwiddie, Fairfax, Fauquier, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Greene, Hanover, Henrico, Isle of Wight, James City, King and Queen, King William, Loudoun, Louisa, Mathews, Montgomery, Nelson, New Kent, Pittsylvania, Powhatan, Prince George, Prince William, Pulaski, Roanoke, Rockingham, Scott, Spotsylvania, Stafford, Surry, Sussex, Warren, Washington, York, Accomack, Alleghany, Augusta, Bath, Bland, Brunswick, Buchanan, Buckingham, Carroll, Charlotte, Culpeper, Dickenson, Essex, Floyd, Grayson, Greensville, Halifax, Henry, Highland, King George, Lancaster, Lee, Lunenburg, Madison, Mecklenburg, Middlesex, Northampton, Northumberland, Nottoway, Orange, Page, Patrick, Prince Edward, Rappahannock, Richmond, Rockbridge, Russell, Shenandoah, Smyth, Southampton, Tazewell, Westmoreland, Wise, Wythe. Independent Cities:

Alexandria, Bedford, Bristol, Charlottesville, Chesapeake, Colonial Heights, Danville, Fairfax, Falls Church, Fredericksburg, Hampton, Harrisonburg, Hopewell, Lynchburg, Manassas, Manassas Park, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, Suffolk, Virginia Beach, Williamsburg, Winchester. Buena Vista, Clifton Forge, Covington, Emporia, Franklin, Galax, Lexington, Martinsville, Norton, Staunton, Waynesboro.

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.

Plan: refers to DentaQuest National Insurance Company, Inc.

You: the *subscriber* of the dental plan.

Part II Benefits

You have the right to benefits on a non-discriminatory basis for the following services, EXCEPT as limited or excluded elsewhere in this Policy. 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). These benefits will cease at the end of the month in which the covered individual turns age nineteen (19).

DIAGNOSTIC AND PREVENTIVE SERVICES

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

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

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); twice every calendar

year. Single tooth x-rays; as needed.

Study models and diagnostic casts used in planning treatment; for non-

orthodontic services. Routine cleaning, scaling and polishing of teeth;

twice every calendar year.

Fluoride treatment; twice every calendar year.

Space maintainers required due to the premature loss of teeth; once every 2 years per quadrant (unilateral) and per arch (bilateral) and not for the replacement of primary or permanent anterior teeth.

Sealants on unrestored permanent molars; once per tooth. Sealants are not covered when placed over restorations.

RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or *fractured* teeth (note: teeth must have a good prognosis to qualify for benefits); (b) repair removable

prosthodontics (e.g. dentures); (c) rebase or reline removable prosthodontics; (d) repair fixed prosthodontics (e.g., bridges, crowns, onlays, retainers, pontics); (e) recement bridges, crowns and onlays; and (f) remove diseased or damaged natural teeth.

Examples of these services include:
Fillings consisting of silver amalgam and synthetic tooth color fillings, but limited to one filling for each tooth

surface every twelve (12) months. No benefits are provided for replacing a filling twelve (12) months of the date that the prior filling was furnished.

Protective restorations.

Stainless steel crowns.

Simple tooth
extractions.

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

Repair of dentures or fixed bridges.

Recementing of fixed bridges.

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

months. Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

Palliative (emergency) treatment of dental pain – minor

procedures. Local anesthesia.

Occlusal guard.

Onlay - porcelain/ceramic- 4 or more surfaces; One per 60 months.

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, removal of odontogenic cyst or tumor or growths, incision and drainage of abscess, occlusal orthotic device (covered only for temporomandibular pain, dysfunction or associated musculature), frenulectomy, and frenuloplasty. Frenulectomy and frenuloplasty are covered once per lifetime, per patient. Additional oral and maxillofacial surgery services include tooth reimplantation or stabilization due to accident, biopsy of oral tissue and brush biopsy, and alveoloplasty. Alveoloplasty is covered once per quadrant, per lifetime.

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

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

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

Provision Splinting; once per tooth.

Bone replacement graft, pedicle soft tissue graft procedure, and subepithelial connective tissue graft procedure.

Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, pulp caps, pulpotomy, pulpal regeneration, pulpal debridement, pulpal therapy, retrograde filling (per root) and retreatment of previous root canal therapy. Vital pulpotomy is limited to deciduous teeth. Retrograde filling is limited to one per lifetime per tooth. Retreatment of previous root canal therapy is limited to one per lifetime per tooth (anterior and bicuspid).

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.

- 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.

  - For the replacement of permanent teeth.

Endosteal implants in lieu of a three-unit bridge

Fixed Prosthodontics

Crowns and Onlays

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

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

Pontics will be covered once per tooth every sixty (60) months.

Retainer will be covered once per tooth every sixty (60) months.

Apicoectomy/periradicular surgery once per tooth per lifetime

Removable prosthesis; once per arch per sixty (60) months.

Maxillofacial prosthetics (feeding aid only)

Veneers (Medically Necessary); once per tooth every sixty (60) months when tooth qualifies for crown.

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

ORTHODONTIC SERVICES

Medically Necessary Orthodontics

- Medically necessary pediatric orthodontia exists when there is a severe, dysfunctional, handicapping malocclusion. Orthodontic services require prior authorization.
- Medically necessary orthodontic services includes:
  - Replacement of a lost or broker retainer; one per day per provider or location per arch; and
  - Removable and fixed appliance therapy, including appliances for thumb sucking and tongue thrusting; fixed appliance therapy is covered once per lifetime per patient

The following list of benefits applies to *covered individuals* age 19 and over. These benefits begin on the first day of the month following the month in which the *covered individual* turns 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 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 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. Examples of these services include:

Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth. Additional oral and maxillofacial surgery services include tooth reimplantation, biopsy of oral tissue, and alveoloplasty, once per quadrant per lifetime.

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.

Fixed Prosthodontics

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.

Pontics will be covered once per tooth every sixty (60) months.

Retainer will be covered once per tooth every sixty (60) months.

Part III
Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

Subject to the appeals process in this Policy, we will not provide benefits for the following. We will not provide benefits for a dental service that is not covered under the terms of the 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:

The following list of exclusions applies to *covered individuals* under age nineteen (19). These exclusions apply until the end of the month in which the *covered individual* turns 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 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, subject to the appeals process in this Policy, arose out of and in the course of your employment. If workers compensation benefits are denied, the Policy will immediately provide coverage for the dental service that is otherwise covered under the Policy.
- 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 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 person who is employed by a licensed dentist and duly licensed or certified to perform the service such as a hygienist.
- Prescription drugs.
- Services that are meant primarily to change or to improve your appearance.
- Repair or reline of an occlusal guard.

- Implants, other than endosteal implants in lieu of a three-unit bridge
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Lab exams.
- Photographs.
- Duplicate dentures and bridges.
- Temporary, complete dentures and temporary fixed bridges or crowns, except temporary crowns for *fractured* teeth.
- 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.
- Consultations.
- 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.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.

The following list of exclusions applies to *covered individuals* age 19 and over. These exclusions begin on the first day of the month following the month in which the *covered individual* turns age 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 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, subject to the appeals process in this Policy, arose out of and in the course of your employment. If workers compensation benefits are denied, the Policy will immediately provide coverage for the dental service that is otherwise covered under the Policy
- 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 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 person who is employed by a licensed dentist and duly licensed or certified to perform the service such as a hygienist.
- 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.
- Consultations.
- Tooth bleach.
- Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
- Transitional implants.
- Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomys, root amps, ridge augmentations and dental implant placements.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
- Veneers.
- Occlusal guards.

Part IV Other Contract Provisions

1. BENEFIT PAYMENTS FOR SERVICES

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

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.
at 1-877-453-8429, or visit our website at https://www.dentaquest.com/en/members/virginia-marketplace-plans/dentaquest-plan.

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 are no annual or lifetime limits applicable to pediatric dental essential health benefits which are benefits for covered individuals under age 19 as set forth in the attached Schedule of Benefits.

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

C. If, for some reason, you receive services from more than one dentist for the same dental procedure or receive services that are furnished in a series during a planned course of treatment. In such a case the total amount of your benefit will not be more than the amount that would have been provided if only one dentist had furnished all the services.

