Subscriber’s Certificate

DentaQuest PPO for Groups

[Plan Sponsor Name]

DSM USA Insurance Company, Inc. certifies that you have the right to benefits for services according to the terms of this Subscriber Certificate and the Agreement. This Subscriber Certificate is part of the DentaQuest PPO for Groups Account Dental Service Agreement.

Preferred Provider Policy Disclosure. This Subscriber Certificate 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.

ATTEST: DSM USA Insurance Company, Inc.

Steven J. Pollock
President
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Introduction

This Subscriber Certificate is part of the Agreement between your Plan Sponsor and DSM USA Insurance Company, Inc., (The Plan). We urge you to read it carefully.

The dental services described in this Subscriber Certificate (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 Subscriber Certificate. Please refer to the Schedule of Benefits, attached to this Subscriber Certificate, which outlines the specific coverage purchased by your Plan Sponsor.

If you have any questions, please contact your Plan Sponsor or our Customer Service department 1-844-876-3982.

Subscriber’s Rights and Responsibilities

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

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

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

You have the responsibility to:

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

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

• Be familiar with the Plan benefits, policies and procedures, by reading our written materials, or calling our Customer Service department.
Part I

Definitions


Agreement: refers to the DentaQuest PPO for Groups Dental Agreement, a contract between the Plan and your Plan Sponsor that provides benefits for dental services. The DentaQuest PPO for Groups Agreement includes the Subscriber’s Certificate, Schedule of Benefits, Group Application, Enrollment Form, and any applicable Riders, Endorsements and Supplemental Agreements.

Appeal: a protest filed by a covered individual or a health care provider with the Plan under its internal appeal process regarding a coverage decision concerning a covered individual.

Benefit Period: the twelve (12) month period for which any applicable deductibles or maximums apply. The Benefit Period is the Plan Year.

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, as shown on our records, on which your coverage begins under this Subscriber Certificate or an amendment to it.

Exchange: The Small Business Health Options Program 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, other than temporary guardianship of less than 12 months duration, and grandchildren in your court-ordered custody who are dependent upon you are covered.

Fee Schedule: the payment amount for the services that may be provided by Participating or Non-participating dentists under this Subscriber Certificate. Benefits are payable in accordance with the terms and conditions of the applicable Schedule of Benefits attached to this Subscriber Certificate and in effect at the time services are rendered.
**Fracture**: the breaking off of rigid tooth structure not including crazing due to thermal changes or chipping due to attrition.

**Health care provider**: any hospital or person that is licensed or otherwise authorized in the State of Georgia to furnish health care services.

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

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

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

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

**Participating Dentist**: a licensed dentist who 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.

**Plan Sponsor**: the person or organization that is your representative if you are a subscriber of a group plan. In the case of an employment group subject to the Employee Retirement Income Security Act of 1974, as amended, the employer is the Plan Sponsor designated under that act. The Plan Sponsor is your agent and is not the agent of the Plan. The Plan Sponsor sends to us the subscription charge due from you and receives all notices from us for you. We will send your Plan Sponsor any subscription refund due to you. It is the Plan Sponsor’s responsibility to notify you of changes.

**Plan Year**: a consecutive 12-month period during which the Plan provides benefits under the Agreement. A Plan Year may be a calendar year or otherwise.

**Qualified Employer**: has the meaning ascribed to the term in 45 C.F.R. § 155.20.

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

**Subscriber**: an employee or Covered Individual certified by the Plan Sponsor, 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 for the minor dependent.

**Plan**: refers to DSM USA 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 Subscriber Certificate. The benefits are limited to a maximum dollar payment for each covered individual for each benefit period. The extent of your benefits is explained in the Schedule of Benefits your Plan Sponsor has purchased and which is incorporated as a part of this Subscriber Certificate.

The following list of benefits applies only to covered individuals under age nineteen (19).

DIAGNOSTIC AND PREVENTIVE SERVICES

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

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

Periodic exam; once every six (6) months.

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

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

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

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

Fluoride treatment Topical Fluoride - Varnish - 2 every 12 months, Topical application of fluoride (excluding prophylaxis) - 2 every 12 months.

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

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

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

RESTORATIVE AND OTHER BASIC SERVICES

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

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

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

Protective restorations.

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

Simple tooth extractions.

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

Consultations.

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

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

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

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

Vital pulpotomy and pulpal therapy is limited to deciduous teeth.

**COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES**

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

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

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

Inlays are paid as an alternative benefit of amalgam.

Implants- once every 60 months.

Dentures and Bridges

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

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

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

- Initial placement of crowns and onlays.

