**Accessing Your Benefits**

Our goal is to make using your benefits as easy and trouble-free as possible. Login as a current Member on our website www.AlwaysCareBenefits.com to search for the most up-to-date listing of AlwaysDental Providers in your area, view benefits, view status of your claims, print ID cards, and access other forms and documents. If you do not have access to the internet, please call our Customer Service Representatives toll free at 1-888-729-5433, Ext. 2013.

We encourage you to submit names and addresses of dental providers not listed on our website whom you would us to contact. We will begin recruiting them as an in-network provider immediately.

The first time you use your plan, identify yourself as an “AlwaysDental - Starmount Member” and let the dental office know your coverage has moved to the DenteMax Network. They do not need to be part of a network for us to pay them. All they need to do is submit a standard claim form, and we will reimburse based on your plan’s allowances.

AlwaysCare and DenteMax strive to offer you an extensive national network, but we also encourage you to take advantage of this flexible plan. You may choose to visit any licensed general dentist or dental specialist. We also have a panel of participating providers who have agreed to provide special pricing to our Members with no balance billing. Visit our website or call Customer Service for this listing.

**Q&A**

**Who will submit my dental claims to AlwaysCare?**
Over 96% of the dental claims we receive are submitted by providers. A Member may submit his/her own claim by downloading a claim form from the “Client Services” tab on our website and mailing the completed form with receipts back to our office. The address is listed on the back of your ID card.

**When should I have a pre-estimate done?**
Please ask your doctor to submit a pre-treatment estimate request for any claims in excess of $300.

**How do we coordinate benefits?**
We follow the birthday rule for coordination of benefits. If a child has coverage under the father and mother’s policy, we use the birthday month of the parent that comes first in the year as primary.

**How do orthodontic benefits work?**
At the time of Initial Placement of Braces or Appliances AlwaysCare will pay 25% of the total fee or 25% of the lifetime maximum, whichever is less. The remaining 75% of benefits will be available for monthly treatments while the Member is eligible for coverage.

**Will my benefits cover any dental procedure?**
Since all policies have limitations, it is recommended that you review the certificate of coverage prior to having work done. Recognizing that dental problems can be resolved with more than one type of treatment, AlwaysCare will reimburse for the least expensive method that would produce the same resolution within professionally acceptable limits.

**More procedure-specific information:** On most plans, the policy will pay for a replacement of a crown, bridge, inlay, onlay or denture if it is at least 5 years old and cannot be made serviceable. A claim is considered incurred on the date an impression is taken for a bridge or dentures, the date a tooth is prepped for a crown, and when the pulp chamber is opened for a root canal. If your policy does not include composite (white) fillings on molars, we will pay the alternate benefit of an amalgam (silver) filling. You will be responsible for the difference in cost.

**NEW Benefits from AlwaysCare!**
- One additional cleaning for pregnant women in their 2nd or 3rd trimesters
- One adjunctive, prediagnostic test per year for Members 40+ years of age who demonstrate risk factors for oral cancer or suspicious lesions
- Up to two extra cleanings per year for Members diagnosed as diabetic (optional benefit)
GROUP DENTAL INSURANCE CERTIFICATE

This Certificate explains the dental insurance coverage under the Group Policy (the Policy) issued to the Policyholder by Starmount Life Insurance Company (called “We,” “Our” or “Us” in this Certificate). The Policy provides the benefits for the Insured Member (called "You" or "Your" in this Certificate) and any Covered Dependents.

The Policyholder and the Policy Number are shown in the Schedule of Benefits.

This, together with the Schedule of Benefits applying to Your Eligible Class, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your dental benefits. All benefits are governed by the terms and conditions of the Policy.

The Policy alone constitutes the entire contract between the Policyholder and Us.

Chairman /CEO

Secretary

NON-PARTICIPATING
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PART I. DEFINITIONS

**Administrator** - The entity which will provide complete service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

**Calendar Year Plan** - Benefits begin anew on January 1 of each Calendar Year.

**Claim** - A statement signed by an Insured and his treating dentist for a request of payment under a dental benefit plan. It shall include services rendered, dates of services and itemization of costs.

**Co-Pay** - The fixed amount that an Insured is required to pay directly to a Participating Provider for Covered Expenses. The Co-Pay may vary by Procedure Code.

**Covered Dependent** – Means an Eligible Dependent who is insured under this Certificate.

**Covered Expense** - The lesser of the following for a Covered Procedure: (1) the actual charge; or (2) the Maximum Reimbursement.

**Covered Procedure** - The procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for necessary dental treatment to an Insured while His coverage under this Certificate is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a:
   1. licensed dentist who is acting within the scope of his or her license;
   2. licensed physician performing dental services within the scope of his or her license; or
   3. licensed dental hygienist acting under the supervision and direction of a dentist.

**Deductible** - The Deductible is shown on the Schedule of Benefits. The Individual Deductible is the amount that each Insured must satisfy once each Certificate Year (or lifetime, when applicable) before benefits are payable for Covered Procedures. We apply amounts used to satisfy Individual Deductibles to the Maximum per Family Deductible, if any. Once any Maximum per Family Deductible is satisfied, no further Individual Deductibles are required to be met for that Certificate Year. If multiple procedures are performed on the same date, the Deductibles will be satisfied in order of Procedure Class (that is, toward Procedure Class B, and then C.)

**Eligible Class** – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown on the Schedule of Benefits. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Eligibility Period, if any.

**Eligible Dependent** - Means a person listed below:
   1. Your spouse;
   2. Your unmarried dependent child under age 19, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
   3. Your unmarried child age 19 or older but less than age 25 who is:
      a. Not regularly employed on a full-time basis;
      b. Primarily dependent upon You for support and maintenance; and
      c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.
   4. Your unmarried child who has reached age 19 and who is:
      a. primarily dependent upon You for support and maintenance; and
      b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

**Eligibility Period** – The period of time a Member must wait before He is eligible for coverage. The Eligibility Period, if any, is specified in the Policyholder’s Group Application and shown in the Schedule of Benefits.

**He, Him and His** – Refers to the male or female gender.
Initial Term - The period following the group’s initial effective date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

In-Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Insured – Means You and each Covered Dependent.

Insured Member– Means a person:
   1. who is a Member of an Eligible Class; and
   2. who has qualified for insurance by completing the Eligibility Period, if any; and
   3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling outside the Policyholder’s initial Eligibility Period as indicated in the Schedule of Benefits. Benefits may be limited for Late Entrants under Limitations.

Maximum Reimbursement – An amount used to determine the Covered Expense. There are 3 types of Maximum Reimbursement, depending on the plan issued:
   1. Maximum Allowable Charge (MAC): The MAC may be used if a dentist who is a Non-Participating Provider performs a Covered Procedure. The amount of the MAC is equal to the lesser of: (a) the dentist’s actual charge; or (b) the “customary charge” for the dental service or supply. We determine the “customary charge” from within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area.
   2. Participating Provider Maximum Allowable Charge (PMAC): The PMAC may be used if a dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the dentist has agreed with Us to accept as payment in full for a dental service or supply.
   3. Scheduled Fee (SF): Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the dentist.

The Schedule of Covered Procedures shows the Type Of Maximum Reimbursement used by the plan.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Non-Participating Provider - A dentist who is not a Participating Provider. These dentists have not entered into an agreement with Us to limit their charges.

Out-of–Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider - A dentist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

Participating Provider Program - Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

Participating Provider Program Directory - The list which consists of selected dentists who:
   1. are located in Your area; and
   2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated.

Policyholder - The entity stated on the front page of the Policy.

Policy Year Plan - Benefits begin immediately on the Policyholder’s effective date and renew 12 months following the initial effective date.
Re-enrollee - Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits are limited for Re-enrollees under Part VI. Limitations.

You or Your – The Insured Member.

Waiting Period - The period of time during which an Insured’s coverage must be in force before benefits may become payable for Covered Procedures. The Waiting Period, if any, for each Covered Procedure is shown in the Schedule of Covered Procedures.

PART II. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be a Member of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Member’s Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage may automatically become effective under the other spouse’s coverage. OR enrollment will default to the Policyholder’s rules.

B. ENROLLMENT

The term “Enrollment” means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Eligibility Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder. It usually occurs once each Calendar Year but may, at the Policyholder’s discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll or change is made within 31 days of the event. A change in family status means any of the following events:

1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.
PART III. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder’s Effective Date, shown on the Schedule of Benefits; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, birth or adoption, coverage is effective on the first of the month following the date such dependent was acquired. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child’s placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 31 days of the placement in order to continue the coverage beyond the initial 31-day period.

PART IV. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder’s coverage terminates under the Policy;
3. the first of the month following the date You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within 31 days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date he is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART V. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Schedule of Benefits shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of 31 days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 12 month period. We will give the Policyholder written notice at least 45 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.
PART VI. DESCRIPTION OF COVERAGE

A. COVERED DENTAL EXPENSES

We determine if benefits are payable under the policy if an Insured incurs expenses for a Covered Procedure. Before we determine benefits, the Insured must satisfy the Deductible and Waiting Period, if any.

The Deductible is shown on the Schedule of Benefits. The Waiting Period is listed separately for each Covered Procedure. It is shown on the Schedule of Covered Procedures.

We then pay the Insurance Percentage of the Covered Expense, minus any Co-Pay. The Insurance Percentage is based on: (1) the length of time the Insured has been covered under this Certificate; and (2) the Procedure Class. The Insurance Percentage is shown in the Table of Insurance Percentages on the Schedule of Benefits.

The Co-Pay, if any, is listed for each Covered Procedure in the Schedule of Covered Procedures.

The benefit is subject to the following:
1. The Covered Procedure must start and be completed while the Insured’s coverage is in force, except as provided in the Takeover Benefits provision.
2. Each Covered Procedure may be subject to specific Limitations, as shown on the Schedule of Covered Procedures.
3. A Certificate Year Maximum Annual Benefit may apply to each Insured. This is shown on the Schedule of Benefits.
4. A Maximum Annual and/or Maximum Lifetime Benefit may apply to each Procedure Class. If applicable, these maximums are shown in the Table of Covered Insurance Percentages on the Schedule of Benefits.
5. Other limitations and exclusions that may affect coverage are shown in the “Limitations and Exclusions” provision.

B. WHEN A COVERED PROCEDURE IS STARTED AND COMPLETED

1. We consider a dental treatment to be started as follows:
   a. for a full or partial denture, the date the first impression is taken;
   b. for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
   c. for root canal therapy, on the date the pulp chamber is first opened;
   d. for periodontal surgery, the date the surgery is performed; and
   e. for all other treatment, the date treatment is rendered.

2. We consider a dental treatment to be completed as follows:
   a. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
   b. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
   c. for root canal therapy, the date a canal is permanently filled.

NOTE: If Orthodontia Services are covered, see Procedure Class D in the Schedule of Covered Procedures for start and completion dates.

C. HOW TO SUBMIT EXPENSES

Expenses submitted to Us must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.
D. CHOICE OF PROVIDERS

An Insured may choose a dentist of his choice. An Insured may choose the services of a dentist who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Insured will generally incur less out-of-pocket cost unless the Policyholder has selected a Participating Provider Only plan.

E. PRE-ESTIMATE

If the charge for any treatment is expected to exceed $300, We suggest that a dental treatment plan be submitted to Us by Your dentist for review before treatment begins. In addition to a dental treatment plan, We may request any of the following information to help Us determine benefits payable for certain services:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models; and
4. a statement specifying:
   a. degree of overjet, overbite, crowding and open bite;
   b. whether teeth are impacted, in crossbite, or congenitally missing;
   c. length of orthodontic treatment; and
   d. total orthodontic treatment charge.

An estimate of the benefits payable will be sent to You and Your dentist. The pre-estimate is not a guarantee of the amount We will pay. The pre-estimate process lets an Insured know in advance approximately what portion of the expenses We will consider as a Covered Expense. Our estimate may be for a less expensive alternative benefit if it will produce professionally satisfactory results.

F. ALTERNATE BENEFIT PROVISION

Many dental problems can be resolved in more than one way. If: 1) We determine that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, We may use the less expensive alternative benefit to determine the amount payable under the Certificate. For example: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base our benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-participating Provider performs the service.

G. SERVICES PERFORMED OUTSIDE THE U.S.A.

Any Claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the Maximum Allowable Charge, Participating Provider Maximum Allowable Charge, or applicable Scheduled Fee amounts for the Insured’s zip code.

PART VII. LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS

1. LIMITATION FOR LATE ENTRANTS OR RE-ENROLLEES: Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coverage with AlwaysCare will have a twelve (12) month waiting period applied to all basic, major, and orthodontia services upon re-applying.

2. MISSING TEETH LIMITATION: We will not pay benefits for replacement of teeth missing on an Insured’s effective date of insurance under this Certificate for the purpose of the initial placement of a full denture, partial denture or fixed bridge. However, expenses for the replacement of teeth missing on the effective date will be considered for payment as follows:
a. The initial placement of full or partial dentures will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while the Insured is covered under the policy.

b. The initial placement of a fixed bridge will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while an Insured is covered under the policy. However, the following restrictions will apply:
   (i) Benefits will only be paid for the replacement of the teeth extracted while an Insured is covered under the policy or under the “Prior Extraction” clause;
   (ii) benefits will not be paid for the replacement of other teeth which were missing on the Insured’s effective date.
   (iii) missing teeth limitation will be waived after Members have been covered under the plan for (3) three continuous years unless it is a replacement of an existing unserviceable prosthesis.

3. Other Limitations: Multiple restorations on one surface are payable as one surface. Coverage is limited to either one prophylaxis or one periodontal maintenance per six-month period. Coverage is limited to one full mouth radiograph or panoramic film per the limitation period listed in the Schedule of Covered Procedures.

B. EXCLUSIONS

No benefits are payable under the Policy for the procedures listed below unless such procedure or service is listed as covered in the Schedule of Covered Procedures. Additionally, the procedures listed below will not be recognized toward satisfaction of any Deductible amount.

1. any service or supply not shown on the Schedule of Covered Procedures;
2. any procedure begun after an Insured’s insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty days after an Insured’s insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations;
6. the replacement of lost or discarded or stolen appliances;
7. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
8. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
9. replacement of crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
10. appliances, services or procedures relating to: (a) the change or maintenance of vertical dimension; (b) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (c) splinting; (d) correction of attrition, abrasion, erosion or abfraction; (e) bite registration or (f) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
12. orthognathic surgery;
13. prescribed drugs, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
21. any procedure We determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured’s household;
23. expenses compensable under Workers’ Compensation or Employers’ Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile “No-Fault” coverage);
24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the “Payment of Claims” provision;
25. procedures started but not completed;
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures, plus the services of anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

Notice Of Claim: Written notice of Claim must be given within thirty (30) days after a loss occurs, or as soon as reasonably possible. The notice must be given to the Administrator. Claims should be sent to:

Starmount Life Insurance Company, Inc.
c/o AlwaysCare Benefits, Inc. – Dental Claims
P.O. Drawer 80139
Baton Rouge, LA 70898

Claim Forms: When the Administrator receives notice of Claim that does not contain all necessary information or is not on an appropriate Claim form, forms for filing proof of loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss.