3. PRE-TREATMENT ESTIMATES

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

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

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

4. WHEN YOUR *PARTICIPATING DENTIST* IS TERMINATED

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

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

5. WHEN YOUR COVERAGE BEGINS

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

6. DENTAL RECORDS AND/OR OTHER RELEVANT RECORDS

When you submit a claim for benefits under this Policy, we may request that you provide us the right to obtain all dental records and/or other related information that we need for claims processing purposes in order to make payment on the claim. 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 claims experience under the Policy shall be provided, upon request. This record shall be made available not less than thirty (30) days prior to the date upon which premiums or contractual terms of the Policy may be amended.

7. PREMIUMS

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 sixty (60) 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. WHEN YOUR COVERAGE ENDS

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

A. Your dependent child under your *family coverage* attains the limiting age for coverage (please see Part 1 for the definition of Family Coverage and eligibility requirements for dependents).

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

also trigger a special enrollment period (see section 18 of the Policy.)

9. TERMINATION OF A POLICY

A. TERMINATION BY INSURED

NONRENEWAL
If You don't want to renew this Policy, You must notify the Exchange of Your intent not to renew. If You provide notification of Your intent not to renew, this Policy will end on the last day before the renewal date.

CANCELLATION

You may cancel your Policy for any reason.

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

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

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

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

1. You may cancel this Policy at any time by written notice delivered or mailed to us effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, we shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

2. If you cancel your Policy, you must wait at least one year after your cancellation before you can enroll again as a *subscriber.*

B. TERMINATION DUE TO LOSS OF ELIGIBILITY.

Your Policy will be terminated if you are no longer eligible because you no longer reside in Virginia. The termination date of this coverage shall be the last day of the month, at 11:59 PM., in which we were notified of your move and for which the premium has been paid.

For information regarding benefits after termination, see Part IV, Section 13 of this Policy.

C. TIME AT WHICH TERMINATION TAKES EFFECT

Any termination of this Policy under paragraphs A. or B of this Section 9 shall take effect at 11:59 PM on the effective date of termination.

10. EFFECT OF TERMINATION ON SPOUSE

Your spouse will not be terminated solely because of the occurrence of an event that results in termination of your coverage, other than nonpayment of premium. In the event of the Subscriber's death, the spouse of the Subscriber, if covered under this Policy, shall become the Subscriber.

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

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

13. BENEFITS AFTER TERMINATION

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

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

14. GRACE PERIOD

The *subscriber* shall be given a 31-day grace period for the payment of any premium falling due after the first premium during which coverage remains in effect. If payment is not received within the 31 days, coverage may be cancelled after the thirty-first day. 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.

15. NOTICES

A. To you: When we send a notice to you by first class mail. Once we mail the notice or bill, we are not responsible for its delivery. This applies to a notice of a change in the 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 National Insurance Company, Inc., c/o DentaQuest Management, Inc., P.O. Box 2906, Milwaukee, WI 53201. 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. A minor for whom guardianship is granted by court, placement in foster care, or testamentary appointment shall be covered from the date of appointment. A child, who the court orders to be covered under a *subscriber's* dental coverage, shall be covered from the date of the order. *The Plan* must be notified of new covered dependents within thirty-one (31) days. For newborn children, notification of the birth of a newly born child and payment of the required premium must be submitted within thirty-one (31) days after the birth. Failure to notify *the Plan* of new dependents, including newborn children, within thirty-one (31) days shall result in *the Plan* never recognizing coverage for the new dependent(s) beyond the thirty-one (31) days; except that if you already have family coverage and another family member is added, *the Plan* requests timely notification of the additional individual to facilitate claims payments but the thirty-one (31) day deadline shall not apply.

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

17. ENROLLING DEPENDENTS

Under certain situations, dependents may be added to your coverage at anytime. Qualifying events could be a result of court order and your spouse's death. Under those circumstances, you must notify *the Plan* within seventy-two (72) days or six (6) months (only if specified below) of the qualifying event.

a. Death of Spouse – If your spouse dies, you may add your dependent child(ren) to the coverage provided

under this Policy at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's Policy or contract. You must notify *the Plan within* six (6) months of this event.

b. Court Order – If you are required under a court order (whether from this state or another state that recognizes the right of the child to receive benefits under the *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.

