DentaQuest EPO Group Dental Services Binder and Agreement

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

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This Group Dental Services Binder and Agreement ("Agreement") is made on the date and year noted below by and between DentaQuest of Florida, Inc., a Florida Corporation, ("DentaQuest"), and _________________________________ ("Group").

1 DEFINITIONS. For purposes of this Agreement, capitalized words and phrases have the meaning specified in the Definitions section.

2 ENGAGEMENT. Group hereby agrees to engage DentaQuest to provide Dental Services to Members, and DentaQuest agrees to provide such Dental Services pursuant to the terms, conditions and limitations set forth in this Agreement and the attachments hereto.

3 ENROLLMENT PROCEDURES

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

A. Annual Open Enrollment Period. A Qualified Employee may enroll for coverage during an Annual Open Enrollment Period. The employee must apply for coverage through his or her employer or the Marketplace. The Annual Open Enrollment Period will occur annually on dates established by the Marketplace. The Annual Open Enrollment for 2016 will begin November 1, 2015 and end January 31, 2016. The effective date of coverage will depend on the enrollment date. Qualified Employers may also change plans at this time and enrollees will be notified in writing about the Annual Open Enrollment Period in September of each Plan Year.

B. Automatic Enrollments. The Marketplace may automatically enroll Qualified Employees and his or her eligible dependents for good cause which will be determined by the Marketplace.

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

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

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

Loss of minimum essential coverage is any event that triggers a loss of eligibility for other minimum essential coverage. No triggering events include:

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

INITIAL ENROLLMENT. Individuals who meet the eligibility requirements of Group during the initial enrollment period will be covered on the effective date of this Agreement, provided Group sends DentaQuest notification thereof, and provided further that DentaQuest has received the required premiums. Group’s eligibility requirement must strictly comply with all applicable federal and state laws, rules and regulations. DentaQuest reserves the right from time to time, to verify Member’s eligibility.

OPEN ENROLLMENT. An open enrollment period(s) of at least thirty (30) days, each Plan Year this Agreement is in effect, will be designated and agreed upon by DentaQuest and Group. During this open enrollment period(s), the following may occur:

1. Eligible Members may elect coverage for themselves and any dependents
2. The Primary Subscriber may make changes to his/her coverage.

4. COVERAGE EFFECTIVE DATE. A Qualified Employee or his or her dependent’s enrollment in this plan during an Initial, Annual or Special Enrollment Period will be effective as of the date provided to Us by the Marketplace.

5. ELIGIBLE DEPENDENTS. The Qualified Employee may elect coverage for the following eligible dependents:

A. The legal spouse of the Qualified Employee.

B. The domestic partner of the Qualified Employee with proper legal documentation, if domestic partnership is accepted by the Group.

C. The dependent child of the Qualified Employee or spouse, or child of a domestic partnership (if coverage elected by Group) who is under the age of twenty-six.

D. Any unmarried child who currently has coverage will be eligible for benefits beyond the age of 26 if he or she:
   a. is incapable of self-sustaining employment by reason of mental or physical handicap or disability
b. is predominately dependent upon the Qualified Employee for support and maintenance.

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

6 ENROLLING DEPENDENTS. Eligible dependents must be included on the Qualifying Employee’s initial application in order to be enrolled in this plan. Other eligible dependents may be added to the Qualifying Employee’s coverage only during the Annual Open Enrollment Period of if eligible, Special Enrollment Periods.

Primary Subscribers desiring to add Dependents to their coverage due to a change in status created by the following circumstances must do so within thirty (30) days of the date of the event the dependent became eligible:

B Newly acquired Spouse, Domestic Partner (if coverage offered) or other newly acquired Dependent children may be added to Primary Subscriber’s coverage prior to open enrollment;

C Children who are legally adopted pursuant to Chapter 63, Florida Statutes, are considered Dependents from the moment of permanent placement in the residence of the Primary Subscriber, or from the moment of birth if a written agreement to adopt such child has been entered into by the Primary Subscriber prior to the birth of the child; or

D Newborn children of the Primary Subscriber or covered Dependents are eligible from the moment of birth.