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

ORTHODONTIC SERVICES

Orthodontic services for members who have a severe handicapping as the result of a deep impinging overbite that shows palatal impingement of the majority of lower incisors, true anterior overbite, anterior crossbite, impacted incisors or canines, overjet greater than 9mm, negative overjet greater than 3.5mm, cleft palate/lip deformities and other significant craniofacial anomalies, or malocclusions requiring a combination of orthodontics and orthognathic surgery for correction.

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

DIAGNOSTIC AND PREVENTIVE SERVICES

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

Comprehensive oral examination (including the initial dental history and charting of teeth); once every sixty (60) months.

Periodic exam; twice every Plan 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 Plan Year.

Single tooth x-rays; as needed.

Routine cleaning, scaling and polishing of teeth; twice every Plan Year.

**RESTORATIVE AND OTHER BASIC SERVICES**

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth (note: teeth must have a good prognosis to qualify for benefits); (b) repair dentures or bridges; (c) rebase or reline dentures; and (d) repair or recement bridges, crowns and onlays.

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist’s charge. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.

Protective restorations; once per tooth every sixty (60) months.

Simple tooth extractions.

General anesthesia only when necessary and appropriate for impacted wisdom teeth removal and only when provided by a licensed, practicing dentist.

Repair of dentures or fixed bridges; once every twelve (12) months. Recementing of fixed bridges; once each twelve (12) months.

Rebase or reline dentures; once every thirty-six (36) months.

Tissue conditioning; two treatments every thirty-six (36) months.

Repair or recement crowns and onlays. Recementing is limited to once every twelve (12) months per tooth.

Adding teeth to existing partial or full dentures; once per tooth every twelve (12) months.

Palliative (emergency) treatment of dental pain – minor procedures; three (3) times every Plan Year.

**COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES**

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

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

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

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

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

Dentures and Bridges

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

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

- Temporary partial dentures as follows:
  - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.

Crowns and Onlays

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

- Initial placement of crowns and onlays.

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

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of the Subscriber Certificate. 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 Subscriber Certificate: 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 Subscriber Certificate even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

2. WE DO NOT PROVIDE BENEFITS FOR:

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 Subscriber Certificate.
- 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 Subscriber Certificate.
- 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.
• Nitrous oxide.
• Oral sedation.
• Topical medicament center.

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

• Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
• A service or procedure that is not described as a benefit in this Subscriber Certificate.
• Services that are rendered solely due to the requirements of a third party, such as an employer or school.
• Travel time and related expenses.
• An illness or injury that we determine arose out of and in the course of your employment.
• A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Subscriber Certificate.
• An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare.
• A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
• A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
• Appointments with your dentist that you fail to keep.
• A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
• Prescription drugs.
• A service to treat disorders of the joints of the jaw (temporomandibular joints).
• Services that are meant primarily to change or to improve appearance.
• Implants.
• Transplants.
• Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
• Lab exams.
• Photographs.
• Duplicate dentures and bridges.
• Services related to congenital anomalies unless otherwise covered.
• Consultations.
• Tooth bleach.
• Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
• Transitional implants.
• Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomies, root amps, ridge augmentations and dental implant placements.
• Sinus lifts.
• Treatment of dental implant failures including surgical debridement and bone grafts to repair implant.
• Veneers.
• Occlusal guards.
Part IV

Other Contract Provisions

1. BENEFIT PAYMENTS FOR SERVICES BY A PARTICIPATING DENTIST

The amount if any, that you may be required to pay your Participating Dentist is explained in the Schedule of Benefits your Plan Sponsor has purchased. Payments are made directly to Participating Dentists from the 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 Plan Year, including the service that caused you to reach the maximum.

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

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

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. BENEFIT PAYMENTS FOR SERVICES BY NON-PARTICIPATING DENTISTS

Benefits for covered services provided by a Non-participating Dentist are based on the lesser of the dentist’s submitted fee or the payment amount for services that may be provided by Participating or Non-participating Dentists as indicated on the Fee Schedule. 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.

You will be responsible for paying any difference between the Plan’s payment to a Non-participating dentist, after any deductible or coinsurance amounts selected by the Plan Sponsor are calculated based on the maximum allowable charge as indicated on the Fee Schedule, and the Non-participating Dentist’s total charge, if his/her total charge exceeds the Fee Schedule amount for that covered procedure(s). Benefits are payable in accordance with the terms and conditions of the applicable Schedule of Benefits attached to this Subscriber Certificate and in effect at the time services are rendered.

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, visit our website, or check the directory of Participating Dentists on file with your Plan Sponsor.

5. WHEN YOUR COVERAGE BEGINS

The dental services described in this Subscriber Certificate are covered as of your effective date, as set out in the Enrollment Form unless your benefits are subject to a waiting period or there exists some limitations or exclusions on your membership.

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

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

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

If you receive services from a Non-participating Dentist, you must obtain all dental records or other related information needed to determine your benefits. We will not pay the dentist in order to obtain this information. If the Non-participating Dentist does not provide the required information, we may not be able to provide benefits for his or her services.