18. OPEN AND SPECIAL ENROLLMENT PERIODS AND PREMIUM PAYMENTS

The open and special enrollment periods and effective dates of coverage in 45 C.F.R. §§ 155.410 and 155.420 will apply with respect to enrollment through the *Exchange* or enrollment outside of the *Exchange*. Any conflict between this Section 18 and any other provision of this Policy shall be resolved in favor of this Section 18. Any conflict between this Section 18 and rules promulgated by the U.S. Department of Health and Human Services shall be resolved in favor of rules promulgated by the U.S. Department of Health and Human Services.

Annual open enrollment period:

An open enrollment period is a window of time that happens once a year — typically in the fall — when you can sign up for health insurance, change your current plan or cancel your plan.

Special enrollment periods exist under the following circumstances:

1. A qualified individual or dependent either: (1) loses minimum essential coverage; or (2) is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage;

2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order;

3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;

4. A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of the *Exchange* or the U.S. Department of Health and Human Services, or its instrumentalities, or a non-*Exchange* entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the *Exchange*. In such cases, the *Exchange* may take such action as may be

necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

5. An enrollee adequately demonstrates to the *Exchange* that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

6. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The *Exchange* must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming *Benefit Year* to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

7. A qualified individual or enrollee gains access to new qualified health plans as a result of a permanent move and either (i) had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the date of the permanent move, or (ii) was living outside of the United States or in a United States territory at the time of the permanent move;

8. For coverage issued through the *Exchange*, an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;

9. A qualified individual or enrollee demonstrates to the *Exchange*, in accordance with guidelines issued by the U.S. Department of Health and Human Services, that the individual meets other exceptional circumstances as the *Exchange* may provide;

10. A qualified individual or his or her dependent is enrolled in an eligible employer-sponsored plan that is not qualifying coverage in an eligible employer-sponsored plan, as the term is defined in 45 C.F.R. § 155.300, and is allowed to terminate existing coverage

11. Loss of pregnancy related coverage;

12. Loss of medically needy coverage;

13. The *Exchange* determined that individual or dependent was not enrolled in a qualified heath plan, not enrolled in the qualified health plan selected by the individual, or is eligible for, but not receiving, advance payment of premium tax credits or cost-sharing reductions as a result of misconduct of a non-exchange entity; and

14. A qualified individual who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion State, who either experiences a change in household income or moves to a different State resulting in the qualified individual becoming newly eligible for advance payments of the premium tax credit.

The Plan is required to process enrollments through the *Exchange* 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. COVERED SERVICES

Benefits will be provided ONLY for those covered services that are furnished on or after the effective date of this Policy and after any waiting period applicable to such services for covered individuals age 19 and older as set forth in the attached Schedule of Benefits.

20. WHEN AND HOW BENEFITS ARE PROVIDED

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.

21. 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.

22. CONFORMITY WITH STATE STATUTES:

Any provision of this Policy that on its effective date is in conflict with the laws of the state in which the *subscriber* resides on that date is hereby amended to conform to the minimum requirements of the laws.

23. CHOICE OF LAW

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

24. LEGAL ACTIONS

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

25. ENTIRE CONTRACT; CHANGES

This Policy, including the *Schedule of Benefits*, Policy Declarations and any applicable rider(s) or attachments, and the Application constitute the entire contract of insurance. No change in this Policy shall be valid until approved by an officer of *the Plan* and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Policy or to waive any of its provisions.

26. APPEALS/COMPLAINT PROCEDURES

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

. If a satisfactory dentist-patient relationship with the s*ubscriber* and/or his/her dependent(s) cannot be established or maintained after the selection of three *Participating Dentists or Non-Participating Dentist*,during the term of the contract, then coverage of the *subscriber* and his/her dependents will terminate after *the Plan* gives the *subscriber* written notice at least thirty (30) days before termination. A *pro rata* refund of the unearned portion of the premium will be made.

Appeals from *adverse benefit determinations* may be directed to the Quality Assurance Department of DentaQuest National Insurance Company, Inc., c/o DentaQuest Management, Inc., at P.O. Box 2906, Milwaukee, WI 53201 within one hundred and eighty (180) days.