Proof Of Loss: Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

Payment Of Claims: Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

If any beneficiary is a minor or mentally incapacitated, We will pay the proper share of Your insurance amount to such beneficiary's court appointed guardian.

Time of Payment Of Claims: Indemnities payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. If We are unable to immediately pay due to deficiencies in Your claim, We will notify You within thirty (30) days if Your claim was filed electronically or within forty-five (45) days if Your claim was filed on paper of those deficiencies and how they can be remedied. Our failure to notify You of any deficiencies within the stated time frames will establish the submitted claim as a clean claim. We will pay or deny a clean claim: (1) if filed electronically, within thirty (30) days after the date We receive the claim; or (2) if the claim is filed on paper, within forty-five (45) days after the date We receive the claim.

Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of our liability will be paid immediately upon receipt of due written proof.
**Recovery Of Overpayments:** We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured if claim payments previously were made with respect to an Insured.

**PART IX. COORDINATION OF BENEFITS (COB)**

This provision applies when an Insured has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

**A. DEFINITIONS RELATED TO COB**

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.

3. **Plan:** Any plan, including this one that provides benefits or services for dental expenses on either a group or individual basis. “Plan” includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). “Plan” shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

4. **Primary Plan:** The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

**B. BENEFIT COORDINATION**

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured’s Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured’s benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

**C. THE ORDER OF BENEFIT DETERMINATION**

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

   a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.
b. **Dependent Child/Parents Not Separated or Divorced.** For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;

ii. The Plan of the parent with custody of the child;

iii. The Plan of the spouse of the parent with custody; and

iv. The Plan of the parent without custody of the child.

d. **Dependent Child/Joint Custody:** If the joint custody court decree does not specifically state which parent is responsible for the child’s medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee’s dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. **Right to Receive and Release Needed Information**

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. **Right to Make Payments To Another Plan**

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. **Right to Recovery**

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

**PART X. GRIEVANCE PROCEDURE**

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

**Starmount Life Insurance Company, Inc.**
\c/o AlwaysCare Benefits, Inc.
Grievance Committee
P.O. Drawer 80139
Baton Rouge, LA 70898

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person.
who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

PART XI. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

PART XII. REPLACEMENT OF EXISTING COVERAGE

The following provisions are applicable if this dental plan is replacing an existing group dental plan in force (referred to as “Prior Plan”) at the time of application. These are called “Takeover Benefits.” The Schedule of Benefits shows if Takeover Benefits apply.

Waiting Period Credit: When We immediately take over an entire dental group from another carrier, those persons insured by the Prior Plan on the day immediately prior to the takeover effective date will receive Waiting Period credit if they are eligible for coverage on the effective date of Our plan. The Waiting Period credit does not apply to new Insureds, Eligible Dependent add-ons, Late Entrants, or Re-enrollees.

Annual Maximums And Deductible Credits: For Calendar Year Plans: Deductible credits will be granted for the amount of Deductible satisfied under the Prior Plan during the current Calendar Year. Any benefits paid under the Prior Plan with respect to such replaced coverage will be applied to and deducted from the maximum benefit payable under this Certificate.

For Policy Year Plans: The annual maximums and annual Deductibles will begin on the policy’s takeover effective date, which marks the start of a new Policy Year. Deductible credit will not be given. Any benefits paid under the Prior Plan with respect to such replaced coverage will not be applied to or deducted from the maximum benefits payable for services under this Certificate.

Maximum Benefit Credit: All paid benefits applied to the maximum benefit amounts under the Prior Plan will also be applied to the maximum benefit amounts under this Certificate.

If You had orthodontic coverage for Your covered dependent children under the Prior Plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

1. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the Prior Plan; and
2. orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
3. orthodontic treatment is continued while Your covered dependent is insured under this Certificate.
If you submit the required proof, the maximum benefit for orthodontic treatment will be the lesser of this Certificate’s Overall Maximum Benefit for Class D Orthodontic Services or the Prior Plan’s ortho maximum benefit. The ortho maximum benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

**Verification:** The Policyholder’s application must be accompanied by a current month’s billing from the current dental carrier, a copy of an in-force certificate, as well as proof of the effective date for each Insured (and dependent), if insured under the Prior Plan.

**Prior Carrier’s Responsibility:** The prior carrier is responsible for costs for procedures begun prior to the effective date of this coverage.

**Prior Extractions:** If: (1) treatment is dentally necessary due to an extraction which occurred before the effective date of this coverage while an Insured was covered under the Prior Plan; (2) the replacement of the extracted tooth must take place within thirty-six (36) months of extraction; and (3) treatment would have been covered under the Policyholder’s Prior Plan; We will apply the expenses to this plan as long as they are Covered Expenses under both this Certificate and the Prior Plan.

**Coverage for Treatment in Progress:** If an Insured was covered under the Prior Plan on the day before this Certificate replaced the Prior Plan, the Insured may be eligible for benefits for treatment already in progress on the effective date of this Certificate. However, the expenses must be covered dental expenses under both this Certificate and the Prior Plan. This is subject to the following:

1. **Extension of Benefits under Prior Plan.** We will not pay benefits for treatment if:
   (a) the Prior Plan has an Extension of Benefits provision;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed during the extension of benefits.

2. **No Extension of Benefits under Prior Plan.** We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:
   (a) the Prior Plan has no extension of benefits when that plan terminates;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed while insured under this Certificate.

3. **Treatment Not Completed during Extension of Benefits.** We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan and during the extension if:
   (a) the Prior Plan has an extension of benefits;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was not completed during the Prior Plan’s extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.
# PART XIII. SCHEDULE OF COVERED PROCEDURES

The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable limitations. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

## Key for Schedule of Covered Procedures

<table>
<thead>
<tr>
<th>Procedure Class</th>
<th>Type of Maximum Reimbursement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Preventive/Diagnostic</td>
<td>PMAC – Participating Provider Maximum Allowable Charge</td>
</tr>
<tr>
<td>B Basic</td>
<td>MAC – Maximum Allowable Charge (based on “Customary Charge”)</td>
</tr>
<tr>
<td>C Major</td>
<td>SF – Scheduled Fee</td>
</tr>
</tbody>
</table>

## Limitations

<table>
<thead>
<tr>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Limited to Dependent Children under age 16</td>
</tr>
<tr>
<td>(b) Limited to Dependent Children under age 17+</td>
</tr>
<tr>
<td>(c) Limited to those age 25+</td>
</tr>
<tr>
<td>(d) Limited to those age 7 year period</td>
</tr>
<tr>
<td>(e) Limited to those age 1 year period</td>
</tr>
<tr>
<td>(f) Limited to those age 3 year period</td>
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<tr>
<td>(g) Limited to those age 4 year period</td>
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<td>(h) Limited to those age 5 year period</td>
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<tr>
<td>(i) Limited to those age 6 year period</td>
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<td>(j) Limited to those age 7 year period</td>
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<td>(k) Limited to those age 8 year period</td>
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<td>(m) Limited to those age 10 year period</td>
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<td>(n) Limited to those age 11 year period</td>
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<tr>
<td>(p) Limited to those age 13 year period</td>
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<tr>
<td>(q) Limited to those age 14 year period</td>
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<tr>
<td>(r) Limited to those age 15 year period</td>
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<tr>
<td>(s) Limited to those age 16 year period</td>
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<tr>
<td>(t) Limited to those age 17 year period</td>
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<tr>
<td>(u) Limited to those age 18 year period</td>
</tr>
<tr>
<td>(v) Limited to those age 19 year period</td>
</tr>
<tr>
<td>(w) Limited to those age 20 year period</td>
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</table>

## Covered Procedures

<table>
<thead>
<tr>
<th>Procedure Class</th>
<th>Waiting Period (Months)</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite or Periodic Oral Exam</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Problem Focused Exam</td>
<td>B</td>
<td>(0)</td>
</tr>
<tr>
<td>Comprehensive Periodontal Exam</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Emergency Palliative Treatment</td>
<td>B</td>
<td>(0)</td>
</tr>
<tr>
<td>Single Film</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Additional Films</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Intra-Oral Occlusal Film</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Panoramic Film or Full Mouth X-Ray</td>
<td>B</td>
<td>(0)</td>
</tr>
<tr>
<td>Bitewing – Single Film, or</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Bitewing – Two Films, or</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Bitewing – Four Films</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Adjunctive Pre-Diagnostic Oral Cancer Screening</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Topical Application of Fluoride</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Sealant</td>
<td>A</td>
<td>(0)</td>
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<tr>
<td>Space Maintainer – Fixed Unilateral</td>
<td>A</td>
<td>(0)</td>
</tr>
<tr>
<td>Space Maintainer – Fixed Bilateral</td>
<td>A</td>
<td>(0)</td>
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## Maximum Reimbursement

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td>PMAC</td>
<td>MAC</td>
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<td>PMAC</td>
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<td>MAC</td>
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<tr>
<td>PMAC</td>
<td>MAC</td>
</tr>
</tbody>
</table>

* Procedure Class

* Waiting Period (Months)

* Limitation

* Maximum Reimbursement

**In-Network**

**Out-of-Network**

* Notice of coverage (NOC) procedures and subject to review.

* Benefits will be based on the benefit for the corresponding non-cosmetic restoration.

* Only in conjunction with listed oral surgery procedures and subject to review.

* Applications made to permanent molar teeth only

* Only those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion.

* Additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient’s physician and claim narrative from dentist must be submitted at the time of the claim.

* Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient’s physician and claim narrative from dentist must be submitted at the time of the claim.
<table>
<thead>
<tr>
<th>Procedure (Dental)</th>
<th>A</th>
<th>(0)</th>
<th>(x)</th>
<th>(o)</th>
<th>PMAC</th>
<th>MAC</th>
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</thead>
<tbody>
<tr>
<td>FILLINGS</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>One Surface Amalgam</td>
<td>B</td>
<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Two Surface Amalgam</td>
<td>B</td>
<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Three Surface Amalgam</td>
<td>B</td>
<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Four + Surface Amalgam</td>
<td>B</td>
<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>One Surface Resin – Anterior</td>
<td>B</td>
<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Two Surface Resin – Anterior</td>
<td>B</td>
<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Three Surface Resin – Anterior</td>
<td>B</td>
<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Four + Surface or Incisal Resin – Anterior</td>
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<td>(0)</td>
<td>(r)</td>
<td>(s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Sedative Fillings</td>
<td>B</td>
<td>(0)</td>
<td>(o)</td>
<td>PMAC</td>
<td>MAC</td>
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</tr>
<tr>
<td>ORAL SURGERY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extraction, erupted tooth or exposed root</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
<td></td>
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<tr>
<td>Coronal Remnants</td>
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<td>(0)</td>
<td>PMAC</td>
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<tr>
<td>Surgical Extraction</td>
<td>B</td>
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<td>PMAC</td>
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<tr>
<td>Impacted (soft tissue)</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
<td></td>
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<tr>
<td>Impacted (partial bony)</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impacted (complete bony)</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Removal of Root</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
<td></td>
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<tr>
<td>Alveoplasty (with extraction) – per quadrant</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alveoplasty (without extraction) – per quadrant</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
<td></td>
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<tr>
<td>Incision and Drainage of Abscess – Intraoral</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
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<td></td>
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<tr>
<td>General Anesthesia/Intravenous Sedation</td>
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<td>(0)</td>
<td>(w)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
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<tr>
<td>CROWN AND BRIDGE REPAIR</td>
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<tr>
<td>Inlay Recementation</td>
<td>B</td>
<td>(0)</td>
<td>(bb)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
</tr>
<tr>
<td>Crown Recementation</td>
<td>B</td>
<td>(0)</td>
<td>(bb)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
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<tr>
<td>Bridge Repair</td>
<td>B</td>
<td>(0)</td>
<td>(bb)</td>
<td>PMAC</td>
<td>MAC</td>
<td></td>
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<tr>
<td>Crown Repair</td>
<td>B</td>
<td>(0)</td>
<td>(bb)</td>
<td>PMAC</td>
<td>MAC</td>
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<tr>
<td>Bridge Recementation</td>
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<td>Crown Resin – resin with high noble metal</td>
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<td>Crown Resin – resin with predominately base metal</td>
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<td>Crown – porcelain/ceramic substrate</td>
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<td>Crown - porcelain fused to high noble metal</td>
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<td>Crown – porcelain fused to noble metal</td>
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<td>Crown Prefabricated Stainless Steel</td>
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<td>Veneers – excluding cosmetic; restorative only</td>
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<td>Pontic Resin with High Noble Metal</td>
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<td>Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer</td>
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<td>Core Build-up for Retainer, (including any pins)</td>
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<td>Core Build-up (including any pins)</td>
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<td>Maxillary (Upper) Partial – Resin Base</td>
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<td>Mandibular (Lower) Partial – Resin Base</td>
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<td>Maxillary (Upper )Partial – Cast Metal Framework with Resin Base</td>
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<td>Removable Unilateral Partial Denture</td>
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<td>Endosteal Implants (with applicable crown - subject to alternate benefit provision)</td>
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<td>Initial Placement of Braces or Appliances</td>
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<td>Continuing Treatment for Braces or Appliances</td>
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* Orthodontia Services
If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured except as provided in the Replacement of Existing Coverage provision. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each Covered Dependent child, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

We will make a payment for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in monthly installments as claims are submitted over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and monthly installments will be determined as follows:
1. We will determine the lesser of the MAC and the orthodontist’s fee and multiply that amount by the Insurance Percentage shown in the Schedule.
2. The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule of Benefits will be the maximum benefit payable. An initial amount of 25% of the Overall Maximum Benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.
3. The remaining 75% of the Overall Maximum Benefit payable will be paid at the applicable co-pay on a monthly basis as
claims are submitted. The subsequent monthly payments will be made only if Your dependent remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the Overall Maximum Benefit payable has been paid, no further benefits will be paid.
PART XIV. SCHEDULE OF BENEFITS

Policyholder: Pearl River Community College – Gold Plan

Policyholder’s Address: 101 Hwy 11 North, Poplarville, MS 39470

Effective Date: October 1, 2009

Initial Term: 24 Months

Eligible Classes: ALL FULL TIME EMPLOYEES WORKING AT LEAST 20 HOURS PER WEEK

Eligibility Period: Immediately following the first day of Active Work

Mode of Premium Payment: MONTHLY

Method of Premium Payment: Remitted by Policyholder

Premium Due Date: 1st of every month

Certificate Year: Your Certificate Year is on a Policy Year Plan.