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

7. SUBSCRIPTION CHARGE

A. Payments: The amount of money that your Plan Sponsor pays to the Plan for your benefits under this Agreement is called your subscription charge. We will send your Plan Sponsor a bill and will expect payment in full. We are not responsible if your Plan Sponsor fails to pay us. This is true even if your Plan Sponsor has charged you for all or part of the subscription charge.

B. Changes: We will send your Plan Sponsor a written notice at least sixty (60) days before any increase in your subscription charge goes into effect. Rates will not change more than once every twelve (12) months. It is your Plan Sponsor’s responsibility to notify you of any change in the subscription charge.

8. WE MAY CHANGE YOUR SUBSCRIBER CERTIFICATE

We will send your Plan Sponsor a notice each time we change all or part of your Subscriber Certificate, describing the change(s) being made. Changes to the Subscriber Certificate may include the addition or deletion of riders as well as plan design changes. We will expect your Plan Sponsor to notify you of the changes. We are not responsible if your Plan Sponsor does not notify you. Your Subscriber Certificate will be changed whether or not your Plan Sponsor has notified you. You can also call our Customer Service department to get information on your plan change. Our telephone number is listed at the end of this Subscriber Certificate.

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

9. WHEN YOUR COVERAGE ENDS

A covered individual may have the right to continue dental coverage for a period of time under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You and covered eligible dependent family members as defined by COBRA may be entitled to continue participating in this plan for a period of time specified under law even under conditions (such as your death or termination of employment) that would otherwise make you ineligible for coverage, so long as you pay the appropriate subscription in full. No change in benefits will occur as a result of coverage under COBRA. Contact your Plan Sponsor for more detailed information regarding continuation of coverage.

10. TERMINATION OF A SUBSCRIBER CERTIFICATE

A. You or your Plan Sponsor may cancel your Subscriber Certificate.
1. Your Plan Sponsor may cancel your Subscriber Certificate for any reason. To do so, your Plan Sponsor must give us notice in writing at least sixty (60) days prior to the termination date.

2. You may also cancel your Subscriber Certificate through your Plan Sponsor. To do so, your Plan Sponsor must give us notice in writing within seventy-two (72) days of cancellation. If your subscription charge is paid for a period beyond your cancellation date, we will refund the subscription charge for that period to your Plan Sponsor provided no claim payments have been made for services rendered after your termination date. Your Plan Sponsor is responsible for any refunds due you.

If you cancel your Subscriber Certificate and coverage is provided other than through the Exchange, you must wait at least one year after your cancellation before you can enroll again as a subscriber. You can only enroll on your group’s anniversary date or when a special re-opening occurs. If coverage is received through the Exchange, you may enroll under open and special enrollment periods established by the Exchange and under federal regulations.

B. The Plan may cancel your Subscriber Certificate.

1. We may cancel or not renew your Plan Sponsor’s Agreement under the terms of our Agreement with your Plan Sponsor. If your Plan Sponsor’s Agreement is canceled or not renewed, your coverage will automatically be terminated as of the same date.

2. We may, upon thirty (30) days notice to you or your Plan Sponsor, cancel your Subscriber Certificate under any of the following circumstances:
   a) We may cancel your Subscriber Certificate if you make any fraudulent claim or intentional misrepresentation of material fact to us or to any dentist, such as an incorrect or incomplete statement on your application, which led us to believe you were eligible for this coverage when in fact you were not, or you perform another act, practice or omission that constitutes fraud. In such a case, cancellation will be as of your effective date. We will refund your Plan Sponsor the subscription charge you have paid us. We will subtract from the refund any payments made for claims under this Subscriber Certificate. If we have paid more for claims under this Subscriber Certificate than you have paid us in subscription charges, we have the right to collect the excess from you.
   b) We may cancel your Subscriber Certificate if your plan sponsor has not paid your subscription charges, subject to the Grace Period provision under Section 15 under this Part IV. Cancellation will be effective on a date we choose, but not earlier than the subscription charge due date. The Plan Sponsor will owe us the subscription charge due for the period between the due date and the cancellation date. You agree that we may use your rights against the Plan Sponsor to collect those subscription charges.
C. Cancellation due to loss of eligibility.

Your Subscriber Certificate will be canceled when you are no longer eligible in the group through which the Subscriber Certificate was issued.

The termination date of this coverage shall be the date that your Plan Sponsor specifies in a written notice to us. The termination date will not be more than seventy-two (72) days prior to the date of notice, and there are no paid claims past the date of termination. For certain treatments, benefits will continue beyond the termination date as specified above, the Schedule of Benefits and any applicable rider(s) identified in the Agreement. The claims experience will be charged to the Plan Sponsor. The Plan Sponsor will be charged claims experience for the claims incurred after the effective date and prior to the date of our receipt of the Plan Sponsor's notice of termination.