All other complaints (hereinafter "Complaints") may be directed to the Quality Assurance Department of DentaQuest National Insurance Company, Inc., c/o DentaQuest Management, Inc., at P.O. Box 2906, Milwaukee, WI 53201 within one hundred eighty (180) days of the date of service or occurrence. The Quality Assurance Department: will handle the Complaint and attempt to resolve it in an equitable and fair manner. If the Complaint is of an administrative nature, the Quality Assurance Department may resolve it alone or may assign its disposition to the Member Services or Provider Relations Departments. If the Complaint relates to the performance or nonperformance of dental services, the Quality Assurance Department will attempt to resolve it through discussions with the members' *Participating Dentist or Non-Participating Dentist*, the member, and if necessary, a consulting dentist. *The Plan* will initially respond to the Complaint within twenty (20) days from the date the Complaint is filed. The disposition of the Complaint shall be communicated orally or in writing to the Complainant within thirty (30) to sixty (60) days of receipt of the Complaint. This time period may be extended by mutual agreement. The date and disposition of the Complaint shall be recorded.

A *covered individual* who is dissatisfied with the disposition of the Complaint may seek a review by the Dental Advisory Board (the "Board") of DentaQuest National Insurance Company, Inc., c/o DentaQuest Management, Inc., at P.O. Box 2906, Milwaukee, WI 53201. A request for review by the Dental Advisory Board shall be initiated by a written request to the Board within fourteen (14) days following receipt of the decision on the initial Complaint. This fourteen (14) day period may be extended by mutual agreement of the parties. The Board shall have thirty (30) to sixty (60) days to review the case and to reach a consensus. The Board may call members of the Quality Assurance department and consultants and the patient in its review. The Board will then have ten (10) working days to notify the Complainant in writing of its decision. If the Complainant is dissatisfied with the result, the Complainant may request that the Board's decision be reviewed by the President of DentaQuest National Insurance Company, Inc., within fourteen (14) days following receipt of the Board's decision. The President shall have thirty (30) days to review the record and may call members of the Quality Assurance Department, the Board, consultants, and the patient in this process. The decision of the President shall be sent in writing to the Complainant and shall be considered final. All records concerning a Complaint shall be kept on file for five (5) years.

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

IMPORTANT INFORMATION ABOUT YOUR INSURANCE

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

DentaQuest National Insurance Company, Inc.
c/o DentaQuest P.O. Box 2906
Milwaukee, WI 53201
Telephone: 1-877-453-8429

If you are unable to contact or obtain satisfaction from DentaQuest National Insurance Company, Inc. or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

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

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

If there are any questions regarding an appeal or complaint concerning the health care services

provided which have not been satisfactorily addressed by *the Plan*, you may contact the Office of the Managed Care Ombudsman for assistance at:

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

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

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

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

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

26. DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

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

27. REINSTATEMENT

If the renewal premium is not paid before the grace period ends, the Policy will lapse. Later acceptance of the premium by *the Plan* or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the Policy. If *the Plan* or its agent requires an application for reinstatement, the *subscriber* will be given a conditional receipt for the premium. If the application is approved the Policy will

be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless *the Plan* has previously written the *subscriber* of its disapproval. The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than 10 days after such date, with the exception of pediatric essential health benefits which are not subject to the reinstatement waiting period. In all other respects the rights of the *subscriber* and *the Plan* will remain the same, subject to any provisions noted or attached to the reinstated Policy. Any premiums *the Plan* accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

28. UNPAID PREMIUM

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

29. PHYSICAL EXAMINATIONS.

The *Plan* at its own expense shall have the right and opportunity to examine a *covered individual* when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Part V Filing a Claim

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

2. WHO FILES A CLAIM: *Participating Dentists or Non-Participating Dentist* will file claims directly to us for the services covered by this *contract*. We will make benefit payments within sixty (60) days to them.

3. NOTICE OF CLAIM: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to *the Plan* at DentaQuest National Insurance Company, Inc., c/o DentaQuest Management, Inc., P.O. Box 2906, Milwaukee, WI 53201, or to *the Plan's* agent. Notice should include the name of the *covered individual*, and claimant if other than the *covered individual*, and the Policy number.

4. CLAIM FORMS: When *the Plan* receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days after the giving of such notice, the claimant shall meet the proof of loss requirements by giving *the Plan* a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

5. PROOFS OF LOSS: Written proof must be given within 90 days after a loss. If it was not reasonably possible to give written proof in the time required, *the Plan* shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

6. TIME OF PAYMENT OF CLAIMS: Benefits for any loss covered by this Policy will be paid as soon as *the Plan* receives proper written proof.