7 TERM OF AGREEMENT. This Agreement between DentaQuest and the Group is for an initial term of 12 months commencing as of the Group Effective Date and will automatically renew for successive terms of 12 months unless terminated or non-renewed as provided for in this Agreement.

8 TERM OF COVERAGE. Enrollment in a DentaQuest plan will be for a minimum period of twelve (12) consecutive months unless the Group requests, in writing, termination of this Agreement.

Once coverage for a Member is voluntarily terminated by the Member, the Member can only re-enroll during an Annual Open Enrollment Period or if eligible, a Special Enrollment Period, provided that all eligibility requirements are met.

9 RENEWAL OF CURRENT COVERAGE. DentaQuest guarantees the Group the right to renew this plan each year. DentaQuest will send the Group a renewal packet 60 days prior the plan renewal date which must be signed and returned within 30 days of the renewal date in order to renew this plan.

However, DentaQuest may refuse to renew this plan if one of the following circumstances has occurred:

A. Failure to timely pay premium in accordance with the terms of this plan;
B. DentaQuest ceases offering this plan to all Members;
C. The Qualified Employee has performed an act or practice constituting fraud or misrepresentation of a material fact;
D. The Primary Subscriber no longer lives in the DentaQuest Service Area; or
E. DentaQuest elects to discontinue offering dental coverage through the Health Insurance Marketplace.

10. RESCISSION DentaQuest will rescind coverage due to an act or practice constituting fraud or an intentional misrepresentation of a material fact. We will provide the Group thirty (30) days advance written notice before coverage is rescinded.
11. TERMINATION OF GROUP COVERAGE. The Group may terminate this plan at any time with appropriate notice of at least 14 days to either DentaQuest or the Health Insurance Marketplace. Coverage will terminate on the date specified or 14 days after termination is requested, whichever is later.

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

12. TERMINATION OF THIS PLAN DUE TO NON-PAYMENT OF PREMIUM

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

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

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

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

13. TERMINATION OF GROUP MEMBERSHIP Coverage for the Group and each Qualified Employee and his or her dependents will cease at midnight on the last day of the month prior to renewal if the Group fails to renew this plan. It is the Group’s obligation to immediately notify each Qualified Employee of any such termination.

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

A. A Members’ behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member’s continuing participation would impair DentaQuest’s or a Provider’s ability to provide covered Dental Services to Member or to other Members. DentaQuest will make a reasonable effort to resolve any conflict through the use of the grievance procedures;

B. A Member commits fraud or makes a material misrepresentation in seeking Dental Services;

C. A Member willfully misuses any documents provided as evidence of benefits available under this Agreement;

D. A Member furnishes to DentaQuest incorrect or incomplete information for the purpose of fraudulently obtaining covered Dental Services;

E. A Member permanently relocates from the DentaQuest Service Area;

F. Dependent no longer meets eligibility requirements to continue enrollment as established by the Marketplace.

Coverage for Dependents shall automatically terminate in the event the Qualified Employee is disenrolled. In the event the disenrolled Member is not the Qualified Employee, DentaQuest shall have the option to disenroll any Member listed on the terminated Qualified Employee’s enrollment card if the member is found to have committed any of the acts for disenrollment set forth in this Agreement. Such termination shall occur at 12:00 a.m., local time on the termination date.

14. TERMINATION OF COVERAGE BY THE HEALTH INSURANCE MARKETPLACE OR DENTAQUEST. The Health Insurance Marketplace may terminate the Group’s coverage in a
Qualified Health Plan and will also permit DentaQuest to terminate coverage for any of the following reasons:

A. Loss of eligibility to purchase a Qualified Health Plan through the Marketplace.
B. Nonpayment of premiums provided that the grace period has elapsed.
C. Coverage is rescinded.
D. DentaQuest terminates or is decertified by the Marketplace.
E. The Group switches to another Qualified Health Plan during an Annual Open Enrollment Period or a Special Enrollment Period.

14 TERMINATION OF GROUP COVERAGE. This Agreement may be terminated by the party not in default upon the occurrence of any of the following events. It is the Group’s obligation to immediately notify each Primary Subscriber of any such termination.