12. 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.

13. CONTESTABILITY OF COVERAGE

1. The Agreement may not be contested, except for nonpayment of subscription charges, after it has been in force for two (2) years from its date of issue.

2. A statement made by you relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two (2) years during your lifetime.

3. Each statement made by an applicant, the Plan Sponsor or you is considered to be a representation and not a warranty.

4. A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under the Subscriber Certificate unless (a) the statement is contained in a written instrument signed by the Plan Sponsor or covered individual, and (b) a copy of the statement is given to the Plan Sponsor, covered individual or covered beneficiary or personal representative of the covered individual.

This provision does not preclude the assertion at any time of defenses based upon the person’s eligibility for coverage under the Agreement or upon other provisions in the Agreement.

14. BENEFITS AFTER CANCELLATION

If you or your Plan Sponsor cancels your Subscriber Certificate or if we cancel your Subscriber Certificate, no benefits will be provided for services that you receive after the cancellation date.
15. GRACE PERIOD

A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period the Subscriber Certificate shall continue in force unless the subscriber shall have given the Plan notice of discontinuance thirty (30) days in advance of the date of discontinuance. The subscriber is liable to the Plan for the payment of a pro rata premium for the time the coverage was in force during the grace period.

16. NOTICES

A. To you: When we send a notice to your Plan Sponsor we will send it by first class mail. Once we mail the notice or bill we are not responsible for its delivery. It will be your Plan Sponsor’s responsibility to notify you. This applies to a notice of a change in the subscription charge or a change in the Subscriber Certificate. If your name or mailing address should change, you should notify your Plan Sponsor at once. Be sure to give your Plan Sponsor both your old name and address as well as your new name and address.

B. To us: Send letters to DSM USA Insurance Company, Inc., c/o DentaQuest Management, Inc., P.O. Box 9708 Boston, MA 02114-9708. Always include your name and subscriber identification number.

17. ENROLLMENT AND CONTRACT CHANGES

All enrollment applications and any additions or changes to the Subscriber Certificate are allowed ONLY when they conform to our underwriting guidelines. Coverage for new spouses shall be effective from the date of marriage. Newly born children, newly adopted dependent children or grandchildren shall be covered from the moment of birth or date of adoptive or parental placement with an insured for the purpose of adoption. The Plan requires that notification of the birth of a newly born child and payment of the required premium must be submitted within thirty-one (31) days after the birth in order to have the coverage continue beyond the thirty-one (31) day period. A minor for whom guardianship is granted by court 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.

Changes to the Subscriber Certificate may result in a change in your subscription charge. If additional payments of subscription charges are required to provide coverage for the newly dependent spouse, children or grandchildren, you must notify your Plan Sponsor, who must then notify us, 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 your Plan Sponsor.

You must notify the Plan of any new covered dependents within the thirty-one (31) days. Failure to notify the Plan of new dependents within thirty-one (31) days shall result in the Plan never recognizing coverage for the new dependent(s) during the thirty-one (31) days; provided
that if You already has 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.

18. ENROLLING DEPENDENTS

Under certain situations, dependents may be added to your coverage at any time. Qualifying events could be a result of court order, involuntary employment termination, and your spouse’s death. Under those circumstances, you must notify your Plan Sponsor within seventy-two (72) days or six (6) months (only if specified below) of the qualifying event. A qualifying event may also be any triggering event has occurred as a result of which the Exchange is required under federal or state law or regulations to allow qualified individuals and enrollees to enroll in or change from one plan to another.

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

3. You may not terminate coverage for the child unless written evidence is provided to us that the order is no longer in effect, that the child is or will be enrolled under other reasonable dental coverage that will take effect on or before the effective date of termination, the Plan Sponsor has eliminated family coverage for all of its employees or the Plan Sponsor no longer employs you. If the Plan Sponsor no longer employs you, COBRA benefits shall be available under the conditions specified in Section 11 under this Part IV.

c. Involuntary Loss of Spouse’s Job - If your spouse involuntarily loses his or her job other than for cause and loses dental coverage as a result, the Plan shall provide continuous open enrollment for a married subscriber to alter his or her enrollment to include his or her spouse or children. You must notify the Plan Sponsor within six (6) months of this event.
d. If you or a dependent is permitted to enroll because a triggering event has occurred as a result of which the Exchange is required under federal or state law or regulations, including 45 C.F.R. § 155.420(d), to allow qualified individuals and enrollees to enroll in or change from one plan to another, including an error on the part of the Exchange, an individual or dependent gains access to new plans due to a permanent move, or loss of eligibility for coverage under a Medicaid plan or a Children’s Health Insurance Plan. Effective dates for coverage shall be as established by the applicable law or regulation, including as set forth in 45 C.F.R. § 155.420(b).

19. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after the effective date of this contract. If before a subscriber’s effective date he or she started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure.

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 twelve (12) months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

20. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

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

21. COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies if you or any of your dependents have another plan that provides coverage for services that are benefits under your contract including: group insurance, closed panel or other forms of group or group-like coverage (whether insured or uninsured), hospital indemnity benefits in excess of $200 a day, medical care components of group long-term care policies, and Medicare or other governmental benefits as permitted by law. A plan may also include indemnity programs, PPO programs, discounted fee for service programs, point of service programs, and capitation programs. The following are not treated as plans for the purposes of COB: an individual or family insurance, or other individual coverage (except for group-type insurance), amounts of hospital indemnity insurance of $200 or less per day, school accident type coverage, benefits for non-medical components of group long-term care policies, Medicaid policies and coverage under other governmental plans unless permitted by law, and an individual guaranteed renewable specified disease policy or intensive care policy that does not provide benefits on an expense-incurred basis. The Plan will administer the COB according to the
applicable state Coordination of Benefits law and this Subscriber’s Certificate.

A. Definitions:

1. **Claim determination period** means a *Plan Year*. However, it does not include any part of a year during which a person has no coverage under the *Plan*, or before the date this COB provision or a similar provision takes effect.

2. **Custodial parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

3. The plan that provides benefits first under the COB rules is known as the **primary plan**. The primary plan is responsible for providing benefits in accordance with its terms and conditions of coverage without regard to coverage under any other plan.

4. The plan that provides benefits next is the **secondary plan**. It provides benefits toward any remaining balance for covered services in accordance with its terms and conditions of coverage, including its COB provision.

B. Secondary Plan’s Benefits:

The secondary plan’s benefits are determined after those of another plan and may be reduced because of the primary plan’s benefits. This *Plan*, as the secondary plan, will provide benefits toward any remaining patient balance for covered services in accordance with your *contract*, provided that the amount paid by this *Plan* as the secondary plan, when added to the amount paid by the primary plan, will not exceed the lesser of the provider’s submitted charge or the amount allowed under your *contract*.

C. Order of Benefit Determination Rules:

1. The coverage from both plans shall be coordinated so that the *covered individual* receives the maximum allowable benefit from each plan.

2. A plan that does not contain a COB provision is always primary. An exception to this rule is coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits provided by the Plan Sponsor. An example of this type of coverage is a point-of-service benefit written in connection to a closed panel (capitation) panel.

3. In determining which plan is the primary and which is the secondary, the following rules shall apply and in this order:

   a. The plan that covers the *covered individual* other than as a dependent is the primary plan. The secondary plan is the one that covers that *covered individual* as a dependent. However, if federal law requires Medicare to be a secondary plan, then this rule may be reversed.
b. When both plans cover the covered individual as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary. The parents should be married, not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits shall be:

1) the plan of the custodial parent
2) the plan of the spouse of the custodial parent
3) the plan of the noncustodial parent
4) the plan of the noncustodial parent’s spouse.

d. If a determination cannot be made with the rules as set out above, the plan that has covered either of the parents for a longer time should be considered as primary. This rule shall apply if the parents have the same birthday.

e. If a court decree states that one of the parents is responsible for the 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 shall apply to claim determination periods or plan years commencing after the plan is given notice of the court decree.

4. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

5. If one of the plans is a medical plan and the other is a dental plan, the medical plan will always be the primary plan.

6. Whichever plan that covered the covered individual as an employee, covered dependent, subscriber or retiree longer is the primary.

22. RIGHT TO RECOVER OVERPAYMENTS

If we pay more than we should have under COB, then you must refund any overpayment to the Plan.

IMPORTANT: No statement in this section should be interpreted to mean that we will provide any more benefits than those already described in the Benefits Section of this Subscriber Certificate. Remember that under COB, the total of the payments made for covered health care services will not be more than the total of the allowed charges for those covered services. We will not provide duplicate benefits for the same services. If you have any questions about COB and your Subscriber Certificate, please contact our Customer Service department. The telephone number is listed at the end of this Subscriber Certificate.
23. CHOICE OF LAW

This Subscriber Certificate shall be construed according to the laws of the State of Georgia. This Subscriber Certificate will be automatically revised in order to conform to statutory requirements of the laws of the State of Georgia.

24. LEGAL ACTIONS

No action in law or equity will be brought to recover under this contract prior to sixty (60) days after a claim has been presented to us, nor will any such action be brought unless brought within three (3) years from the expiration of the time within such claim submission is required.