7. PAYMENT OF CLAIMS: The Plan may pay all or a portion of any dental benefits provided to a Participating Dentist, or to a Non-Participating Dentist who submits a claim on behalf of a subscriber, unless the subscriber directs otherwise in writing by the time proofs of loss are filed. Benefits for services provided by a Non-Participating Dentist will be paid to the subscriber if the subscriber submits the claim to the Plan. Any benefits unpaid at death may be paid at the Company's option, either to the insured's beneficiary or the insured's estate

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

Part VI Index

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

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DentaQuest National Insurance Company, Inc.
96 Worcester Street
Wellesley Hills, MA 02481
Customer Service Department 1-877-453-8429

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DentaQuest National Insurance Company, Inc.

96 Worcester Street, Wellesley Hills, MA 02481

SCHEDULE OF BENEFITS
PPO for Individuals and Families
Family Basic Option

To be attached to and form a part of the DentaQuest National Insurance Company, Inc., (*the Plan*), PPO for Individuals and Families Policy.

You should read your Policy carefully. Benefits for covered services described in the Policy are reimbursed as follows:

COVERAGE

In-Network Benefits		Out-of-Network Benefits
Diagnostic and Preventive Services		
The Plan pays 100% of covered charges for 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 Participating Dentist.*
Restorative and other Basic Services		
The Plan pays 40% of covered charges for covered charges up to the *fee schedule* amounts for services by a *Participating Dentist* for individuals under age nineteen (19). *The Plan* pays 50% of covered charges for covered charges up to the *fee schedule* amounts for services by a *Participating Dentist* for individuals age nineteen (19) and older.		The Plan pays 40% of covered charges up to the fee schedule amounts for services by a Participating Dentist for individuals under age nineteen (19).* The Plan pays 50% of covered charges up to the fee schedule amounts for services by a Participating Dentist for individuals age nineteen (19) and older.*
Complex and Major Restorative Dental Services		
The Plan pays 40% of covered charges for covered charges up to the *fee schedule* amounts for services by a *Participating Dentist* for individuals under age nineteen (19).		The Plan pays 40% of covered charges up to the fee schedule amounts for services by a Participating Dentist for individuals under age nineteen (19).*
Orthodontic Services **(Under age 19 only)**		
The Plan pays 40% of covered charges for covered charges up to the *fee schedule* amounts for medically necessary orthodontic services by a *Participating Dentist. The Plan* does not pay any portion of charges exceeding the *fee schedule* amounts.		The Plan pays 40% of covered charges up to the fee schedule amounts for services by a Participating Dentist for individuals under age nineteen (19).*

NOTE: *Non-participating dentists* are permitted to charge for the difference between the *fee schedule* and the *non-participating dentist's* billed charges. You may be required to pay more for services obtained from a *non-participating dentist* than the same services provided by a *participating dentist.

The following list of benefits applies only *to covered individuals* under age nineteen (19). These benefits will cease at the end of the month in which the *covered individual* turns age nineteen (19).

DIAGNOSTIC AND PREVENTIVE SERVICES

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

Comprehensive oral examination (including the initial dental history and charting of teeth); once every six (6) months, beginning with the eruption of the first tooth.

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); twice every calendar year.

Single tooth x-rays; as needed.

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

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

Fluoride treatment; twice every calendar year.

Space maintainers required due to the premature loss of teeth; once every 2 years per quadrant (unilateral) and per arch (bilateral) and not for the replacement of primary or permanent anterior teeth.

Sealants on unrestored permanent molars; once per tooth. Sealants are not covered when placed over restorations.

RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or *fractured* teeth (note: teeth must have a good prognosis to qualify for benefits); (b) repair removable prosthodontics (e.g. dentures); (c) rebase or reline removable prosthodontics; (d) repair fixed prosthodontics (e.g., bridges, crowns, onlays, retainers, pontics); (e) recement bridges, crowns and onlays; and (f) remove diseased or damaged natural teeth. Examples of these services include:

Fillings consisting of silver amalgam and synthetic tooth color fillings, but limited to one filling for each tooth surface every twelve (12) months. No benefits are provided for replacing a filling twelve (12) months of the date that the prior filling was furnished on the same tooth.