Deductible: In-Network $100 Lifetime.
Maximum Individual Deductible per Family: unlimited
Applies to Classes: B
Out-of-Network $100 Lifetime.
Maximum Individual Deductible per Family: unlimited
Applies to Classes: B

Co-Pay: See Schedule of Covered Procedures

Certificate Year Maximum Annual Benefit: Per Insured
In-Network
Year 1 $1,000 Year 2 $1,000 Year 3 & Forward $1,000
Out-of-Network
Year 1 $1,000 Year 2 $1,000 Year 3 & Forward $1,000

Waiting Periods See Schedule of Covered Procedures
### TABLE OF INSURANCE PERCENTAGES:

**Certificate Year 1:**

<table>
<thead>
<tr>
<th>Class</th>
<th>Insurance Percentage In-Network</th>
<th>Insurance Percentage Out-of-Network</th>
<th>Subject to Certificate</th>
<th>Maximum Annual/Lifetime Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100%</td>
<td>100%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>B</td>
<td>80%</td>
<td>80%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
</tbody>
</table>

**Certificate Year 2:**

<table>
<thead>
<tr>
<th>Class</th>
<th>Insurance Percentage In-Network</th>
<th>Insurance Percentage Out-of-Network</th>
<th>Subject to Certificate</th>
<th>Maximum Annual/Lifetime Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100%</td>
<td>100%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>B</td>
<td>80%</td>
<td>80%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
</tbody>
</table>

**Certificate Year 3 and later:**

<table>
<thead>
<tr>
<th>Class</th>
<th>Insurance Percentage In-Network</th>
<th>Insurance Percentage Out-of-Network</th>
<th>Subject to Certificate</th>
<th>Maximum Annual/Lifetime Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100%</td>
<td>100%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>B</td>
<td>80%</td>
<td>80%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
</tbody>
</table>

Takeover Benefits: Do takeover benefits apply for Employees who currently have dental coverage? Yes

- **Plan Type:**
  - □ Indemnity: No participating provider network
  - √ Participating Provider Program:
    - √ In and Out-of-Network Benefits
    - □ In-Network Benefit only
  - □ Scheduled Plan
ENDORSEMENT

The policy and certificate to which this endorsement is attached are amended as follows:

1. It is hereby understood and agreed that no change in premium will be effective unless and until We have given the Policyholder and each covered person at least 60 days prior written notice.

2. The provision entitled Time Payment of Claims is hereby deleted and the following provision is added:

   Time of Payment of Claims: Time of Payment of Claims” Provision: “All benefits payable under this Policy will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a Clean Claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of Clean Claim where claims are submitted in paper format. Benefits due under this Policy are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after We have received a Clean Claim containing necessary medical information and other information essential for Us to administer any preexisting condition, coordination of benefits and subrogation provisions.

   If the claim is not denied for valid and proper reasons by the end of the applicable time period described above, We will pay the provider (where the claim is owed to the provider) or the Insured person (where the claim is owed to the Insured Person) interest on accrued benefits at the rate of one and one-half percent (1½%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due is less than one dollar ($1.00), such amount will be credited to the account of the Insured Person or entity to whom such amount is owed.

   In the event that We fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue, and any other damages as may be allowable by law.

This Endorsement is effective on the later of the policy effective date or the certificate effective date to which it is attached.

There are no other changes to the policy or certificate.

In witness whereof We have caused this Endorsement to be signed by Our Chairman and Secretary.

[Signature]
Chairman /CEO

[Signature]
Secretary
Residents of this state who purchase life insurance, health insurance or annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

IMPORTANT DISCLAIMER

The Mississippi Life and Health Insurance Guaranty Association (the “Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations and exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association when selecting an insurer.

COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR CONTRACT OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS NON-GUARANTEED AMOUNTS HELD IN A SEPARATE ACCOUNT UNDER A VARIABLE LIFE OR VARIABLE ANNUITY CONTRACT.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance. You may contact either the Guaranty Association or the Mississippi Insurance Department at the following addresses if you should have any questions regarding this notice.

Mississippi Life and Health Insurance Guaranty Association
330 North Mart Plaza Suite 2
Jackson, Mississippi   39206

Mississippi Insurance Department
1001 Woolfolk, State Office Building
501 N. West Street
Jackson, Mississippi   39201

SUMMARY

The state law that provides for this safety-net coverage is called the Mississippi Life and Health Insurance Guaranty Association Act (the “Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

Coverage: Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract or policy, or an annuity contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

(please turn to back of page)
Exclusions From Coverage:

However, persons holding such policies are NOT protected by the Guaranty Association if:

They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a hospital or medical service organization whether profit or nonprofit, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or other person that operates on an assessment basis, an insurance exchange, or any similar entity.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.
- Any policy or contract of reinsurance, unless assumption certificates were issued pursuant to the reinsurance policy or contract;
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits or payment of any fees or allowances to any person in connection with this service to or administration of the policy or contract;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under federal Pension Benefit Guaranty Corporation ("PBGC ") regardless of whether the PBGC has yet become liable to make any payments with respect to the benefit plan;
- Portions of any unallocated annuity contract not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association with respect to the policy or contract are preempted by State or Federal law;
- Obligations that do not arise under the express written terms of the policy or contract, including claims based on marketing materials, side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements, or claims for policy misrepresentations, or extra-contractual or penalty or consequential or incidental damages claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

Limits on Amount of Coverage. The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts, the maximum obligation of the Guaranty Association is $300,000 in benefits except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Guaranty Association is $500,000. Within these overall limits, the Guaranty Association will not pay more than $300,000 in life insurance death benefits, $100,000 in net cash surrender and net cash withdrawal values, $300,000 for disability insurance benefits, $500,000 for basic hospital medical and surgical insurance or major medical insurance benefits, $100,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $5,000,000 limit with respect to any contract owner for unallocated annuity benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or to the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

05GA-MS
This Notice Describes How Medical and Financial Information About You May Be Used and Disclosed. Please Review This Notice Carefully.

Starmount Life Insurance Company and its insurance affiliates are committed to protecting your privacy and the confidentiality of information we collect from you or about you in compliance with Gramm-Leach-Bliley (GLB) law.

We are required by law to maintain the privacy of your protected health and financial information. This notice outlines our duties and practices in this regard.

How We Collect Information: We get most information from you or anyone you have authorized to provide the information. Information is obtained from your application for insurance, from other related forms or through a verification phone call with you. If additional information is needed, we may obtain it from your independent sales agent, physicians, hospitals, or other medical personnel, your employer, other transactions with our company or its affiliates, other insurers, the Medical Information Bureau or consumer reporting agencies.

Information collected may relate to your personal characteristics, employment, health, avocations, finances, as well as transactions with us or our affiliates. The information we collect might include name, address, Social Security number, telephone number, date of birth, medical and family history and dependent information. It may also include type and plan of insurance, other insurance you own, claim data, the amount of insurance premiums, or any other information.

How We Protect Information: Starmount Life Insurance Company and its affiliates maintain physical, electronic and procedural safeguards to protect the information we have obtained about you and to assist us in preventing unauthorized access to that information.

Electronic records are protected by multiple computer software products that use security features such as passwords, encryption, user identification numbers, and personal identification numbers to guard against unauthorized access. Our internal systems contain electronic firewalls and other security measures designed to prevent unauthorized access to our electronic records. We also employ surveillance software to determine if any abnormal activity occurs. Electronic points of entry, as well as databases, servers, e-mail and workstations are generally protected by virus detection/removal software.

We train all employees on our Privacy Policy and the importance of the privacy and confidentiality of all information we collect.

How We Use and Disclose Information: We may disclose any information we collect when we believe it is necessary for us to conduct or service our business or where disclosure is permitted or required by law. For example, information may be disclosed while you are insured, or after your insurance terminates, to:

- Anyone to whom you have authorized us to disclose the information;
- Your independent sales agent;
- Claims adjusters to process your claims;
- Underwriters to accept or reject your request for insurance;
- Investigators and attorneys;
- Consultants, Third-party administrators, PPO Networks, and Health care clearinghouses; Data processing firms and billing firms;
- Our affiliated companies, business associates, other insurance companies and reinsurers;
- Persons or organizations that conduct audits and scientific research, including actuarial or underwriting studies;
- Persons/entities performing general administrative and claim processing activities for us; and
- Insurance regulators, courts or government agencies or others as may be permitted or required by law.

Information may also be shared with our affiliates so that they may offer you other products and services. We may also provide information to others outside Starmount Life Insurance Company with whom we have a joint marketing agreement. For example, we may have a joint marketing agreement with another insurer to enable us to offer you that company’s insurance products. Any person or entity with whom we share information must maintain the same high standards of privacy and confidentiality that we require of our own employees and affiliates.

We do not make disclosures of information to any other companies that may want to sell their products or services to you. We will not sell any information to a catalog company. We do not disclose information subject to the Fair Credit Reporting Act.

Other disclosures will be made only with your written authorization, which you may revoke at any time.

Right to Access and Correct Information:
You have a right to inspect and copy your protected health information. You have a right to ask for an accounting of any disclosures of information. We may impose a reasonable fee for this service where permitted. You may ask us to correct or change our records regarding your information. If we agree, we will make the correction/change. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of information. You can contact us by phone at 225-926-2888 or by mail to E. Sternberg, Starmount Life Insurance Company, 7800 Office Park Boulevard, Baton Rouge, LA 70809-7603, or e-mail Erich@StarmountLife.com.
Starmount Life Insurance Company, Inc.
AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Starmount Life Insurance Company, Inc. and AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company), (collectively “Starmount”) are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How Starmount May Use or Disclose Your Health Information

1. **Payment Functions.** Starmount may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. **Health Care Operations.** Starmount may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. **Required by Law.** As required by law, Starmount may use and disclose your health information. Starmount may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. **Public Health.** As required by law, Starmount may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. **Coroners, Medical Examiners and Funeral Directors.** Starmount may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Health and Safety.** Starmount may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. **Government Functions.** Starmount may disclose your health information for military, national security, prisoner and government benefits purposes.

9. **Worker’s Compensation.** Starmount may disclose your health information as necessary to comply with worker’s compensation or similar laws.

10. **Disclosures to Plan Sponsors.** Starmount may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When Starmount May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Starmount will not use or disclose your health information without written authorization from you. If you do authorize Starmount to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. Starmount is not required to agree to the restrictions that you request.
2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. Starmount is not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, Starmount may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that Starmount amend your health information. Starmount is not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. Starmount will provide one list per 12 month period free of charge; Starmount may charge you for additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

**Starmount’s Obligations Under This Notice**

Starmount is required by law to:

1. Maintain the privacy of your health information.
2. Provide you with a notice of its legal duties and privacy practices with respect to your health information.
3. Abide by the terms of this Notice.
4. Notify you if Starmount is unable to agree to a requested restriction on how your information is used or disclosed.
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

Starmount reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that Starmount maintains. Revised Notices will be distributed to you by mail.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer  
Starmount Life Insurance  
7800 Office Park Boulevard  
Baton Rouge, LA 70809-7603

You may also file a complaint with the Secretary of the Department of Health and Human Services. Starmount will not retaliate against you in any way for filing a complaint.

**Effective Date of This Notice: April 14, 2003.**
FIRST NOTICE OF COBRA

*VERY IMPORTANT NOTICE*

A Federal law, usually called COBRA, requires that most employers sponsoring group dental and vision plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. Both you and your spouse should take the time to read this notice carefully.

You have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of employment (for reasons other than gross misconduct on your part), or because your employer files for reorganization under Chapter XI of the Bankruptcy Law while you are retired.

If you are the spouse of an employee covered by this employer, you have the right to choose continuation coverage for yourself if you lose your group health coverage for any of the following five reasons:

1. The death of your spouse;

2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

3. Divorce or legal separation from your spouse;

4. Your spouse becomes entitled to Medicare; or

5. Your spouse's employer files for reorganization under Chapter XI of the Bankruptcy Law while your spouse is retired.

In the case of a dependent child of an employee covered by the plan, he or she has the right to continuation coverage if group health coverage is lost for any of the following six reasons:

1. The death of a parent;

2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;

3. Parents' divorce or legal separation;

4. A parent becomes entitled to Medicare;

5. The dependent ceases to be a "dependent child" under the Group Health Plan; or

6. The parent's employer files for reorganization under Chapter XI of the Bankruptcy Law while the parent is retired.
Under COBRA, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the happening of any such event. If notice is not received within that 60 day period, the dependent will not be entitled to choose continuation coverage. The employer has the responsibility to notify Starmount Life Insurance Company of the employee's death, termination of employment, or reduction in hours or Medicare entitlement.

When the employer is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have at least 60 days from the date you would lose coverage, because of one of the events described above, to inform the employer that you want continuation coverage.

If you do not choose continuation coverage, your group dental and vision insurance coverage will end.

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for 3 years unless you lost your group health coverage because of a termination of employment or reduction of hours. In that case, the required continuation coverage period is 18 months. If, during that 18-month period, another event takes place that would also entitle a dependent spouse or child (other than a spouse or child who became covered after continuation coverage became effective) to his or her own continuation coverage, (for example, the former employee dies, is divorced or legally separated, or be entitled to Medicare, or a dependent ceases to be a "dependent child" under the dental and vision plan the continuation coverage may be extended. However, in no case will any period of continuation coverage be more than 36 months.

If you are entitled to 18 months of continuation coverage, and if you are determined to be disabled under the terms of the Social Security Act as of the date your employment terminated (or the date your hours, were reduced), you are eligible for an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the employer within 60 days after you receive a determination of disability from the Social Security Administration, provided notice is given before the end of the initial 18 months of continuation coverage. During the additional 11 months of continuation coverage, your premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

However, the new law also provides that your continuation coverage may be cut short for any of the following four reasons:

1. The employer no longer provides group dental and/or vision coverage to any of its employees;

2. The premium for your continuation coverage is not paid in a timely fashion;

3. You become covered under another group health plan, unless that other plan contains an exclusion or limitation with respect to any pre-existing condition affecting you or a covered dependent; or

4. You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you may have to pay all or part of the premium for your continuation coverage. You will have an initial grace period of 45 days starting with the date you choose continuation coverage to pay any premiums; and after that initial 45 day grace period, you will have a grace period of at least 30 days to pay any subsequent premiums. COBRA also says that, at the end of the 18 month, 29 month or 3 year continuation coverage period, you must be allowed to enroll in any individual conversion health plan which may be provided under the plan.

If you have any questions about COBRA, please contact the employer. Also, if you have changed marital status, if a dependent ceases to be a "dependent child" under the plan, or if you or your spouse have a changed address, please notify the employer.
Carryover Benefits Rider

Attached to and made part of this Policyholder’s Group Dental Policy and each Certificate of Insurance issued under such policy. It is hereby agreed that the policy and certificate is amended by adding the Carryover Benefits provision as defined below:

Effective Date: This rider is effective on October 1, 2009.

Policyholder Status:
This is a Takeover group. Carryover Benefits will be accumulated based on the prior Benefit Year’s claim activity, subject to availability of applicable data from the prior insurance carrier.

Benefits Description:
An Insured may be eligible for carryover of a portion of his or her unused Certificate Year Maximum Benefit, as follows:

If an Insured submits Qualifying Claims for Covered Expenses during a Benefit Year and, in that Benefit Year, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Threshold Limit, the Insured will be credited a Carryover Benefit for that Benefit Year.

Carryover Benefits will be accrued and stored in the Insured’s Carryover Account. If an Insured reaches his or her Certificate Year Maximum Benefit, We will pay a benefit from the Insured’s Carryover Account up to the amount stored in the Insured’s Carryover Account. The accrued Carryover Benefits stored in the Carryover Account may not be greater than the Carryover Account Limit.

An Insured’s Carryover Account will be eliminated, and the accrued Carryover Benefits lost, if the Insured has a break in coverage of any length of time, for any reason.