25. ENTIRE AGREEMENT; CHANGES

This Subscriber Certificate, attached to the Agreement, including the Schedule of Benefits, and any applicable rider(s) or attachments, and the Enrollment Form shall constitute the entire Agreement. A copy of any application of the policyholder shall be attached to the group policy when issued and will also form part of the Agreement. No change in this Subscriber Certificate 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 Subscriber Certificate or to waive any of its provisions.

26. UTILIZATION REVIEW/RIGHT TO APPEAL

This is the formal process designed to monitor the use of, or evaluate the medical appropriateness or efficiency of health care services. A utilization review program has been established to ensure that any guidelines and criteria used to evaluate the medical appropriateness of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients and characteristics of the local delivery system. The program was developed in conjunction with actively practicing dentists in all specialty areas of expertise and is reviewed at least annually to ensure that criteria are applied consistently.

Any utilization review conducted under your Subscriber Certificate is done retrospectively or at the time a claim for services has been submitted for reimbursement. In order for a submitted claim to be covered, the procedure must be a covered procedure. If a procedure is not a covered procedure then the claim for that procedure will be denied in accordance with the terms of your Subscriber Certificate. Coverage of certain procedures may also be limited by frequency, age, effective dates of coverage, etc which are stated in your Subscriber Certificate. There are also a number of listed procedures which are only considered a covered expense if a patient presents with a specified health history and/or has been diagnosed with a specified condition. During the claims review of these specific procedures, there may be a determination by a licensed dental practitioner that the procedure that was performed was not determined to be medically appropriate in accordance with the criteria that has been established in accordance with our utilization review program. In these situations, the claim for that procedure may be denied or partially reimbursed in accordance with the benefit for an alternate procedure.
For all claims submissions you and your dentist will receive an explanation of benefits which details how each submitted procedure was reimbursed and/or the reason for denial. A covered individual, or the covered individual’s agent, parent or guardian if the covered individual is a minor, has the right to appeal any decision to deny coverage for health care services recommended by a dentist. An appeal may be made by submitting a written request to DSM USA Insurance Company, Inc., 12121 N. Corporate Pkwy, Mequon, WI 53092

27. ELIGIBILITY

Your Plan Sponsor will inform us when you are eligible as a covered individual based upon the Plan’s underwriting guidelines. A covered individual will not be eligible for coverage when any of the following occurs:

A. The subscriber is no longer enrolled in the group. We will cover you under this Subscriber Certificate until your Plan Sponsor notifies us.

B. 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).

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

28. LIMITED RIGHT TO RECOVERY

You may have a legal right to recover some costs of your dental care from someone else because another person has caused your injury. In the event of recovery for another person for costs of dental care, we may require reimbursement from you for benefits we have paid on account of such injury, up to the amount allocated to the cost of dental care in the settlement documents or judgment, if: (1) the amount of the recovery exceeds the sum of all economic and noneconomic losses incurred as a result of the injury, exclusive of losses for which you may be required to reimburse us under this provision; and (2) the amount of the reimbursement claim is reduced by the pro rata amount of the attorney's fees and expenses of litigation incurred by you in bringing the claim.

You must give us information and assistance and sign necessary documents to help us receive our repayment. You must not do anything that might limit our repayment.
Part V

Filing a Claim

1. EXPLANATION OF BENEFITS (EOB)

Each time we process a claim for you under this Subscriber Certificate, 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

A. Participating Dentists: Participating Dentists will file claims directly to us for the services covered by this contract. We will make benefit payments within sixty (60) days to them.

B. Non-participating Dentists: When you receive covered services from a Non-participating Dentist, either you or the dentist may file a claim. You can obtain claim forms from your Plan Sponsor, or we will mail you all the forms that you need.

3. TIME LIMIT

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

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

4. FILING AND PAYMENT OF CLAIMS

If you file a claim, the following rules apply. You must provide written notice within twenty days after the occurrence or commencement for any loss; provide, however, that failure to give notice within that time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible. Obtain an Attending Dentist’s Statement claim form from your Plan Sponsor or the Plan. As the Plan does
not require a written request for a claims form, the *covered individual* may also call the Customer Service Department at 1-844-876-3982 to request a form. A *covered individual* may request a claims form at any time after services are rendered keeping in mind that completed claims forms must be submitted to the *Plan* no more than ninety (90) days after services are rendered, except under circumstances set out in Section 3 above.

All claims are payable by the *Plan* upon the *Plan*'s receipt of written or electronic proof of loss or claim for payment for services provided. The *Plan* shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the Subscriber or other person claiming payments for such benefits or a letter or electronic notice which states the reasons the *Plan* may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. If the *Plan* disputes a portion of the claim, any undisputed portion of the claim shall be paid by the *Plan*. When all of the listed documents or other information needed to process the claim has been received by the *Plan*, the *Plan* shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the Subscriber or other person claiming payments under this Subscriber Certificate the reasons for such denial.