Protective restorations.

Stainless steel crowns.

Simple tooth extractions.

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

Repair of dentures or fixed bridges.

Recementing of fixed bridges.

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

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

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

Local anesthesia.

Occlusal guard (for grinding and clenching of teeth).

Onlay - porcelain/ceramic- 4 or more surfaces; One per 60 months.

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, removal of odontogenic cyst or tumor or growths, incision and drainage of abscess, occlusal orthotic device (covered only for temporomandibular pain, dysfunction or associated musculature), frenulectomy, and frenuloplasty. Frenulectomy and frenuloplasty are covered once per lifetime, per patient. Additional oral and maxillofacial surgery services include tooth reimplantation or stabilization due to accident, biopsy of oral tissue and brush biopsy, and alveoloplasty. Alveoloplasty is covered once per quadrant, per lifetime.

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

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

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

Provision Splinting; once per tooth.

Bone replacement graft, pedicle soft tissue graft procedure, and subepithelial connective tissue graft procedure.

Endodontic services for root canal treatment of primary and permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, pulp caps, pulpotomy, pulpal regeneration, pulpal debridement, pulpal therapy, retrograde filling (per root) and retreatment of previous root canal therapy. Vital pulpotomy is limited to deciduous teeth. Retrograde filling is limited to one per lifetime per tooth. Retreatment of previous root canal therapy is limited to one per lifetime per tooth (anterior and bicuspid).

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.
- 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.

− For the replacement of permanent teeth.

Endosteal implants in lieu of a three-unit bridge

Fixed Prosthodontics

Crowns and Onlays

Crowns and onlays as follows, but only when the teeth cannot be restored with the

fillings due to severe decay or *fractures* (note teeth must have a good prognosis to qualify for benefits):

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

Pontics will be covered once per tooth every sixty (60) months.

Retainer will be covered once per tooth every sixty (60) months.

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

Apicoectomy/periradicular surgery once per tooth per lifetime

Removable prosthesis; once per arch per sixty (60) months.

Maxillofacial prosthetics (feeding aid only)

Veneers (Medically Necessary); once per tooth every sixty (60) months when tooth qualifies for crown.

ORTHODONTIC SERVICES

Medically Necessary Orthodontics

- Medically necessary pediatric orthodontia exists when there is a severe, dysfunctional, handicapping malocclusion. Orthodontic services require prior authorization.
- Medically necessary orthodontic services includes:
  - Replacement of a lost or broker retainer; one per day per provider or location per arch; and
  - Removable and fixed appliance therapy, including appliances for thumb sucking and tongue thrusting; fixed appliance therapy is covered once per lifetime per patient

The following list of benefits applies to *covered individuals* age 19 and over. These benefits begin on the first day of the month following the month in which the *covered individual* turns age 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 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 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.

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* in each calendar year. The total deductible payment for all *covered individuals* in a family shall not exceed $150 for Restorative and other Basic Services, and Complex and Major Restorative Dental Services. This means the *covered individual(s)* must pay the first $50 of benefits provided in each calendar year, not to exceed $150 for families with three or more *covered individuals*. No family member will be required to meet more than the $50 deductible in each calendar year.

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

Total benefits are limited to a maximum of $1000 for each *covered individual* for each calendar year.

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

The *out of pocket maximum* is $400 every calendar year. The *out of pocket* maximum applies per *covered individual* under age 19. 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. Adult coverage has an unlimited *out of pocket maximum.* No family member under age 19 will be required to meet more than the $400 *out of pocket maximum* per calendar year. The *out of pocket maximum* applies only to in-network services.

WAITING PERIOD

For *covered individuals* age 19 and older, Restorative and other Basic Services are subject to a six (6) 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 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 balance resulting from plan specific deductibles.

OUT-OF-NETWORK SERVICES:

The subscriber or covered individual is responsible for paying the non-participating Dentist the difference between the dentist's fee and the amount paid by the Plan, including the difference between the Plan's payments and any balances resulting from plan specific deductibles and coinsurance.

CLAIMS SUBMISSION:

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

NOTE: Italicized terms are defined in the Policy.

If you have questions about this coverage, please contact our Account Service Department at 1-877-453-8429.

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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