The Threshold Limit, Carryover Benefit, and Carryover Account Limits for this Policy/Certificate are:
- Threshold Limit: $500
- Carryover Benefit: $250
- Carryover Account Limit: $1,000

Eligibility for a Carryover Benefit will be established or reestablished at the time the first Qualifying Claim in a Benefit Year is received for Covered Expenses incurred during that Benefit Year.

In order to properly calculate the Carryover Benefit, claims should be submitted timely in accordance with the Proof of Loss provision found within the Claims Provision. You have the right to request review of prior Carryover Benefit calculations. The request for review must be within 12 months from the date the Carryover Benefit was established.

Other Specifications:
Policy Year Plans: If the effective date of an Insured’s dental coverage is within the three months prior to the start of this plan’s next Policy Year, this benefit rider will not apply to the Insured until the next Policy Year. And:
- Only claims incurred on or after the start of the next Policy Year will count toward the Threshold Limit; and
- Carryover Benefits will not be applied to an Insured’s Carryover Account until the Policy Year that starts one year from the date the rider first applies.

If charges for Class C Services are not payable for an Insured due to a benefit Waiting Period for certain Covered Procedures, this rider will not apply to the Insured until the end of such Waiting Period. And, if the Waiting Period ends within the three months prior to the start of this plan’s next Benefit Year, this rider will not apply to the Insured until the next Benefit Year, and:
- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit; and
Carryover Benefits will not be applied to an Insured’s Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

If Covered Insurance Percentages increase each Benefit Year for certain Covered Procedures, this rider will not apply to the Insured until all Covered Insurance Percentages reach the ultimate level. And, if the Covered Insurance Percentages reach the ultimate level within the three months prior to the start of this plan’s next Benefit Year, this rider will not apply to the Insured until the next Benefit Year, and:

- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit; and
- Carryover Benefits will not be applied to an Insured’s Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

Definitions:
- “Benefit Year” means Calendar Year or Policy Year, according to the type of plan applicable under the Policy/Certificate to which this rider is attached.
- “Carryover Account” means the amount of an Insured’s accrued Carryover Benefits.
- “Carryover Account Limit” means the maximum amount of cumulative Carryover Benefits that an Insured can store in his or her Carryover Account.
- “Carryover Benefit” means the dollar amount, which will be added to an Insured’s Carryover Account when he or she receives benefits in a Benefit Year that do not exceed the Threshold Limit.
- Qualifying Claim means a claim under Procedure Classes A, B and C, but not Class D, Orthodontia.

- “Threshold Limit” means the maximum amount of benefits that an Insured can receive during a Benefit Year and still be entitled to receive the Carryover Benefit.

This Rider takes effect on the date shown on Page 1 of the Rider and expires with the Policy/Certificate to which it is attached. It is subject to all the terms, conditions, limitations and exclusions of the Policy/Certificate that are not inconsistent with it. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy/Certificate except as stated in this Rider.

Signed for Starmount Life Insurance Company.

Hans J. Sternberg,
Chairman and
Chief Executive Officer

DN-2002CT CB Rider
Accessing Your Benefits

Our goal is to make using your benefits as easy and trouble-free as possible. Login as a current Member on our website www.AlwaysCareBenefits.com to search for the most up-to-date listing of AlwaysDental Providers in your area, view benefits, view status of your claims, print ID cards, and access other forms and documents. If you do not have access to the internet, please call our Customer Service Representatives toll free at 1-888-729-5433, Ext. 2013.

We encourage you to submit names and addresses of dental providers not listed on our website whom you would us to contact. We will begin recruiting them as an in-network provider immediately.

The first time you use your plan, identify yourself as an “AlwaysDental - Starmount Member” and let the dental office know your coverage has moved to the DenteMax Network. They do not need to be part of a network for us to pay them. All they need to do is submit a standard claim form, and we will reimburse based on your plan’s allowances.

AlwaysCare and DenteMax strive to offer you an extensive national network, but we also encourage you to take advantage of this flexible plan. You may choose to visit any licensed general dentist or dental specialist. We also have a panel of participating providers who have agreed to provide special pricing to our Members with no balance billing. Visit our website or call Customer Service for this listing.

Q&A

Who will submit my dental claims to AlwaysCare?
Over 96% of the dental claims we receive are submitted by providers. A Member may submit his/her own claim by downloading a claim form from the “Client Services” tab on our website and mailing the completed form with receipts back to our office. The address is listed on the back of your ID card.

When should I have a pre-estimate done?
Please ask your doctor to submit a pre-treatment estimate request for any claims in excess of $300.

How do we coordinate benefits?
We follow the birthday rule for coordination of benefits. If a child has coverage under the father and mother’s policy, we use the birthday month of the parent that comes first in the year as primary.

How do orthodontic benefits work?
At the time of Initial Placement of Braces or Appliances AlwaysCare will pay 25% of the total fee or 25% of the lifetime maximum, whichever is less. The remaining 75% of benefits will be available for monthly treatments while the Member is eligible for coverage.

Will my benefits cover any dental procedure?
Since all policies have limitations, it is recommended that you review the certificate of coverage prior to having work done. Recognizing that dental problems can be resolved with more than one type of treatment, AlwaysCare will reimburse for the least expensive method that would produce the same resolution within professionally acceptable limits.

More procedure-specific information: On most plans, the policy will pay for a replacement of a crown, bridge, inlay, onlay or denture if it is at least 5 years old and cannot be made serviceable. A claim is considered incurred on the date an impression is taken for a bridge or dentures, the date a tooth is prepped for a crown, and when the pulp chamber is opened for a root canal. If your policy does not include composite (white) fillings on molars, we will pay the alternate benefit of an amalgam (silver) filling. You will be responsible for the difference in cost.

NEW Benefits from AlwaysCare!
- One additional cleaning for pregnant women in their 2nd or 3rd trimesters
- One adjunctive, prediagnostic test per year for Members 40+ years of age who demonstrate risk factors for oral cancer or suspicious lesions
- Up to two extra cleanings per year for Members diagnosed as diabetic (optional benefit)

See your Certificate of Insurance or contact us at 1-888-729-5433, Ext. 2013 for a complete explanation of benefits. DNTTIP1008 Dental Tips-Rev8/08
GROUP DENTAL INSURANCE CERTIFICATE

This Certificate explains the dental insurance coverage under the Group Policy (the Policy) issued to the Policyholder by Starmount Life Insurance Company (called “We,” “Our” or “Us” in this Certificate). The Policy provides the benefits for the Insured Member (called "You" or "Your" in this Certificate) and any Covered Dependents.

The Policyholder and the Policy Number are shown in the Schedule of Benefits.

This, together with the Schedule of Benefits applying to Your Eligible Class, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your dental benefits. All benefits are governed by the terms and conditions of the Policy.

The Policy alone constitutes the entire contract between the Policyholder and Us.

Chairman /CEO

Secretary

NON-PARTICIPATING
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PART I. DEFINITIONS

Administrator - The entity which will provide complete service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.

Claim - A statement signed by an Insured and his treating dentist for a request of payment under a dental benefit plan. It shall include services rendered, dates of services and itemization of costs.

Co-Pay - The fixed amount that an Insured is required to pay directly to a Participating Provider for Covered Expenses. The Co-Pay may vary by Procedure Code.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Expense - The lesser of the following for a Covered Procedure: (1) the actual charge; or (2) the Maximum Reimbursement.

Covered Procedure - The procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for necessary dental treatment to an Insured while His coverage under this Certificate is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a:
1. licensed dentist who is acting within the scope of his or her license;
2. licensed physician performing dental services within the scope of his or her license; or
3. licensed dental hygienist acting under the supervision and direction of a dentist.

Deductible - The Deductible is shown on the Schedule of Benefits. The Individual Deductible is the amount that each Insured must satisfy once each Certificate Year (or lifetime, when applicable) before benefits are payable for Covered Procedures. We apply amounts used to satisfy Individual Deductibles to the Maximum per Family Deductible, if any. Once any Maximum per Family Deductible is satisfied, no further Individual Deductibles are required to be met for that Certificate Year. If multiple procedures are performed on the same date, the Deductibles will be satisfied in order of Procedure Class (that is, toward Procedure Class B, and then C.)

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown on the Schedule of Benefits. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Eligibility Period, if any.

Eligible Dependent - Means a person listed below:
1. Your spouse;
2. Your unmarried dependent child under age 19, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried child age 19 or older but less than age 25 who is:
   a. Not regularly employed on a full-time basis;
   b. Primarily dependent upon You for support and maintenance; and
   c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.
4. Your unmarried child who has reached age 19 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.
   Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

Eligibility Period – The period of time a Member must wait before He is eligible for coverage. The Eligibility Period, if any, is specified in the Policyholder’s Group Application and shown in the Schedule of Benefits.

He, Him and His – Refers to the male or female gender.
Initial Term - The period following the group’s initial effective date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

In-Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Insured – Means You and each Covered Dependent.

Insured Member – Means a person:
1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Eligibility Period, if any; and
3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling outside the Policyholder’s initial Eligibility Period as indicated in the Schedule of Benefits. Benefits may be limited for Late Entrants under Limitations.

Maximum Reimbursement – An amount used to determine the Covered Expense. There are 3 types of Maximum Reimbursement, depending on the plan issued:
1. Maximum Allowable Charge (MAC): The MAC may be used if a dentist who is a Non-Participating Provider performs a Covered Procedure. The amount of the MAC is equal to the lesser of: (a) the dentist’s actual charge; or (b) the “customary charge” for the dental service or supply. We determine the “customary charge” from within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area.
2. Participating Provider Maximum Allowable Charge (PMAC): The PMAC may be used if a dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the dentist has agreed with Us to accept as payment in full for a dental service or supply.
3. Scheduled Fee (SF): Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the dentist.

The Schedule of Covered Procedures shows the Type Of Maximum Reimbursement used by the plan.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Non-Participating Provider - A dentist who is not a Participating Provider. These dentists have not entered into an agreement with us to limit their charges.

Out-of–Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider - A dentist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

Participating Provider Program - Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

Participating Provider Program Directory - The list which consists of selected dentists who:
1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated.

Policyholder - The entity stated on the front page of the Policy.

Policy Year Plan - Benefits begin immediately on the Policyholder’s effective date and renew 12 months following the initial effective date.
Re-enrollee - Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits are limited for Re-enrollees under Part VI. Limitations.

You or Your – The Insured Member.

Waiting Period - The period of time during which an Insured’s coverage must be in force before benefits may become payable for Covered Procedures. The Waiting Period, if any, for each Covered Procedure is shown in the Schedule of Covered Procedures.

PART II. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:
1. be a Member of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Member’s Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage may automatically become effective under the other spouse’s coverage. OR enrollment will default to the Policyholder’s rules.

B. ENROLLMENT

The term “Enrollment” means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Eligibility Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder. It usually occurs once each Calendar Year but may, at the Policyholder’s discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within 31 days of the event. A change in family status means any of the following events:
1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.
PART III. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:
1. the Policyholder’s Effective Date, shown on the Schedule of Benefits; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, birth or adoption, coverage is effective on the first of the month following the date such dependent was acquired. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child’s placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 31 days of the placement in order to continue the coverage beyond the initial 31-day period.

PART IV. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:
1. the date the Policy terminates;
2. the date the Policyholder’s coverage terminates under the Policy;
3. the first of the month following the date You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within 31 days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:
1. the date he is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART V. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:
1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Schedule of Benefits shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of 31 days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 12 month period. We will give the Policyholder written notice at least 45 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.
PART VI. DESCRIPTION OF COVERAGE

A. COVERED DENTAL EXPENSES

We determine if benefits are payable under the policy if an Insured incurs expenses for a Covered Procedure. Before we determine benefits, the Insured must satisfy the Deductible and Waiting Period, if any.

The Deductible is shown on the Schedule of Benefits. The Waiting Period is listed separately for each Covered Procedure. It is shown on the Schedule of Covered Procedures.

We then pay the Insurance Percentage of the Covered Expense, minus any Co-Pay. The Insurance Percentage is based on: (1) the length of time the Insured has been covered under this Certificate; and (2) the Procedure Class. The Insurance Percentage is shown in the Table of Insurance Percentages on the Schedule of Benefits.

The Co-Pay, if any, is listed for each Covered Procedure in the Schedule of Covered Procedures.

The benefit is subject to the following:
1. The Covered Procedure must start and be completed while the Insured’s coverage is in force, except as provided in the Takeover Benefits provision.
2. Each Covered Procedure may be subject to specific Limitations, as shown on the Schedule of Covered Procedures.
3. A Certificate Year Maximum Annual Benefit may apply to each Insured. This is shown on the Schedule of Benefits.
4. A Maximum Annual and/or Maximum Lifetime Benefit may apply to each Procedure Class. If applicable, these maximums are shown in the Table of Covered Insurance Percentages on the Schedule of Benefits.
5. Other limitations and exclusions that may affect coverage are shown in the “Limitations and Exclusions” provision.

B. WHEN A COVERED PROCEDURE IS STARTED AND COMPLETED

1. We consider a dental treatment to be started as follows:
   a. for a full or partial denture, the date the first impression is taken;
   b. for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
   c. for root canal therapy, on the date the pulp chamber is first opened;
   d. for periodontal surgery, the date the surgery is performed; and
   e. for all other treatment, the date treatment is rendered.

2. We consider a dental treatment to be completed as follows:
   a. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
   b. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
   c. for root canal therapy, the date a canal is permanently filled.

NOTE: If Orthodontia Services are covered, see Procedure Class D in the Schedule of Covered Procedures for start and completion dates.

C. HOW TO SUBMIT EXPENSES

Expenses submitted to Us must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as we see fit, to determine benefits.
D. CHOICE OF PROVIDERS

An Insured may choose a dentist of his choice. An Insured may choose the services of a dentist who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Insured will generally incur less out-of-pocket cost unless the Policyholder has selected a Participating Provider Only plan.

E. PRE-ESTIMATE

If the charge for any treatment is expected to exceed $300, We suggest that a dental treatment plan be submitted to Us by Your dentist for review before treatment begins. In addition to a dental treatment plan, We may request any of the following information to help Us determine benefits payable for certain services:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models; and
4. a statement specifying:
   a. degree of overjet, overbite, crowding and open bite;
   b. whether teeth are impacted, in crossbite, or congenitally missing;
   c. length of orthodontic treatment; and
   d. total orthodontic treatment charge.

An estimate of the benefits payable will be sent to You and Your dentist. The pre-estimate is not a guarantee of the amount We will pay. The pre-estimate process lets an Insured know in advance approximately what portion of the expenses We will consider as a Covered Expense. Our estimate may be for a less expensive alternative benefit if it will produce professionally satisfactory results.

F. ALTERNATE BENEFIT PROVISION

Many dental problems can be resolved in more than one way. If: 1) We determine that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, We may use the less expensive alternative benefit to determine the amount payable under the Certificate. **For example:** When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base our benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-participating Provider performs the service.

G. SERVICES PERFORMED OUTSIDE THE U.S.A.

Any Claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the Maximum Allowable Charge, Participating Provider Maximum Allowable Charge, or applicable Scheduled Fee amounts for the Insured’s zip code.

PART VII. LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS

1. LIMITATION FOR LATE ENTRANTS OR RE-ENROLLEES: Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coverage with AlwaysCare will have a twelve (12) month waiting period applied to all basic, major, and orthodontia services upon re-applying.