Receipt of any proof, claim, or documentation by an entity which administers or processes claims on behalf of the *Plan* shall be deemed receipt by the *Plan*.

The *Plan* shall pay to the Subscriber or other person claiming payments under the Subscriber Certificate interest equal to 12 percent per annum on the proceeds or benefits due under the terms of this Subscriber Certificate for failure to comply with this provision.
Part VI

Index

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

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The following list of benefits applies only to Members under age nineteen (19).

**DIAGNOSTIC AND PREVENTIVE SERVICES**

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

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

Periodic exam; once every six (6) months.

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

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

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

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

Fluoride treatment Topical Fluoride - Varnish - 2 every 12 months, Topical application of fluoride (excluding prophylaxis) - 2 every 12 months.

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

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

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

RESTORATIVE AND OTHER BASIC SERVICES

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

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

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

Protective restorations.

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

Simple tooth extractions.

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

Consultations.

Repair of dentures or fixed bridges. Recementing of fixed bridges.
Rebase or reline dentures; once every thirty-six (36) months. 6 months after initial installation.

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

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

Vital pulpotomy and pulpal therapy is limited to deciduous teeth.

**COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES**

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

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

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

Inlays are paid as an alternative benefit of amalgam.

Implants- once every 60 months.

**Dentures and Bridges**

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

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

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

- Initial placement of crowns and onlays.

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

**ORTHODONTIC SERVICES**

Orthodontic services for members who have a severe handicapping as the result of a deep impinging overbite that shows palatal impingement of the majority of lower incisors, true anterior overbite, anterior crossbite, impacted incisors or canines, overjet greater than 9mm, negative overjet greater than 3.5mm, cleft palate/lip deformities and other significant craniofacial anomalies, or DQ.GA.IND.FAM.PPO.L 2.15
malocclusions requiring a combination of orthodontics and orthognathic surgery for correction.

The following list of benefits applies to Members age 19 and over.

DIAGNOSTIC AND PREVENTIVE SERVICES

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

Comprehensive oral examination (including the initial dental history and charting of teeth); once every sixty (60) months.

Periodic exam; twice every calendar year.

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

Bitewing x-rays (x-rays of the crowns of the teeth); one set twice every calendar year.

Single tooth x-rays; as needed.

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

RESTORATIVE AND OTHER BASIC SERVICES

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth (note: teeth must have a good prognosis to qualify for benefits); (b) repair dentures or bridges; (c) rebase or reline dentures; and (d) repair or recement bridges, crowns and onlays. Examples of these services include:

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist’s charge. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.

Protective restorations; once per tooth every sixty (60) months.

Simple tooth extractions.

General anesthesia only when necessary and appropriate for impacted wisdom teeth removal only when provided by a licensed, practicing dentist.

Repair of dentures or fixed bridges; once every twelve (12) months.

Re cementing 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.

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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, alveoplasty and vestibuloplasty.

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

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

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

**Dentures and Bridges**

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every sixty (60) months.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.
- Temporary partial dentures as follows:
  - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.

**Crowns and Onlays**

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

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

**DEDUCTIBLES**

Restorative and other Basic Services, and Complex and Major Restorative Dental Services described DQ.GA.IND.FAM.PPO.L 2.15
above are subject to a $100 deductible for each covered individual every calendar year. In the case of a family contract, the total deductible payment for all covered individuals shall not exceed $300 for Restorative and other Basic Services, and Complex and Major Restorative Dental Services in a calendar year. This means the covered individual(s) must pay the first $100 of benefits provided every calendar year, not to exceed $300 per calendar year for families with three or more covered individuals.

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

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

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

The out of pocket maximum is $350 every calendar year. The out of pocket maximum applies per covered individual. A family with 2 or more covered individuals under age 19 will have an aggregate out of pocket maximum of $700 for individuals under age 19. The out of pocket maximum applies to in-network benefits only. No out of pocket maximum applies to out of network benefits or to adult coverage.

WAITING PERIOD

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

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

DEPENDENT COVERAGE

Dependent children are covered up to and including age 26.

BENEFIT PAYMENTS

IN-NETWORK SERVICES:

For services performed by a Participating Dentist, the in-network benefit allowance is based 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

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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 1-844-876-3982.
This Outline of Coverage provides a brief description of some important features of the individual Policy. This is not the insurance policy and only the actual Policy provisions will control. The Policy sets forth, in detail, the rights and obligations of the subscriber, covered individuals and the insurance company. It is, therefore, important to READ THE POLICY CAREFULLY. The individual Policy is designed to provide coverage for covered dental services, subject to all conditions, limitations, exclusions and maximums set forth in the Policy.