A. Any Premium payment is not made to DentaQuest when due in accordance with the terms of this Agreement. Termination of this Agreement as a result of Group’s failure to pay Premiums due to DentaQuest, will not relieve Group of the duty to pay such Premiums and shall not limit the right of DentaQuest to recover any monies or other damages to which it is entitled under the terms of the Agreement as provided by law.

B. Group or DentaQuest is in default hereunder, for any non-monetary reason, and said default is not cured within ten (10) days after the date of written notice which states with particularity the nature of the default, provided however, if the defaulting party has undertaken to cure such default, which is of a nature that cannot be cured within the ten (10) day period, and is diligently pursuing same, then the defaulting party shall be afforded an additional period of time, of reasonable duration, but in no event more than thirty (30) days in which to cure the default to the satisfaction of the other party.

a. DentaQuest or Group is declared bankrupt or enters into a judicially sanctioned arrangement for the benefit of creditors because of its insolvency, this Agreement may be terminated by the other party, provided that such termination is consistent with applicable law, upon thirty (30) days advance written notice to the other.

b. Termination or revocation by the Department of Financial Services, Office of Insurance Regulation of DentaQuest’s certificate of authority to operate a prepaid limited health services organization.

15. EXTENSION OF BENEFITS. If this Agreement is terminated for any of the reasons provided in the Termination provisions, except failure to pay Premiums (unless due to the acts of the Group), the Member may be entitled to Extension of Benefits. Termination of the Agreement by DentaQuest is without prejudice to any continuous loss which commenced while the Agreement was in force. Benefits will be extended until the specific covered treatment or procedure undertaken is completed or for ninety (90) days from the termination date, whichever is the lesser period of time.

DentaQuest Providers shall complete all treatments and procedures commenced on Members prior to the effective date of termination of the Agreement to the extent that such Members would have been entitled to receive such Dental Services had this Agreement continued in effect, subject to the following conditions:

1. During the period required for completion of such procedures, each Member shall continue to pay Fees, directly to the Participating Dentist, as required under the applicable Benefit Schedule and all exclusions and limitations in this Agreement will continue to apply during the extension;
2. The term “treatment or procedures commenced on such Member prior to the date of termination” shall be construed to mean only those treatments and/or operative dental procedures actually commenced but unfinished, such as prosthetic appliances which have been cast, and dentures commenced but unfinished, prior to the effective date of termination of the Agreement. It shall not include dental defects which may have been diagnosed, but on which treatment or operative work may not have been commenced, prior to the effective date of termination.

16. CONTINUATION OF BENEFITS. A Qualified Employee whose employment, membership or association with Group is terminated, for any reason, and any Dependent of said Qualified Employee, may elect within sixty (60) days of the effective date of termination to continue coverage with DentaQuest directly if he/she was enrolled in an DentaQuest plan at the time of termination. A Member may elect to continue coverage under any of the individual plans offered by DentaQuest.

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

A failing to pay Premium, unless the fault lies with the group;

B committing fraud or provided a material misrepresentation in applying for coverage;

C willfully and knowingly misusing the Member ID card;

D willfully and knowingly providing incorrect or incomplete information to fraudulently obtain coverage

E leaving the geographic service area for the purposes of relocation; or

F acting in a way that was so disruptive, unruly, abusive or uncooperative that continuing coverage would prevent DentaQuest from providing proper services to that person or to any other patients and the grievance process was unable to resolve the problem.

17. OBTAINING DENTAL SERVICES. DentaQuest contracts with Dentists to provide Dental Services to Members. To receive Dental Services, the Member must obtain treatment from a Participating Dental Office during regular office hours, except in the case of an emergency. Members may schedule appointments by contacting the Participating Dental Office directly, at any time on or after the Effective Date of coverage, and identifying themselves as a DentaQuest Member. Members must present an identification card at the time of the appointment in order to be eligible for the fees as stipulated in the applicable Benefit Schedule. A listing of Participating Dental Offices can be obtained by visiting our website at www.dentaquest.com.

18. PRE-EXISTING CONDITIONS. Members are eligible to receive all Dental Services. There are no exclusions for pre-existing conditions.

