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

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

Fluoride treatment Topical Fluoride - Varnish - 1 every 12 months, Topical application of fluoride (excluding prophylaxis) - 1 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 4 years.

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 (resin-based) tooth color fillings; once every twelve (12) months per tooth. 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.

Protective restorations (sedative fillings).

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

Simple tooth extractions.

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

Nitrous oxide when medically necessary.

Non-intravenous conscious sedation when medically necessary.

Therapeutic drug injection when medically necessary.

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.

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

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:

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

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.

Inlays are paid as an alternative benefit of amalgam.

Implants- once every 60 months.

Prosthodontic services including dentures and bridges

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

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

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

Maxillofacial prosthetics

ORTHODONTIC SERVICES

Orthodontic services for individuals who are under age nineteen (19) who achieve a minimum Salzmann Evaluation Criteria Index score of forty-two (42) points. Other medically necessary qualifiers are considered. Orthodontic services require prior authorization.

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

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this 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.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints), except for covered medically necessary orthodontics for individuals under age 19.
- Services that are meant primarily to change or to improve your appearance.
- Repair or reline of an occlusal guard.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Lab exams.
- Photographs.
- Duplicate dentures and bridges.
- Services related to congenital anomalies unless otherwise covered. However, this exclusion does not apply to covered orthodontic services.
- Occlusal adjustment.
- Dietary advice and instructions in dental hygiene including proper methods of 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.
- Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
- Transitional implants.
- Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomies, root amps, ridge augmentations and dental implant placements.
- Sinus lifts.
- Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
- Cone Beam Imaging and Cone Beam MRI procedures
- Topical medicament center

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. 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 for the calendar year.

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:

For services performed by a *Non-participating Dentist*, *the Plan* will pay the dentist directly by applying the out-of-network benefit coinsurance payments for each type of service against the maximum allowable charge indicated on the negotiated *Plan* Fee Schedule, or the dentist's submitted fee if lower.

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

CLAIMS SUBMISSION:

All claims for benefits under this *Agreement* must be submitted within ninety (90) days of the 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) 876-3980.

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].

ضالررية Arabic: ن---م ن---ود ي---اقفلك------تة. للتحدث مع ت----مرجم ت----صل ب [1-844-876-3981] ن--إ ن---الكديك وأل----د ص---خش دعاس-تةلوئس--------أصوص-----خب ب---------لكغ

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 પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેિળ્ નો અિવક ર છે. તે ખ્યચ્ િવન તમ રી ભ ષમ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષો િ ત િકર મ ટે,આ [1-844-876-3981] પર કોલ કરો.

Hindi: के बारे मΛ प्रश्न ह, ,तो आपके पास अपनी भाषा मΛ मुफ्त मΛ सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषषए से बात करने के िलए , [1-844-876-3981] पर कॉि करΛ।

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, Louisiana, Tennessee, 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።