Preferred Provider Policy Disclosure. The Policy provides the same benefits for covered services provided by dentists that participate in the insurer’s provider network and non-participating dentists. The subscriber is responsible for paying his or her portion of any coinsurance or deductible for covered services as specified in the schedule of benefits. Non-participating dentists may also charge the subscriber for the difference between the amount paid by the insurer and the dentist’s actual charge.

COVERED DENTAL SERVICES

The following list of benefits applies only to individuals under age nineteen (19).

DIAGNOSTIC AND PREVENTIVE SERVICES

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

Periodic exam; once every six (6) months.

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

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

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

Routine cleaning, scaling and polishing of teeth; Once every six (6) months.
Fluoride treatment Topical Fluoride - Varnish - 2 every 12 months, Topical application of fluoride (excluding prophylaxis) - 2 every 12 months.

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

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

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

**RESTORATIVE AND OTHER BASIC SERVICES**

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

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

Protective restorations.

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

Simple tooth extractions.

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

Consultations.

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

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

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.
Vital pulpotomy and pulpal therapy is limited to deciduous teeth.

**COMPLEX AND MAJOR RESTORATIVE DENTAL SERVICES**

Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery). Periodontal benefits are determined according to the insurer’s administrative “Periodontal Guidelines.”

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

Inlays are paid as an alternative benefit of amalgam.

Implants- once every 60 months.

Dentures and Bridges

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

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

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

- Initial placement of crowns and onlays.

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

**ORTHODONTIC SERVICES**

Orthodontic services for members who have a severe handicapping as the result of a deep impinging overbite that shows palatal impingement of the majority of lower incisors, true anterior overbite, anterior crossbite, impacted incisors or canines, overjet greater than 9mm, negative overjet greater than 3.5mm, cleft palate/lip deformities and other significant craniofacial anomalies, or malocclusions requiring a combination of orthodontics and orthognathic surgery for correction.

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

**DIAGNOSTIC AND PREVENTIVE SERVICES**
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

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

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

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

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

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

Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every sixty (60) months.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.
- Temporary partial dentures as follows:
  - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.

Crowns and Onlays

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

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

The following list of limitations and exclusions apply to 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 the 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 the 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.
• Nitrous oxide.
• Oral sedation.
• Topical medicament center.

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

• Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
• A service or procedure that is not described as a benefit in the Policy.
• Services that are rendered solely due to the requirements of a third party, such as an employer or school.
• Travel time and related expenses.
• An illness or injury that we determine arose out of and in the course of your employment.
• A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under the Policy.
• An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare.
• A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
• A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
• Appointments with your dentist that you fail to keep.
• A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
• Prescription drugs.
• A service to treat disorders of the joints of the jaw (temporomandibular joints).
• Services that are meant primarily to change or to improve appearance.
• Implants.
• Transplants.
• Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
• Lab exams.
• Photographs.
• Duplicate dentures and bridges.
• Services related to congenital anomalies unless otherwise covered. However, this exclusion does not apply to any covered orthodontic services.
• Consultations.
• Tooth bleach.
• Computerized tomography (CT) scans, surgical stents, surgical guides for implants.
• Transitional implants.
• Bone grafts and guided tissue regeneration in conjunction with extractions, apicoectomies, 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.

**RIGHT TO RENEWAL**

The Policy is renewable subject to the right of the insurer to cancel or nonrenew upon 30 days’ notice under the following circumstances:

1. Submission of a fraudulent claim or a fraudulent or material misrepresentation or an intentional misrepresentation of material fact, or fraudulent dealings with the insurer.
2. Failure to pay premiums.
3. Discontinuance by the insurer of a particular product or all coverage in the individual market in Georgia in accordance with Georgia law.
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 có quyền được giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một người dịch viên, vui lòng gọi [1-844-876-3981].

**Arabic:** هل لديك الحق في الحصول على مساعدة ومعلومات باللغة الخاصة بك بدون تكلفة. لتواصل مع مترجم، الرد على الرقم [1-844-876-3981].

**Korean:** 예 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 makaasap ang isang tagasalin, tumawag sa [1-844-876-3981].

**Gujarati:** વિશે પ્રશ્નો છે તો તમને મુફ્તે મેળવવામાં આવી છે. તે કકસી ભાષામાં તમે પાંચ મિનિટ વચ્ચે સુધીમાં પૂછી શક છે. તથાપંચ વખત તમે તે,અથ [1-844-876-3981] પર કોલ કરો.

**Hindi:** के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी भाषाएँ से बात करने के लिए , [1-844-876-3981] पर कॉल करें।

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

*Products underwritten by DSM USA 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 [Tennessee and Texas].

日本語：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].

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].

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

アマハリ: የስፋ ከለችሁ፣ የል የምንም እና የእርዳታና መረጃ የማግኝት ሲስፋ ከለችሁ። ከልሆቶር እር መስፋ ከለችሁ፣ [1-844-876-3981] ከለችሁ።