19. EMERGENCY COVERAGE. Members are covered for Emergency Dental Services at Participating Dental Offices. Emergency office visits may be subject to additional charges as stipulated in the applicable Benefit Schedule. Members are also covered for Emergency Dental Services while temporarily more than fifty (50) miles from a Participating Dentist. Palliative Treatment should be obtained from a licensed dentist and payment made for services rendered. DentaQuest will reimburse Members the usual and customary fees for covered dental services, subject to any applicable fees, not exceeding $100.00 per claim. To receive reimbursement, the Member must submit the following information to DentaQuest within ninety (90) days of the date of service: 1) paid receipt; 2) Member's name, identification number, address and phone number; 3) Qualified Employee’s name and identification number; and 4) any other supporting documentation necessary to process the reimbursement.
20. THIRD PARTY INJURY. If the services rendered hereunder are required due to injury caused by the negligence of a third person, and if the Member receives a recovery against the negligent party, or if the Member receives Workers' Compensation or insurance benefits, then any DentaQuest Provider shall be entitled to charge and collect from the Member, his/her usual, customary and reasonable fees for any dental services rendered up to the time and to the extent of recovery for such dental services.

21. MEMBER GRIEVANCE PROCEDURES. Members are encouraged to attempt to resolve any issues or grievances directly with the Participating Dentist. However, if a Member has a complaint or inquiry regarding any DentaQuest operations or services, the Member may make an informal grievance by calling the DentaQuest toll free at the number listed herein.

Members may also submit a formal grievance to DentaQuest, in writing within twelve (12) months of the incident. The written grievance must be specifically identified as a grievance, and must include a summary of the incident and a statement of the action requested of DentaQuest. The Member's name, address, identification number, signature, the current date, and a copy of the paid receipt, if the grievance involves a payment issue, must also be included. Formal grievances should be forwarded to:

DentaQuest of Florida, Inc.
PO Box 2906
Milwaukee, WI 53201-2906
1-800-964-7811
Monday-Friday: 8 a.m.-7 p.m. EST

Attention: Grievance Department

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

22. DENTAL RECORDS. Providers are required to keep records and charts of all Dental Services rendered to Members in accordance with the ADA code of Professionalism and Ethics. These records are the property of the Provider. Upon enrollment the Qualified Employee authorizes DentaQuest to request and obtain, for use exclusively by DentaQuest, Member records, radiographs or any other information from any dentist that has rendered treatment to the Member. Upon the request of the Member, the Provider will furnish copies of x-rays and service records. The Participating Dental Office has the right to charge the Member an amount not to exceed the amount charged by the Clerk of Courts for the specific county in which the Dental Office is located for photocopies of dental records and copies of x-rays requested by the Member. Neither any Provider nor DentaQuest will be required to transfer any original records or x-rays, unless required by law.

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

24. ADVERTISING. Any promotional, advertising, or informational materials prepared by or on behalf of the Group regarding DentaQuest Providers, and Participating Dental Offices shall be approved in advance of dissemination by DentaQuest. The Group agrees that it will not advertise the Dental Offices or solicit patients on behalf of any Provider. Group may, however, inform employees and others regarding Dental Services and benefits hereunder which are available to Members in accordance with the Benefit Schedules and the terms of this Agreement.

25. BILLING AND PREMIUM. In the event a monthly payment is not received by DentaQuest prior to the expiration of the grace period, DentaQuest may terminate all coverage effective as of the first day of the month following the month for which the premium was due. The Member’s obligation to pay all premium due while coverage remains in effect, shall survive termination of this Agreement.

Group must notify DentaQuest of changes in enrollment via proper written documents or approved electronic method at least ten (10) days prior to the desired effective date of the change. Clerical errors or delays in keeping or reporting data relative to coverage will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise be validly terminated. Upon discovery of such errors or delays, an equitable adjustment of changes will be made. In no event, however, will credits to Groups be made retroactive more than two (2) premium due dates prior to the date that DentaQuest is notified in writing of a requested addition/deletion to, or change in, a Member’s enrollment status.

The premium that began on the Group’s effective date will not change during the Plan Year. DentaQuest will give Group, written notice of any change in premium at least 45 days prior to implementation. The Group is responsible for notifying the Group’s members of any change in premium upon notice from DentaQuest.