2. MISSING TEETH LIMITATION: We will not pay benefits for replacement of teeth missing on an Insured’s effective date of insurance under this Certificate for the purpose of the initial placement of a full denture, partial denture or fixed bridge. However, expenses for the replacement of teeth missing on the effective date will be considered for payment as follows:
a. The initial placement of full or partial dentures will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while the Insured is covered under the policy.

b. The initial placement of a fixed bridge will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while an Insured is covered under the policy. However, the following restrictions will apply:
   (i) Benefits will only be paid for the replacement of the teeth extracted while an Insured is covered under the policy or under the “Prior Extraction” clause;
   (ii) benefits will not be paid for the replacement of other teeth which were missing on the Insured’s effective date.
   (iii) missing teeth limitation will be waived after Members have been covered under the plan for (3) three continuous years unless it is a replacement of an existing unserviceable prosthesis.

3. Other Limitations: Multiple restorations on one surface are payable as one surface. Coverage is limited to either one prophylaxis or one periodontal maintenance per six-month period. Coverage is limited to one full mouth radiograph or panoramic film per the limitation period listed in the Schedule of Covered Procedures.

B. EXCLUSIONS

No benefits are payable under the Policy for the procedures listed below unless such procedure or service is listed as covered in the Schedule of Covered Procedures. Additionally, the procedures listed below will not be recognized toward satisfaction of any Deductible amount.

1. any service or supply not shown on the Schedule of Covered Procedures;
2. any procedure begun after an Insured’s insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty days after an Insured’s insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations;
6. the replacement of lost or discarded or stolen appliances;
7. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
8. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
9. replacement of crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
10. appliances, services or procedures relating to: (a) the change or maintenance of vertical dimension; (b) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (c) splinting; (d) correction of attrition, abrasion, erosion or abfraction; (e) bite registration or (f) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
12. orthognathic surgery;
13. prescribed drugs, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
21. any procedure We determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured’s household;
23. expenses compensable under Workers’ Compensation or Employers’ Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile “No-Fault” coverage);
24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the “Payment of Claims” provision;
25. procedures started but not completed;
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures, plus the services of anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

Notice Of Claim: Written notice of Claim must be given within thirty (30) days after a loss occurs, or as soon as reasonably possible. The notice must be given to the Administrator. Claims should be sent to:

Starmount Life Insurance Company, Inc.
c/o AlwaysCare Benefits, Inc. – Dental Claims
P.O. Drawer 80139
Baton Rouge, LA 70898

Claim Forms: When the Administrator receives notice of Claim that does not contain all necessary information or is not on an appropriate Claim form, forms for filing proof of loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss.

Proof Of Loss: Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

Payment Of Claims: Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

If any beneficiary is a minor or mentally incapacitated, We will pay the proper share of Your insurance amount to such beneficiary's court appointed guardian.

Time of Payment Of Claims: Indemnities payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. If We are unable to immediately pay due to deficiencies in Your claim, We will notify You within thirty (30) days if Your claim was filed electronically or within forty-five (45) days if Your claim was filed on paper of those deficiencies and how they can be remedied. Our failure to notify You of any deficiencies within the stated time frames will establish the submitted claim as a clean claim. We will pay or deny a clean claim: (1) if filed electronically, within thirty (30) days after the date We receive the claim; or (2) if the claim is filed on paper, within forty-five (45) days after the date We receive the claim.

Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of our liability will be paid immediately upon receipt of due written proof.
Recovery Of Overpayments: We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured if claim payments previously were made with respect to an Insured.

PART IX. COORDINATION OF BENEFITS (COB)

This provision applies when an Insured has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. Allowable Expense: An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

2. Coordination of Benefits: Taking other Plans into account when We pay benefits.

3. Plan: Any plan, including this one that provides benefits or services for dental expenses on either a group or individual basis. “Plan” includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). “Plan” shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

4. Primary Plan: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

5. Year: The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured’s Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured’s benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

   a. Non-dependent/Dependent. A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.
b. **Dependent Child/Parents Not Separated or Divorced.** For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

   i.  The Plan of the parent who has responsibility for providing insurance as determined by a court order;
   
   ii. The Plan of the parent with custody of the child;
   
   iii. The Plan of the spouse of the parent with custody; and
   
   iv. The Plan of the parent without custody of the child.

d. **Dependent Child/Joint Custody:** If the joint custody court decree does not specifically state which parent is responsible for the child’s medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee’s dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. **Right to Receive and Release Needed Information**

   We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. **Right to Make Payments To Another Plan**

   COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. **Right to Recovery**

   COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

**PART X. GRIEVANCE PROCEDURE**

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

**Starmount Life Insurance Company, Inc.**

   c/o AlwaysCare Benefits, Inc.
   
   Grievance Committee
   
   P.O. Drawer 80139
   
   Baton Rouge, LA 70898

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person

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who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

PART XI. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

PART XII. REPLACEMENT OF EXISTING COVERAGE

The following provisions are applicable if this dental plan is replacing an existing group dental plan in force (referred to as “Prior Plan”) at the time of application. These are called “Takeover Benefits.” The Schedule of Benefits shows if Takeover Benefits apply.

Waiting Period Credit: When We immediately take over an entire dental group from another carrier, those persons insured by the Prior Plan on the day immediately prior to the takeover effective date will receive Waiting Period credit if they are eligible for coverage on the effective date of Our plan. The Waiting Period credit does not apply to new Insureds, Eligible Dependent add-ons, Late Entrants, or Re-enrollees.

Annual Maximums And Deductible Credits: For Calendar Year Plans: Deductible credits will be granted for the amount of Deductible satisfied under the Prior Plan during the current Calendar Year. Any benefits paid under the Prior Plan with respect to such replaced coverage will be applied to and deducted from the maximum benefit payable under this Certificate.

For Policy Year Plans: The annual maximums and annual Deductibles will begin on the policy’s takeover effective date, which marks the start of a new Policy Year. Deductible credit will not be given. Any benefits paid under the Prior Plan with respect to such replaced coverage will not be applied to or deducted from the maximum benefits payable for services under this Certificate.

Maximum Benefit Credit: All paid benefits applied to the maximum benefit amounts under the Prior Plan will also be applied to the maximum benefit amounts under this Certificate.

If You had orthodontic coverage for Your covered dependent children under the Prior Plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

1. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the Prior Plan; and
2. orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
3. orthodontic treatment is continued while Your covered dependent is insured under this Certificate.
If you submit the required proof, the maximum benefit for orthodontic treatment will be the lesser of this Certificate’s Overall Maximum Benefit for Class D Orthodontic Services or the Prior Plan’s ortho maximum benefit. The ortho maximum benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

**Verification:** The Policyholder’s application must be accompanied by a current month’s billing from the current dental carrier, a copy of an in-force certificate, as well as proof of the effective date for each Insured (and dependent), if insured under the Prior Plan.

**Prior Carrier’s Responsibility:** The prior carrier is responsible for costs for procedures begun prior to the effective date of this coverage.

**Prior Extractions:** If: (1) treatment is dentally necessary due to an extraction which occurred before the effective date of this coverage while an Insured was covered under the Prior Plan; (2) the replacement of the extracted tooth must take place within thirty-six (36) months of extraction; and (3) treatment would have been covered under the Policyholder’s Prior Plan; We will apply the expenses to this plan as long as they are Covered Expenses under both this Certificate and the Prior Plan.

**Coverage for Treatment in Progress:** If an Insured was covered under the Prior Plan on the day before this Certificate replaced the Prior Plan, the Insured may be eligible for benefits for treatment already in progress on the effective date of this Certificate. However, the expenses must be covered dental expenses under both this Certificate and the Prior Plan. This is subject to the following:

1. **Extension of Benefits under Prior Plan.** We will not pay benefits for treatment if:
   (a) the Prior Plan has an Extension of Benefits provision;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed during the extension of benefits.

2. **No Extension of Benefits under Prior Plan.** We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:
   (a) the Prior Plan has no extension of benefits when that plan terminates;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed while insured under this Certificate.

3. **Treatment Not Completed during Extension of Benefits.** We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan and during the extension if:
   (a) the Prior Plan has an extension of benefits;
   (b) the treatment expenses were incurred under the Prior plan; and
   (c) the treatment was not completed during the Prior Plan’s extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.
PART XIII. SCHEDULE OF COVERED PROCEDURES

The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable limitations. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

Key for Schedule of Covered Procedures

<table>
<thead>
<tr>
<th>Procedure Class</th>
<th>Type of Maximum Reimbursement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Preventive/Diagnostic</td>
<td>PMAC – Participating Provider Maximum Allowable Charge</td>
</tr>
<tr>
<td>B Basic</td>
<td>MAC – Maximum Allowable Charge (based on “Customary Charge”)</td>
</tr>
<tr>
<td>C Major</td>
<td>SF – Scheduled Fee</td>
</tr>
<tr>
<td>D Orthodontia</td>
<td></td>
</tr>
<tr>
<td>E Not Covered</td>
<td></td>
</tr>
<tr>
<td>F Other</td>
<td></td>
</tr>
</tbody>
</table>

Limitations

<table>
<thead>
<tr>
<th>Limitation</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Maximum of 1 procedure per 6 months</td>
<td>Limited to Dependent Children under age 16</td>
</tr>
<tr>
<td>(b) Maximum of 1 procedure per 36 months</td>
<td>Maximum of 1 per 24 months for age 17 +</td>
</tr>
<tr>
<td>(c) Maximum of 12 films per 36 months</td>
<td>Maximum of 1 per 12 months for age 16 &amp; under</td>
</tr>
<tr>
<td>(d) Limited to Dependent Children under age 19</td>
<td>Limited to those age 25+</td>
</tr>
<tr>
<td>(e) Maximum of 1 procedure per 12 months</td>
<td>6 months must have passed since initial placement</td>
</tr>
<tr>
<td>(f) Limited to Dependent Children under age 14</td>
<td>Maximum of 1 per 7 year period</td>
</tr>
<tr>
<td>(g) Limited to Dependent Children under age 12</td>
<td>Maximum of 1 per 10 year period</td>
</tr>
<tr>
<td>(h) Maximum of 1 procedure per 24 months</td>
<td>Maximum of 1 per 3 year period</td>
</tr>
<tr>
<td>(j) Applications made to permanent molar teeth only</td>
<td>Maximum of 1 per 4 year period</td>
</tr>
<tr>
<td>(k) Maximum of 2 procedures per arch per 24 months</td>
<td>Maximum of 1 per 5 year period</td>
</tr>
<tr>
<td>(l) Maximum of 1 per 5 year period per tooth</td>
<td>In lieu of a 3 unit bridge when a 3 unit bridge has been approved for coverage</td>
</tr>
<tr>
<td>(m) Maximum of 1 each quadrant per 12 months</td>
<td>Maximum of 2 procedures per 12 months</td>
</tr>
<tr>
<td>(n) Maximum of 1 each quadrant per 24 months</td>
<td>Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion.</td>
</tr>
<tr>
<td>(o) Maximum of 1 each tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>(p) Subject to a yearly and a lifetime maximum</td>
<td>One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient’s physician and claim narrative from dentist must be submitted at the time of the claim.</td>
</tr>
<tr>
<td>(q) Maximum of 1 each quadrant per 36 months</td>
<td>Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient’s physician and claim narrative from dentist must be submitted at the time of the claim.</td>
</tr>
<tr>
<td>(r) Replacement of existing only if in place for 12 months (insured under age 19)</td>
<td>(ii)</td>
</tr>
<tr>
<td>(s) Replace existing only if in place for 36 months</td>
<td>(li)</td>
</tr>
<tr>
<td>(t) Benefits will be based on the benefit for the corresponding non-cosmetic restoration.</td>
<td>Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient’s physician and claim narrative from dentist must be submitted at the time of the claim.</td>
</tr>
<tr>
<td>(u) Maximum 1 time per tooth</td>
<td></td>
</tr>
<tr>
<td>(v) Maximum of 1 per lifetime</td>
<td></td>
</tr>
<tr>
<td>(w) Only in conjunction with listed complex oral surgery procedures and subject to review.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Procedures</th>
<th>Procedure Class*</th>
<th>Waiting Period (Months)</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive or Periodic Oral Exam</td>
<td>A</td>
<td>(0)</td>
<td>(i)</td>
</tr>
<tr>
<td>Problem Focused Exam</td>
<td>B</td>
<td>(0)</td>
<td>(e)</td>
</tr>
<tr>
<td>Comprehensive Periodontal Exam</td>
<td>A</td>
<td>(0)</td>
<td>(e)</td>
</tr>
<tr>
<td>Emergency Palliative Treatment</td>
<td>B</td>
<td>(0)</td>
<td>(e)</td>
</tr>
<tr>
<td>Single Film</td>
<td>A</td>
<td>(0)</td>
<td></td>
</tr>
<tr>
<td>Additional Films</td>
<td>A</td>
<td>(0)</td>
<td></td>
</tr>
<tr>
<td>Intra-Oral Occlusal Film</td>
<td>A</td>
<td>(0)</td>
<td></td>
</tr>
<tr>
<td>Panoramic Film or Full Mouth X-Ray</td>
<td>B</td>
<td>(0)</td>
<td>(h)</td>
</tr>
<tr>
<td>Bitewing – Single Film, or</td>
<td>A</td>
<td>(0)</td>
<td>(e)</td>
</tr>
<tr>
<td>Bitewing – Two Films, or</td>
<td>A</td>
<td>(0)</td>
<td>(e)</td>
</tr>
<tr>
<td>Bitewing – Four Films</td>
<td>A</td>
<td>(0)</td>
<td>(e)</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>A</td>
<td>(0)</td>
<td>(ii) (kk)</td>
</tr>
<tr>
<td>Adjunctive Pre-Diagnostic Oral Cancer Screening</td>
<td>A</td>
<td>(0)</td>
<td>(e) (ji)</td>
</tr>
<tr>
<td>Topical Application of Fluoride</td>
<td>A</td>
<td>(0)</td>
<td>(e) (x)</td>
</tr>
<tr>
<td>Sealant</td>
<td>A</td>
<td>(0)</td>
<td>(b) (x) (j)</td>
</tr>
<tr>
<td>Space Maintainer – Fixed Unilateral</td>
<td>A</td>
<td>(0)</td>
<td>(x) (o)</td>
</tr>
<tr>
<td>Space Maintainer – Fixed Bilateral</td>
<td>A</td>
<td>(0)</td>
<td>(x) (o)</td>
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Maximum Reimbursement