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

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

28. COORDINATION OF THIS CONTRACT’S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan as defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans, does not exceed 100% of the total Allowable expense.
DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense. The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar
reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan’s payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers which have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary. (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan. D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows: (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

• The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
• If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
• The Plan covering the Custodial parent;
• The Plan covering the spouse of the Custodial parent;
• The Plan covering the non-custodial parent; and then
• The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.
EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Organization responsibility for COB administration may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Organization responsibility for COB administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Organization responsibility for COB administration any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Organization responsibility for COB administration may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Organization responsibility for COB administration will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Organization responsibility for COB administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

29. CONFORMITY WITH FLORIDA LAW. DentaQuest and this Agreement are governed by and subject to the laws of the State of Florida and the regulations and guidelines of the Florida Department of Financial Services, Office of Insurance Regulation. Notwithstanding any other provisions for amendment set forth in this Agreement, the enactment of any statute, act, ordinance, or rule or regulation of any governmental agent with enforcement authority over DentaQuest shall cause this Agreement to be automatically amended as necessary to comply with the law, rule or regulation. In the event that any provision of this Agreement is held to be illegal or invalid, it shall not affect the validity of the remaining provisions. Such remaining provisions shall remain in full force and effect. Jurisdiction and venue for any
and all proceedings directly or indirectly arising out of or related to this Agreement shall be in Miami-Dade County, Florida.

30. ATTORNEY’S FEES. If any legal action or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any provision of this Agreement, the prevailing party shall be entitled to recover reasonable attorney’s fees, (including without limitation, all such fees, costs and expenses incident to arbitration, appellate, bankruptcy and post judgment proceedings), incurred in that action or proceeding, in addition to any other relief to which such party may be entitled. Attorney’s fees, administrative costs, and all other charges filed by the attorney to the prevailing party.

31. NOTICES. All notices, requests, consents and other communications required or permitted under this Agreement shall be in writing and addressed as follows:

DentaQuest of Florida, Inc.
PO Box 2906
Milwaukee, WI 53201-2906

If DentaQuest sends notice, requests, consents or other communications to the Group, such notice will be sent in writing to the Group’s last known address on file, or to such other address as any party may designate by notice complying with the terms of this section. Each such notice shall be conclusively deemed to have been given on the day of actual delivery thereof, and if given by facsimile, on the day of transmittal thereof if given during the normal business hours of the recipient, and on the next business day during which such normal business hours next occur if not given during such hours on any day.

32. THIRD PARTIES. Unless expressly stated herein, this Agreement does not create, and shall not be construed as creating, any rights enforceable by any person not a party to this Agreement. Group shall be solely responsible to its Members covered under this Agreement, to advise them of the terms and conditions hereof and shall make accessible a true and correct copy of this Agreement for their review and consideration during reasonable business hours.

33. ASSIGNMENT. You may not assign, delegate or otherwise transfer this Group Agreement and the obligations hereunder without the written consent of DentaQuest. Any assignment, delegation, or transfer made in violation of this provision shall be void. DentaQuest may assign, delegate, or otherwise transfer this Group Agreement to its successor in interest or an affiliated entity without your consent at any time.

34. NON DISCRIMINATION. DentaQuest may not expel or refuse to renew the coverage of or refuse to enroll any individual member of a subscriber group on the basis of the race, color, creed, handicap, marital status, sex, or national origin of the subscriber or individual.

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

36. DEFINITIONS:

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

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

“Agreement” means this written document which is the agreement between the Group and DentaQuest whereby coverage and benefits specified herein will be provided to enrollees. The Binder and Agreement, Certificate of Coverage, Plan Information Page, group and employee applications, addenda
exhibits, riders, schedules of benefits and any amendments which may be incorporated in this Agreement from time to time constitutes the entire agreement between the Group and DentaQuest.

“Annual Maximum/Maximum Benefit” means the total payment amount DentaQuest will make per Member for covered dental services per Plan Year.

“Benefit Schedule” or “Benefit Schedules” shall mean those dental services to which a Member is entitled, subject to all provisions, definitions, and limitations outlined in this Agreement.

“Certificate of Coverage” means this written document which is incorporated into the agreement between the Group and DentaQuest whereby coverage and benefits specified herein will be provided to Members.

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

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

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

“Effective Date of Coverage” or “Effective Date” shall mean, as to an individual Member, the first (1st) day of the month after such Eligible Member has enrolled, has satisfied any applicable waiting period including a Dependent of the Qualified Employee.

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

“Enrollee” means a Qualified Employee and his or her qualified dependents enrolled in a Qualified Health Plan.

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

“Fees” shall mean the specific dollar amount or percentage discount, as specified in the applicable Benefit Schedule(s), payable by the Member directly to the Provider upon receipt of covered Dental Services.

“Group, Qualified Group” shall mean any employer, union, association, or other such group which contracts with DentaQuest for receipt of Dental Services and applies through the Marketplace. With respect to Agreements sold outside the Marketplace, Qualified Group will mean a group that contracts with DentaQuest for receipt of Dental Services.

“Group Effective Date of Coverage” with respect to the Group and to the Group’s eligible members properly enrolled when coverage first becomes effective, means 12:00 a.m., local standard time on the date so specified on the Group Agreement.

“Health Insurance Marketplace (Marketplace)” means a governmental agency or non-profit entity that makes Qualified Health Plans available to Qualified Individuals. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges and a Federally-qualified Exchange.
“Identification Card” shall mean, a card issued by DentaQuest to Members enrolled under this Agreement. The Identification Card is the property of DentaQuest and is not transferable to another person. Possession of such card in no way verifies eligibility to receive benefits under this Agreement.

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

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

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

“Plan Year” means a period of twelve (12) consecutive months as determined from the Effective Date of the Group’s coverage with DentaQuest. A Plan Year may be a calendar year or otherwise.

“Premium” shall mean the advance payments due to DentaQuest by Group on behalf of Members to receive Dental Services as set forth in this Agreement.

“Primary Subscriber” shall mean the employee or member of the Group who is eligible to enroll on behalf of himself/herself and his/her Dependents with DentaQuest for Dental Services.

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

“Qualified Employee” shall mean the employee or member of the Group who is eligible to enroll on behalf of himself/herself and his/her Dependents with DentaQuest for Dental Services through the Marketplace. With respect to Agreements sold outside the Marketplace, Qualified Employee will have the same meaning as Primary Subscriber.

“Specialty Care” shall mean dental services that meet the criterion set forth by the American Dental Association required from recognition as specialty care.

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

“Waiting Period” shall mean the period of time, during which the Primary Subscriber is a member of Group but is not eligible to enroll to receive Dental Services.
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 1-844-241-5605.

**Chinese:** 面對問題，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] 1-844-241-5605。

**Vietnamese:** quý vị có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một người dịch viên, xin gọi 1-844-241-5605.

**Arabic:** صوصخب، وليس أحد يستطيع الذهاب للبلد، ومن ثم يوجد لديهم حق الحصول على مساعدة والمساعدة والتوجيه لأعضاء أسرهم بغير أي ضرائب. للتحدث مع مراسل، الرجاء التصالح على 1-844-241-5605.

**Korean:** 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-241-5605 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 1-844-241-5605.

**Russian:** то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-241-5605.

**Spanish:** tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-241-5605.

**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 1-844-241-5605 an.

**Tagalog:** may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makuasa ang isang tagasalin, tumawag sa 1-844-241-5605.

**Gujarati:** વિશે પ્રશ્નો કેટલી તો તમને માહિતી અને મેદાની મદદ અને તમને પણ પણ પણતારી શક શક્તિ પર નાણા પણ કરી શક્ય છે. તે ભારતીય તમ સૌ જ માં પુષ્પ કરા શક શક શક્તિ મે એ, આ 1-844-241-5605 પર કોલ કરો.

**Hindi:** के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में समय में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी तिथि भाषण से बात करने के लिए , 1-844-241-5605 पर कॉल करें।

**Italian:** hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-241-5605.

*Products underwritten by DSM USA 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 Tennessee and Texas.

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、1-844-241-5605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 1-844-241-5605.

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 1-844-241-5605.

Polish: masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-241-5605.

Amharic: ሰብዱ ከሆነ፣ ያለ ከምንም ከርጥ እርዳታና መረጃ ከማግኝት ከሚባል ከሆነ። ከስተርጓሚ ከር ከም ከርፋ ከሚባል 1-
844-241-5605 ከሆነ።