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
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</thead>
<tbody>
<tr>
<td>PMAC</td>
<td>MAC</td>
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<tr>
<td>PMAC</td>
<td>MAC</td>
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<td>PMAC</td>
<td>MAC</td>
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<td>PMAC</td>
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<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Description</th>
<th>Category</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FILLINGS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Surface Amalgam</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Two Surface Amalgam</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Three Surface Amalgam</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Four + Surface Amalgam</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>One Surface Resin – Anterior</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Two Surface Resin – Anterior</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Three Surface Resin – Anterior</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Four + Surface or Incisal Resin – Anterior</td>
<td>B</td>
<td>(0) (r) (s)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Sedative Fillings</td>
<td>B</td>
<td>(0) (o)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td><strong>ORAL SURGERY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extraction, erupted tooth or exposed root</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Coronal Remnants</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Surgical Extraction</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Impacted (soft tissue)</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Impacted (partial bony)</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Impacted (complete bony)</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Surgical Removal of Root</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Alveoplasty (with extraction) – per quadrant</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Alveoplasty (without extraction) – per quadrant</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Incision and Drainage of Abscess – Intraoral</td>
<td>B</td>
<td>(0)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>General Anesthesia/Intravenous Sedation</td>
<td>B</td>
<td>(0) (w)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td><strong>CROWN AND BRIDGE REPAIR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlay Recementation</td>
<td>B</td>
<td>(0) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Crown Recementation</td>
<td>B</td>
<td>(0) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Bridge Repair</td>
<td>B</td>
<td>(0) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Crown Repair</td>
<td>B</td>
<td>(0) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Bridge Recementation</td>
<td>B</td>
<td>(0) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td><strong>DENTURE REPAIR</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Repair Denture Base</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Repair Teeth – per tooth</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Repair Partial Base</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Repair Partial Framework</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Repair Broken Clasp</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Add Tooth to Existing Partial Denture</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Add Clasp to Existing Partial Denture</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Replace Teeth – per tooth</td>
<td>B</td>
<td>(0) (e) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Reline Upper Denture</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Reline Lower Partial Denture</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Reline Upper Denture (Lab)</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Reline Lower Denture (Lab)</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Reline Upper Partial Denture (Lab)</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Reline Lower Partial Denture (Lab)</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Rebase Complete Denture – Upper</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Rebase Complete Denture – Lower</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Rebase Partial Denture – Lower</td>
<td>B</td>
<td>(0) (h) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Tissue Conditioning – Upper</td>
<td>B</td>
<td>(0) (k) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Tissue Conditioning – Lower</td>
<td>B</td>
<td>(0) (k) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Denture Adjustment Maxillary – Upper</td>
<td>B</td>
<td>(0) (a) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Denture Adjustment Mandibular – Lower</td>
<td>B</td>
<td>(0) (a) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Partial Adjustment Maxillary – Upper</td>
<td>B</td>
<td>(0) (a) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Partial Adjustment Mandibular – Lower</td>
<td>B</td>
<td>(0) (a) (bb)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td><strong>PERIODONTICS (Non-surgical)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling and Root Planing –per quadrant</td>
<td>C</td>
<td>(12) (n)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Periodontal Debridement (full mouth)</td>
<td>C</td>
<td>(12) (v)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Periodontal Maintenance Procedure</td>
<td>C</td>
<td>(12) (ii) (kk)</td>
<td>PMAC</td>
<td>MAC</td>
</tr>
</tbody>
</table>
### ENDODONTICS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Pulpotomy – primary teeth only</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Root Canal – Anterior</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Root Canal – Bicuspid</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Root Canal – Molar</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Apicoectomy – Anterior</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Apicoectomy – Molar</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Retrograde Filling</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Root Amputation</td>
<td>C</td>
<td>(12)</td>
<td>PMAC</td>
</tr>
</tbody>
</table>

### MISCELLANEOUS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occlusal Guard</td>
<td>E</td>
</tr>
</tbody>
</table>

### PERIODONTICS (Surgical)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gingivectomy or gingivoplasty – per quadrant</td>
<td>C</td>
</tr>
<tr>
<td>Gingival Flap Procedure – per quadrant, or</td>
<td>C</td>
</tr>
<tr>
<td>Osseous Surgery – per quadrant</td>
<td>C</td>
</tr>
<tr>
<td>Pedicle Soft Tissue Graft</td>
<td>C</td>
</tr>
<tr>
<td>Free Soft Tissue Graft</td>
<td>C</td>
</tr>
<tr>
<td>Subepithelial Connective Tissue Graft</td>
<td>C</td>
</tr>
</tbody>
</table>

### CROWN

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown Resin – resin with high noble metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Resin – resin with noble metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Resin – resin with predominately base metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown – porcelain/ceramic substrate</td>
<td>C</td>
</tr>
<tr>
<td>Crown - porcelain fused to high noble metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown – porcelain fused to noble metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown – porcelain fused to predominantly base metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown – full cast high noble metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown – ¾ cast high noble metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown – full cast noble metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown – full cast predominantly base metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Prefabricated Stainless Steel</td>
<td>C</td>
</tr>
<tr>
<td>Cast Post and Core – In Addition to Crown</td>
<td>C</td>
</tr>
<tr>
<td>Prefabricated Post and Core – In Addition to Crown</td>
<td>C</td>
</tr>
<tr>
<td>Inlay</td>
<td>C</td>
</tr>
<tr>
<td>Onlay</td>
<td>C</td>
</tr>
<tr>
<td>Veneers – excluding cosmetic; restorative only</td>
<td>C</td>
</tr>
</tbody>
</table>

### BRIDGE

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pontic Cast High Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Cast Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Cast Predominantly Base Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Porcelain Fused to High Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Porcelain Fused to Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Porcelain Fused to Predominantly Base Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Resin with High Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Resin with Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Pontic Resin with Predominantly Base Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Resin with High Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Resin with Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Resin with Predominantly Base Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Porcelain Fused to Noble / High Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Porcelain Fused to Predominantly Base Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown ¾ Cast High Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Full Cast Noble Metal</td>
<td>C</td>
</tr>
<tr>
<td>Crown Full Cast Predominantly Base Metal</td>
<td>C</td>
</tr>
</tbody>
</table>
### Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer

<table>
<thead>
<tr>
<th>Service Description</th>
<th>MAC Code</th>
<th>MAC Level</th>
<th>PMAC Code</th>
<th>PMAC Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Build-up for Retainer, (including any pins)</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Core Build-up (including any pins)</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
</tbody>
</table>

### DENTURES

<table>
<thead>
<tr>
<th>Service Description</th>
<th>MAC Code</th>
<th>MAC Level</th>
<th>PMAC Code</th>
<th>PMAC Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Upper Denture</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Complete Lower Denture</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Immediate Upper Denture</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Immediate Lower Denture</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Maxillary (Upper) Partial – Resin Base</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Mandibular (Lower) Partial – Resin Base</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Maxillary (Upper) Partial – Cast Metal Framework with Resin Base</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Mandibular (Lower) Partial – Cast Metal Framework with Resin Base</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Removable Unilateral Partial Denture</td>
<td>C</td>
<td>(12)</td>
<td>(l)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Endosteal Implants (with applicable crown - subject to alternate benefit provision)</td>
<td>C</td>
<td>(12)</td>
<td>(hh)</td>
<td>PMAC</td>
</tr>
</tbody>
</table>

### Cosmetic

<table>
<thead>
<tr>
<th>Service Description</th>
<th>MAC Code</th>
<th>MAC Level</th>
<th>PMAC Code</th>
<th>PMAC Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic</td>
<td>E</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TMJ

<table>
<thead>
<tr>
<th>Service Description</th>
<th>MAC Code</th>
<th>MAC Level</th>
<th>PMAC Code</th>
<th>PMAC Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMJ</td>
<td>E</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### ORTHODONTIA *

<table>
<thead>
<tr>
<th>Service Description</th>
<th>MAC Code</th>
<th>MAC Level</th>
<th>PMAC Code</th>
<th>PMAC Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Orthodontic Examination</td>
<td>D</td>
<td>(12)</td>
<td>(d) (p)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Initial Placement of Braces or Appliances</td>
<td>D</td>
<td>(12)</td>
<td>(d) (p)</td>
<td>PMAC</td>
</tr>
<tr>
<td>Continuing Treatment for Braces or Appliances</td>
<td>D</td>
<td>(12)</td>
<td>(d) (p)</td>
<td>PMAC</td>
</tr>
</tbody>
</table>

*Orthodontia Services*

If covered, We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured except as provided in the Replacement of Existing Coverage provision. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each Covered Dependent child, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. Those Insureds who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

We will make a payment for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in monthly installments as claims are submitted over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and monthly installments will be determined as follows:

1. We will determine the lesser of the MAC and the orthodontist’s fee and multiply that amount by the Insurance Percentage shown in the Schedule.
2. The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule of Benefits will be the maximum benefit payable. An initial amount of 25% of the Overall Maximum Benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.
3. The remaining 75% of the Overall Maximum Benefit payable will be paid at the applicable co-pay on a monthly basis as claims are submitted. The subsequent monthly payments will be made only if Your dependent remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the Overall Maximum Benefit payable has been paid, no further benefits will be paid.
PART XIV. SCHEDULE OF BENEFITS

Policyholder: Pearl River Community College – Platinum Plan

Policyholder’s Address: 101 Hwy 11 North, Poplarville, MS 39470

Effective Date: October 1, 2009

Initial Term: 24 Months

Eligible Classes: ALL FULL TIME EMPLOYEES WORKING AT LEAST 20 HOURS PER WEEK

Eligibility Period: Immediately following the first day of Active Work

Mode of Premium Payment: MONTHLY

Method of Premium Payment: Remitted by Policyholder

Premium Due Date: 1st of every month

Certificate Year: Your Certificate Year is on a Policy Year Plan.

Deductible:
In-Network $100 Lifetime.
Maximum Individual Deductible per Family: unlimited
Applies to Classes: B, C
Out-of-Network $100 Lifetime.
Maximum Individual Deductible per Family: unlimited
Applies to Classes: B, C

Co-Pay: See Schedule of Covered Procedures

Certificate Year Maximum Annual Benefit: Per Insured
In-Network
Year 1  Year 2  Year 3 & Forward
$2,000  $2,000  $2,000
Out-of- Network
Year 1  Year 2  Year 3 & Forward
$2,000  $2,000  $2,000

Waiting Periods See Schedule of Covered Procedures
TABLE OF INSURANCE PERCENTAGES:

Certificate Year 1:

<table>
<thead>
<tr>
<th>Class</th>
<th>Insurance Percentage In-Network</th>
<th>Insurance Percentage Out-of Network</th>
<th>Subject to Certificate</th>
<th>Maximum Annual/Lifetime Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100%</td>
<td>100%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>B</td>
<td>80%</td>
<td>80%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>C</td>
<td>0%</td>
<td>0%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>D</td>
<td>0%</td>
<td>0%</td>
<td>No</td>
<td>$500/$1,000</td>
</tr>
</tbody>
</table>

Certificate Year 2:

<table>
<thead>
<tr>
<th>Class</th>
<th>Insurance Percentage In-Network</th>
<th>Insurance Percentage Out-of Network</th>
<th>Subject to Certificate</th>
<th>Maximum Annual/Lifetime Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100%</td>
<td>100%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>B</td>
<td>80%</td>
<td>80%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
<td>50%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>D</td>
<td>50%</td>
<td>50%</td>
<td>No</td>
<td>$500/$1,000</td>
</tr>
</tbody>
</table>

Certificate Year 3 and later:

<table>
<thead>
<tr>
<th>Class</th>
<th>Insurance Percentage In-Network</th>
<th>Insurance Percentage Out-of Network</th>
<th>Subject to Certificate</th>
<th>Maximum Annual/Lifetime Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100%</td>
<td>100%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>B</td>
<td>80%</td>
<td>80%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
<td>50%</td>
<td>Yes</td>
<td>None/None</td>
</tr>
<tr>
<td>D</td>
<td>50%</td>
<td>50%</td>
<td>No</td>
<td>$500/$1,000</td>
</tr>
</tbody>
</table>

Takeover Benefits: Do takeover benefits apply for Employees who currently have dental coverage? Yes

Plan Type:
- □ Indemnity: No participating provider network
- √ Participating Provider Program:
  - √ In and Out-of-Network Benefits
  - □ In-Network Benefit only
- □ Scheduled Plan
ENDORSEMENT

The policy and certificate to which this endorsement is attached are amended as follows:

1. It is hereby understood and agreed that no change in premium will be effective unless and until We have given the Policyholder and each covered person at least 60 days prior written notice.

2. The provision entitled Time Payment of Claims is hereby deleted and the following provision is added:

   **Time of Payment of Claims:**
   
   Time of Payment of Claims” Provision: “All benefits payable under this Policy will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a Clean Claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of Clean Claim where claims are submitted in paper format. Benefits due under this Policy are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after We have received a Clean Claim containing necessary medical information and other information essential for Us to administer any preexisting condition, coordination of benefits and subrogation provisions.

   If the claim is not denied for valid and proper reasons by the end of the applicable time period described above, We will pay the provider (where the claim is owed to the provider) or the Insured person (where the claim is owed to the Insured Person) interest on accrued benefits at the rate of one and one-half percent (1½%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due is less than one dollar ($1.00), such amount will be credited to the account of the Insured Person or entity to whom such amount is owed.

   In the event that We fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue, and any other damages as may be allowable by law.

This Endorsement is effective on the later of the policy effective date or the certificate effective date to which it is attached.

There are no other changes to the policy or certificate.

In witness whereof We have caused this Endorsement to be signed by Our Chairman and Secretary.

Chairman /CEO

Secretary
Residents of this state who purchase life insurance, health insurance or annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

**IMPORTANT DISCLAIMER**

The Mississippi Life and Health Insurance Guaranty Association (the “Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations and exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association when selecting an insurer.

**COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR CONTRACT OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS NON-GUARANTEED AMOUNTS HELD IN A SEPARATE ACCOUNT UNDER A VARIABLE LIFE OR VARIABLE ANNUITY CONTRACT.**

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance. You may contact either the Guaranty Association or the Mississippi Insurance Department at the following addresses if you should have any questions regarding this notice.

**Mississippi Life and Health Insurance Guaranty Association**
330 North Mart Plaza Suite 2  
Jackson, Mississippi  39206

**Mississippi Insurance Department**
1001 Woolfolk, State Office Building  
501 N. West Street  
Jackson, Mississippi  39201

**SUMMARY**

The state law that provides for this safety-net coverage is called the Mississippi Life and Health Insurance Guaranty Association Act (the “Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

**Coverage:** Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract or policy, or an annuity contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

*(please turn to back of page)*
Exclusions From Coverage:

However, persons holding such policies are NOT protected by the Guaranty Association if:

They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a hospital or medical service organization whether profit or nonprofit, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or other person that operates on an assessment basis, an insurance exchange, or any similar entity.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.
- Any policy or contract of reinsurance, unless assumption certificates were issued pursuant to the reinsurance policy or contract;
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits or payment of any fees or allowances to any person in connection with this service to or administration of the policy or contract;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under federal Pension Benefit Guaranty Corporation ("PBGC ") regardless of whether the PBGC has yet become liable to make any payments with respect to the benefit plan;
- Portions of any unallocated annuity contract not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association with respect to the policy or contract are preempted by State or Federal law;
- Obligations that do not arise under the express written terms of the policy or contract, including claims based on marketing materials, side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements, or claims for policy misrepresentations, or extra-contractual or penalty or consequential or incidental damages claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

Limits on Amount of Coverage. The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts, the maximum obligation of the Guaranty Association is $300,000 in benefits except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Guaranty Association is $500,000. Within these overall limits, the Guaranty Association will not pay more than $300,000 in life insurance death benefits, $100,000 in net cash surrender and net cash withdrawal values, $300,000 for disability insurance benefits, $500,000 for basic hospital medical and surgical insurance or major medical insurance benefits, $100,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $5,000,000 limit with respect to any contract owner for unallocated annuity benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or to the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.
This Notice Describes How Medical and Financial Information About You May Be Used and Disclosed. Please Review This Notice Carefully.

Starmount Life Insurance Company and its insurance affiliates are committed to protecting your privacy and the confidentiality of information we collect from you or about you in compliance with Gramm-Leach-Bliley (GLB) law.

We are required by law to maintain the privacy of your protected health and financial information. This notice outlines our duties and practices in this regard.

How We Collect Information: We get most information from you or anyone you have authorized to provide the information. Information is obtained from your application for insurance, from other related forms or through a verification phone call with you. If additional information is needed, we may obtain it from your independent sales agent, physicians, hospitals, or other medical personnel, your employer, other transactions with our company or its affiliates, other insurers, the Medical Information Bureau or consumer reporting agencies.

Information collected may relate to your personal characteristics, employment, health, avocations, finances, as well as transactions with us or our affiliates. The information we collect might include name, address, Social Security number, telephone number, date of birth, medical and family history and dependent information. It may also include type and plan of insurance, other insurance you own, claim data, the amount of insurance premiums, or any other information.

How We Protect Information: Starmount Life Insurance Company and its affiliates maintain physical, electronic and procedural safeguards to protect the information we have obtained about you and to assist us in preventing unauthorized access to that information.

Electronic records are protected by multiple computer software products that use security features such as passwords, encryption, user identification numbers, and personal identification numbers to guard against unauthorized access. Our internal systems contain electronic firewalls and other security measures designed to prevent unauthorized access to our electronic records. We also employ surveillance software to determine if any abnormal activity occurs. Electronic points of entry, as well as databases, servers, e-mail and workstations are generally protected by virus detection/removal software.

We train all employees on our Privacy Policy and the importance of the privacy and confidentiality of all information we collect.

How We Use and Disclose Information: We may disclose any information we collect when we believe it is necessary for us to conduct or service our business or where disclosure is permitted or required by law. For example, information may be disclosed while you are insured, or after your insurance terminates, to:

- Anyone to whom you have authorized us to disclose the information;
- Your independent sales agent;
- Claims adjusters to process your claims;
- Underwriters to accept or reject your request for insurance;
- Investigators and attorneys;
- Consultants, Third-party administrators, PPO Networks, and Health care clearinghouses; Data processing firms and billing firms;
- Our affiliated companies, business associates, other insurance companies and reinsurers;
- Persons or organizations that conduct audits and scientific research, including actuarial or underwriting studies;
- Persons/entities performing general administrative and claim processing activities for us; and
- Insurance regulators, courts or government agencies or others as may be permitted or required by law.

Information may also be shared with our affiliates so that they may offer you other products and services. We may also provide information to others outside Starmount Life Insurance Company with whom we have a joint marketing agreement. For example, we may have a joint marketing agreement with another insurer to enable us to offer you that company’s insurance products. Any person or entity with whom we share information must maintain the same high standards of privacy and confidentiality that we require of our own employees and affiliates.

We do not make disclosures of information to any other companies that may want to sell their products or services to you. We will not sell any information to a catalog company. We do not disclose information subject to the Fair Credit Reporting Act.

Other disclosures will be made only with your written authorization, which you may revoke at any time.

Right to Access and Correct Information:

You have a right to inspect and copy your protected health information. You have a right to ask for an accounting of any disclosures of information. We may impose a reasonable fee for this service where permitted. You may ask us to correct or change our records regarding your information. If we agree, we will make the correction/change. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of information. You can contact us by phone at 225-926-2888 or by mail to E. Sternberg, Starmount Life Insurance Company, 7800 Office Park Boulevard, Baton Rouge, LA 70809-7603, or e-mail Erich@StarmountLife.com.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Starmount Life Insurance Company, Inc. and AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company), (collectively “Starmount”) are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How Starmount May Use or Disclose Your Health Information

1. Payment Functions. Starmount may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. Health Care Operations. Starmount may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. Required by Law. As required by law, Starmount may use and disclose your health information. Starmount may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. Public Health. As required by law, Starmount may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. Coroners, Medical Examiners and Funeral Directors. Starmount may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. Organ and Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. Health and Safety. Starmount may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. Government Functions. Starmount may disclose your health information for military, national security, prisoner and government benefits purposes.

9. Worker’s Compensation. Starmount may disclose your health information as necessary to comply with worker’s compensation or similar laws.

10. Disclosures to Plan Sponsors. Starmount may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When Starmount May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Starmount will not use or disclose your health information without written authorization from you. If you do authorize Starmount to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. Starmount is not required to agree to the restrictions that you request.
2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. Starmount is not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, Starmount may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that Starmount amend your health information. Starmount is not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. Starmount will provide one list per 12 month period free of charge; Starmount may charge you for additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

**Starmount’s Obligations Under This Notice**

Starmount is required by law to:

1. Maintain the privacy of your health information.
2. Provide you with a notice of its legal duties and privacy practices with respect to your health information.
3. Abide by the terms of this Notice.
4. Notify you if Starmount is unable to agree to a requested restriction on how your information is used or disclosed.
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

Starmount reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that Starmount maintains. Revised Notices will be distributed to you by mail.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer  
Starmount Life Insurance  
7800 Office Park Boulevard  
Baton Rouge, LA 70809-7603

You may also file a complaint with the Secretary of the Department of Health and Human Services. Starmount will not retaliate against you in any way for filing a complaint.

**Effective Date of This Notice: April 14, 2003.**
A Federal law, usually called COBRA, requires that most employers sponsoring group dental and vision plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. Both you and your spouse should take the time to read this notice carefully.

You have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of employment (for reasons other than gross misconduct on your part), or because your employer files for reorganization under Chapter XI of the Bankruptcy Law while you are retired.

If you are the spouse of an employee covered by this employer, you have the right to choose continuation coverage for yourself if you lose your group health coverage for any of the following five reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becomes entitled to Medicare; or
5. Your spouse's employer files for reorganization under Chapter XI of the Bankruptcy Law while your spouse is retired.

In the case of a dependent child of an employee covered by the plan, he or she has the right to continuation coverage if group health coverage is lost for any of the following six reasons:

1. The death of a parent;
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;
3. Parents' divorce or legal separation;
4. A parent becomes entitled to Medicare;
5. The dependent ceases to be a "dependent child" under the Group Health Plan; or
6. The parent's employer files for reorganization under Chapter XI of the Bankruptcy Law while the parent is retired.
Under COBRA, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the happening of any such event. If notice is not received within that 60 day period, the dependent will not be entitled to choose continuation coverage. The employer has the responsibility to notify Starmount Life Insurance Company of the employee's death, termination of employment, or reduction in hours or Medicare entitlement.

When the employer is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have at least 60 days from the date you would lose coverage, because of one of the events described above, to inform the employer that you want continuation coverage.

If you do not choose continuation coverage, your group dental and vision insurance coverage will end.

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for 3 years unless you lost your group health coverage because of a termination of employment or reduction of hours. In that case, the required continuation coverage period is 18 months. If, during that 18-month period, another event takes place that would also entitle a dependent spouse or child (other than a spouse or child who became covered after continuation coverage became effective) to his or her own continuation coverage, (for example, the former employee dies, is divorced or legally separated, or be entitled to Medicare, or a dependent ceases to be a "dependent child" under the dental and vision plan the continuation coverage may be extended. However, in no case will any period of continuation coverage be more than 36 months.

If you are entitled to 18 months of continuation coverage, and if you are determined to be disabled under the terms of the Social Security Act as of the date your employment terminated (or the date your hours, were reduced), you are eligible for an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the employer within 60 days after you receive a determination of disability from the Social Security Administration, provided notice is given before the end of the initial 18 months of continuation coverage. During the additional 11 months of continuation coverage, your premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

However, the new law also provides that your continuation coverage may be cut short for any of the following four reasons:

1. The employer no longer provides group dental and/or vision coverage to any of its employees;
2. The premium for your continuation coverage is not paid in a timely fashion;
3. You become covered under another group health plan, unless that other plan contains an exclusion or limitation with respect to any pre-existing condition affecting you or a covered dependent; or
4. You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you may have to pay all or part of the premium for your continuation coverage. You will have an initial grace period of 45 days starting with the date you choose continuation coverage to pay any premiums; and after that initial 45 day grace period, you will have a grace period of at least 30 days to pay any subsequent premiums. COBRA also says that, at the end of the 18 month, 29 month or 3 year continuation coverage period, you must be allowed to enroll in any individual conversion health plan which may be provided under the plan.

If you have any questions about COBRA, please contact the employer. Also, if you have changed marital status, if a dependent ceases to be a "dependent child" under the plan, or if you or your spouse have a changed address, please notify the employer.
Carryover Benefits Rider

Attached to and made part of this Policyholder’s Group Dental Policy and each Certificate of Insurance issued under such policy. It is hereby agreed that the policy and certificate is amended by adding the Carryover Benefits provision as defined below:

Effective Date: This rider is effective on October 1, 2009.

Policyholder Status:
This is a Takeover group. Carryover Benefits will be accumulated based on the prior Benefit Year’s claim activity, subject to availability of applicable data from the prior insurance carrier.

Benefits Description:
An Insured may be eligible for carryover of a portion of his or her unused Certificate Year Maximum Benefit, as follows:

If an Insured submits Qualifying Claims for Covered Expenses during a Benefit Year and, in that Benefit Year, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Threshold Limit, the Insured will be credited a Carryover Benefit for that Benefit Year.

Carryover Benefits will be accrued and stored in the Insured’s Carryover Account. If an Insured reaches his or her Certificate Year Maximum Benefit, We will pay a benefit from the Insured’s Carryover Account up to the amount stored in the Insured’s Carryover Account. The accrued Carryover Benefits stored in the Carryover Account may not be greater than the Carryover Account Limit.

An Insured’s Carryover Account will be eliminated, and the accrued Carryover Benefits lost, if the Insured has a break in coverage of any length of time, for any reason.

The Threshold Limit, Carryover Benefit, and Carryover Account Limits for this Policy/Certificate are:
- Threshold Limit: $800
- Carryover Benefit: $400
- Carryover Account Limit: $1,500

Eligibility for a Carryover Benefit will be established or reestablished at the time the first Qualifying Claim in a Benefit Year is received for Covered Expenses incurred during that Benefit Year.

In order to properly calculate the Carryover Benefit, claims should be submitted timely in accordance with the Proof of Loss provision found within the Claims Provision. You have the right to request review of prior Carryover Benefit calculations. The request for review must be within 12 months from the date the Carryover Benefit was established.

Other Specifications:
Policy Year Plans: If the effective date of an Insured’s dental coverage is within the three months prior to the start of this plan’s next Policy Year, this benefit rider will not apply to the Insured until the next Policy Year. And:
- Only claims incurred on or after the start of the next Policy Year will count toward the Threshold Limit; and
- Carryover Benefits will not be applied to an Insured’s Carryover Account until the Policy Year that starts one year from the date the rider first applies.

If charges for Class C Services are not payable for an Insured due to a benefit Waiting Period for certain Covered Procedures, this rider will not apply to the Insured until the end of such Waiting Period. And, if the Waiting Period ends within the three months prior to the start of this plan’s next Benefit Year, this rider will not apply to the Insured until the next Benefit Year, and:
- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit; and

DN-2002CT CB Rider
• Carryover Benefits will not be applied to an Insured’s Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

If Covered Insurance Percentages increase each Benefit Year for certain Covered Procedures, this rider will not apply to the Insured until all Covered Insurance Percentages reach the ultimate level. And, if the Covered Insurance Percentages reach the ultimate level within the three months prior to the start of this plan’s next Benefit Year, this rider will not apply to the Insured until the next Benefit Year, and:

• Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit; and
• Carryover Benefits will not be applied to an Insured’s Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

Definitions:
• “Benefit Year” means Calendar Year or Policy Year, according to the type of plan applicable under the Policy/Certificate to which this rider is attached.
• “Carryover Account” means the amount of an Insured’s accrued Carryover Benefits.
• “Carryover Account Limit” means the maximum amount of cumulative Carryover Benefits that an Insured can store in his or her Carryover Account.
• “Carryover Benefit” means the dollar amount, which will be added to an Insured’s Carryover Account when he or she receives benefits in a Benefit Year that do not exceed the Threshold Limit.
• Qualifying Claim means a claim under Procedure Classes A, B and C, but not Class D, Orthodontia.

• “Threshold Limit” means the maximum amount of benefits that an Insured can receive during a Benefit Year and still be entitled to receive the Carryover Benefit.

This Rider takes effect on the date shown on Page 1 of the Rider and expires with the Policy/Certificate to which it is attached. It is subject to all the terms, conditions, limitations and exclusions of the Policy/Certificate that are not inconsistent with it. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy/Certificate except as stated in this Rider.

Signed for Starmount Life Insurance Company.

Hans Sternberg,
Chairman and
Chief Executive Officer

DN-2002CT CB Rider
Important Tips on Using Your Vision Benefits!

Accessing Your Benefits:
Our goal is to make using your benefits as easy and trouble-free as possible. For the most up-to-date listing of AlwaysVision Providers in your area, visit our website at www.AlwaysCareBenefits.com to use our Provider search engine. You can also login to view benefits, view status of your claims, print ID cards, order contact lenses and access other forms and documents. If you do not have access to the internet, please call our Customer Service Representatives toll free at 1-888-729-5433, Ext. 2013.

- When scheduling your appointment, identify yourself as an “AlwaysVision – Starmount Member.” Depending on the Provider, your vision benefit information may best be accessed by using one of the names listed above.
- If your Provider requests your “employer’s name,” please provide your “Corporate Employer’s Name” listed on the front of your card.
- For any questions, your Provider should contact our Customer Service Department. We will work directly with you and the Provider.
- Your AlwaysVision Provider will take care of the rest!

We encourage you to submit names and addresses of vision providers not listed on our website whom you would like us to contact. We will begin immediate recruitment to have them become part of our network for your use.

Quick Tips:
- AlwaysCare is now offering AlwaysVision Members the opportunity to purchase contact lenses online at exceptional prices. AlwaysVision Members may use their available vision benefits to help pay for their purchases. Visit www.AlwaysCareBenefits.com to order now!
- Your plan allowance for the purchase of contact lenses has 2 components: a fitting service (which is completed by your eye doctor), and the contact lenses you purchase. You may apply your plan allowance to either or both of these components. Many providers (including Wal-Mart, Sam’s Club, For Eyes Optical, and others) assign a portion of your plan allowance toward the fitting service which is then deducted (along with any applicable plan co-pay) from the amount your plan will pay toward contact lens materials. If you have not had a fitting service, please remind your provider so they can help you understand your benefits and out-of-pocket costs.
- Your vision exam benefit entitles you to a comprehensive eye exam of principal vision functions including but not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated.
- Material upgrades like polycarbonate lenses, transition lenses, tinting and others are not covered benefits.
- The vast majority of contact lens purchases are considered “elective,” since most people can elect glasses or contacts. Contact lenses are considered “Medically Necessary” when your Provider has determined that contact lenses are optically necessary to correct visual function and glasses are not an option. Purchase of “Medically Necessary” contacts must be approved in advance by AlwaysCare.
- Contact lenses may be selected in lieu of frames and eyeglass lenses. However, your plan will not cover both in one benefit year.
- You may select any frames or contact lenses. AlwaysCare will pay up to the available plan allowance.
- Safety eyewear is not covered.
GROUP VISION CARE INSURANCE CERTIFICATE

Underwritten by: Starmount Life Insurance Company
7800 Office Park Blvd.
P.O. Box 98100
Baton Rouge, LA 70809

Administrator: AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)
P.O. Box 98100
Baton Rouge, LA 70898-9100

This Certificate explains the vision insurance coverage under the Group Policy (the Policy) issued to the Policyholder.

The Policyholder and the Group Policy Number are shown in the Certificate Schedule page.

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your vision care benefits. All benefits are governed by the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.

Jeffrey G. Wild, Secretary
Erich Sternberg, President

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

10-Day Right to Examine this Certificate: It is important to Us that You are satisfied with the coverage provided under this Certificate and that it meets Your insurance goals. If You are not satisfied, You may return it within 10 days after You receive it. We will refund all premiums paid and Your coverage will be void from its effective date.
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PART I. CERTIFICATE SCHEDULE

Policyholder: Pearl River Community College
Policyholder’s Address: 101 Hwy 11 North, Poplarville, MS 39470
Group Policy Number: PRCC1009
Effective Date: October 1, 2009
Initial Term: 24 Months
Eligible Classes: All Full Time Employees Working At Least 20 Hours Per Week Immediately Following The First Day of Active Work
Waiting Period: Immediately following the first day of Active Work
Mode of Premium Payment: MONTHLY
Method of Premium Payment: Remitted by Policyholder
Premium Due Date: 1st of every month
PART II. SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES
Your Certificate is on Rolling Benefit Plan Basis

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam:</td>
<td>Once every 12 Months</td>
</tr>
<tr>
<td>Eyeglass Lenses:</td>
<td>Once every 12 Months</td>
</tr>
<tr>
<td>Frames:</td>
<td>Once every 24 Months</td>
</tr>
<tr>
<td>Contact Lenses:</td>
<td>Once every 12 Months</td>
</tr>
</tbody>
</table>

CO-PAY (PER INSURED)

<table>
<thead>
<tr>
<th></th>
<th>In-Network Provider:</th>
<th>Out-of-Network Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam:</td>
<td>$10.00</td>
<td>See Below</td>
</tr>
<tr>
<td>Eyeglass Lenses:</td>
<td>$10.00</td>
<td>See Below</td>
</tr>
<tr>
<td>Frames:</td>
<td>$10.00</td>
<td>See Below</td>
</tr>
<tr>
<td>Contact Lenses:</td>
<td>$10.00</td>
<td>See Below</td>
</tr>
</tbody>
</table>

BENEFITS AND ALLOWANCES ¹

<table>
<thead>
<tr>
<th></th>
<th>In-Network Provider:</th>
<th>Out-of-Network Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Ophthalmologist</td>
<td>Covered in Full</td>
<td>$35 Allowance</td>
</tr>
<tr>
<td>By Optometrist</td>
<td>Covered in Full</td>
<td>$35 Allowance</td>
</tr>
<tr>
<td>Materials – Eyeglass Lenses³:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in Full</td>
<td>Up to $25</td>
</tr>
<tr>
<td>Bifocals</td>
<td>Covered in Full</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Progressives</td>
<td>$70 Allowance</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocals</td>
<td>Covered in Full</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$80 Allowance</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Materials – Frames²:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$120 allowance ($94 at Wal-Mart, Sam’s Club &amp; Costco*)</td>
<td>Up to $50</td>
<td></td>
</tr>
<tr>
<td>Materials – Contact Lenses³:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Elective</td>
<td>Up to $210 retail</td>
<td>Up to $210 retail</td>
</tr>
<tr>
<td>Elective</td>
<td>Up to $130 retail</td>
<td>Up to $100 retail</td>
</tr>
</tbody>
</table>

¹ Special payment and reimbursement terms apply for materials purchased at Costco.

² The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. Contact Lenses consist of (3) components: materials, exams and fittings. Coverage is for materials and the exam, up to the Contact Lenses allowance. Fittings may be covered but only up to the amount of any unused Contact Lenses allowance – after Materials.

³ Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

¹ Where an “Allowance” is shown, You are responsible for paying any charges in excess of the Allowance.
PART III. DEFINITIONS

Administrator - The entity which provides complete service and facilities for the writing and servicing of the Policy as agreed to in a contract with Us.

Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.

Claim - A request for payment of benefits under this Certificate.

Co-Pay – An Insured’s share of the costs for Covered Services or Materials that are provided by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. If an Out-of-Network Provider is used, the Co-Pay will be deducted from the Out-of-Network Allowance at the time We pay benefits. Co-Pay amounts are listed in the Schedule of Benefits.

Contact Lenses, Elective – Elective contact lenses refer to contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

Contact Lenses, Non-Elective – Non-elective Contact Lenses refer to contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

1. Aphakia (after cataract surgery). A pair of prescription single vision or multifocal eyeglass lenses and an eyeframe can be provided in addition to Non-Elective Contact Lenses for this condition.
2. When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
3. Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.

Reimbursement of Non-Elective Contact Lenses will be considered as payment in-full if utilizing the services of an In-Network Provider. This benefit provides coverage for the Materials only. It does not include the Contact Lens Fitting fee.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Services or Materials – Means the Vision Exam services and Materials that qualify for benefits under the Group Policy. Covered Services or Materials are shown in the Schedule of Benefits.

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown in the Certificate Schedule. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Waiting Period, if any.

Eligible Dependent - Means Your:
1. spouse; or
2. unmarried natural child, grandchild, step-child, foster child, adopted child or a child during the pendency of adoption who:
   a. is less than 19 years old and is dependent on You; or
   b. is less than 25, going to an accredited school full time and must be dependent on You for principal support and maintenance; or
   c. becomes incapable of self-support because of mental or physical handicap while insured under the Group Policy and prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. We must receive proof of incapacity.
within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19; or
d. is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

An Eligible Dependent will also include a child who is placed in Your home following execution of an act of voluntary surrender in Your favor or the favor of Your legal representative effective on the date on which such act of voluntary surrender becomes irrevocable.

The term Dependent does not include a child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student a described in 2.b. above.

If a Dependent is eligible to be an Insured, he is not eligible as a Dependent.

In the event both parents of a Dependent child are Insured under separate Certificates, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

Eyeglass Lenses – A standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

He, Him and His – Refers to the male or female gender.

Immediate Family Member – An Insured’s parent, step-parent, spouse, child, step-child, brother or sister.

Initial Term - The period following the group’s initial effective date and shown in the Certificate Schedule. Rates are guaranteed not to change during this period.

In-Network Provider - An Ophthalmologist, Optometrist or Optician who has entered into a agreement with the Administrator to provide Covered Services or Materials at an agreed to cost. When an In-Network Provider is used, the Insured will generally incur less out-of-pocket cost for the services rendered.

In-Network Provider Directory - A list of In-Network Providers and the services they are contracted for in Your area. The list will be updated periodically.

Insured – Means You (the Insured Member) and each Covered Dependent.

Insured Member– Means a person:
   1. who is a Member of an Eligible Class; and
   2. who has qualified for insurance by completing the Waiting Period, if any; and
   3. for whom insurance under the Policy has become effective.

Late Entrant - Any Member or Eligible Dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits may be limited for Late Entrants. See the section titled “Limitations.”
Materials – Means corrective Eyeglass Lenses, Frames and Contact Lenses.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Ophthalmologist – A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optician – A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist – A person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Out-of-Network Provider – An Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with Us to limit their charges. They are not listed in the In-Network Provider Directory.

Plano Lens – A lens that has no refractive power.

Policyholder – The entity stated on the front page of the Policy.

Re-enrollee – Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

Rolling Benefit Plan – Benefits begin anew 12 OR 24 months from the date of service.

Vision Exam – An examination of principal vision functions. A Vision Exam includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider’s practice is located.

You or Your – The Insured Member.

Waiting Period – The period of time a Member must wait before He is eligible for coverage. The Waiting Period, if any, is specified in the Policyholder’s Group Application and shown in the Certificate Schedule.
PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:
1. be a Member of an Eligible Class of the Policyholder, as defined in the Certificate Schedule; and
2. satisfy the Waiting Period, if any.

The Member’s Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage may become effective under the other spouse’s coverage OR enrollment will default to the Policyholder’s rules.

B. ENROLLMENT

The term “Enrollment” means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Waiting Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder. It usually occurs once each Calendar Year but may, at the Policyholder’s discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within 31 days of the event. A change in family status means any of the following events:
1. Marriage;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART V. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:
1. the Policyholder’s Effective Date, shown on the Certificate Schedule; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, birth or adoption, coverage is effective on the first of the month following the date such dependent was acquired. This is subject to our receipt of the required Enrollment and payment of the premium, if any.
Newborn Coverage: Any child born to You or Your Covered Dependent spouse is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child’s placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 31 days of the placement in order to continue the coverage beyond the initial 31-day period.

**PART VI. INDIVIDUAL TERMINATION DATES**

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder’s coverage terminates under the Policy;
3. the last day of the month in which You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within 31 days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date He is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

**PART VII. INDIVIDUAL PREMIUMS**

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of 31 days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period. We may require payment of any pro-rata premium for the time the insurance was in effect during the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 6 month period. We will give the Policyholder written notice at least 60 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.
PART VIII. DESCRIPTION OF COVERAGE

We pay a benefit if an Insured receives Covered Services or Materials at the allowable Frequency while his coverage under this Certificate is in force. An Insured may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Insured will generally incur less out-of-pocket cost (unless the Policyholder has selected an In-Network Provider Plan only.)

A. In-Network Benefits
When You enroll for coverage, an In-Network Provider Directory will be made available to You with the names, phone numbers and addresses of In-Network Providers. A provider’s status may occasionally change. We recommend that You call the Administrator to verify the provider’s participation status in the network. You may change providers at any time without notice to the Administrator.

When benefits are payable for Covered Services or Materials received from an In-Network Provider, We will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The Insured pays any required Co-Pay and any charges above the covered benefits to the In-Network Provider. The In-Network Provider takes care of claims submission and administrative services.

Note Exception: If you use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that you pay in full and submit Your receipt for reimbursement at the Out-of-Network reimbursement.

Limited In-Network benefits may be payable for certain add-on Materials. These items, if any, are shown in the Supplement To Schedule Of Benefits.

Both the Co-Pay and the Frequency for Covered Services or Materials are shown in the Schedule of Benefits.

B. Out-of-Network Benefits
If an Insured chooses to use an Out-of-Network Provider, You must pay the provider in full for the services and materials purchased. It is your responsibility to send us a Claim by submitting the itemized invoice or receipt to us. (See the “Notice of Claim” provision.) Any Co-Pay that applies should not be paid to the Out-of-Network Providers, as it will be deducted from Us at the time the claim is processed.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, We will reimburse you up to the amount of Out-of-Network benefits shown in the Schedule of Benefits, less any Co-Pay.

C. Covered Services or Materials
Covered Services or Materials are shown in the Schedule of Benefits. In order to be a Covered Service or Material, the services or materials must be furnished to an Insured:

1. To check or improve their vision condition;
2. Within the allowable Frequency shown in the Schedule of Benefits;
3. By an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:

1. the actual cost incurred of the Covered Services or Materials; or
2. the limits of coverage shown in the Schedule of Benefits.
PART IX. LIMITATIONS AND EXCLUSIONS

The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. An Insured is eligible to receive benefits under the Eyeglass Lenses Benefit or the Frame benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses benefit and the Eyeglass Frame benefit is paid in lieu of the Contact Lenses benefit. An Insured is eligible to receive benefits under the Contact Lenses benefit only after the Eyeglass Lenses benefit Frequency has ended.

Coverage for a Late Entrant or Re-Enrollee is limited to the Vision Exam benefit during the first 24 months after such person’s effective date of coverage.

Dilation is covered in full under the Vision Exam benefit ONLY if done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease.

Exclusions
No benefits are payable for the any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

1. Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses;
6. Medical and surgical treatment of the eyes;
7. Charges incurred after (a) the Policy ends; or (b) the Insured’s coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;
9. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
10. Services and materials provided by another vision plan except in the case of Coordination of Benefits;
11. Services for which benefits are paid by Worker’s Compensation;
12. Benefits provided under the employee’s medical insurance except in the case of Coordination of Benefits;
13. Blended bifocal lenses
14. Groove, Drill or Notch, and Roll and Polish;
15. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
16. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.)
17. Cosmetic items;
18. Faceted lenses
19. High-Index Lenses
20. Laminated Lenses
21. Oversize Lenses – any lens with an eye size of 61mm or greater
22. Photochromic (Transition) lenses
23. Polaroid lenses
24. Polished bevel lenses
25. Polycarbonate lenses
26. Prism lenses
27. Slab-off lenses
28. Tints
29. Ultra-violet tint or coating
30. Additional cost for contact lenses over the allowance
31. Additional cost for a frame over the allowance
32. Progressive Power Lenses*
   *Progressive Power Lens Benefit. If this type of lens is not a covered benefit under your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two.

PART X. CLAIM PROVISIONS

A. In-Network Claims
When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for You. In-Network Providers submit charges directly to the Administrator. (Note the exception under Part VI.A, “In-Network Benefits.”)

B. Out-of-Network Claims
In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, You must furnish written proof of loss. Your Claim must be sufficient to identify the Insured, the name of the Policyholder and Your Group Policy Number. Claim forms are available through the Administrator, or You may submit itemized receipts for services.

C. Notice of Claim
Written notice of claim must be given to Us within 30 days after the loss starts or as soon as reasonably possible. Notice should be sent to Our Administrator at the following address:

    AlwaysCare Benefits, Inc. – Claims
    P.O. Box 80139
    Baton Rouge, LA  70898-0139

D. Claim Forms
When the Administrator receives notice of Claim that does not contain all necessary information, forms for filing proof of loss will be sent to You along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, You will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss within the time stated in the Proof of Loss provision.

E. Proof Of Loss
Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

F. Payment Of Claims
Benefits will be paid to You unless an Assignment of Benefits has been requested by You or by operation of law. Benefits due and unpaid at Your death will be paid to Your estate. If benefits are payable to Your estate, We can pay benefits up to $1,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

If any beneficiary is a minor or mentally incapacitated, We will pay the proper share of Your insurance
amount to such beneficiary's court appointed guardian.

G. Time of Payment of Claims
Benefits payable under this Certificate for any loss incurred will be paid within 25 days following Our receipt of written proof of loss in the form of a clean claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of loss where claims are submitted in paper format, unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. For extended periods of disability, We will make payment at least every thirty days during any extended period during which You are entitled to such payments. Any balance remaining unpaid at the end of Our liability will be paid within 30 days following our receipt of written proof of loss.

Failure to comply with the requirements of this provision will subject Us to a penalty payable to You of double the amount of the benefits due under the terms of this Certificate during the period of delay, together with attorney's fees to be determined by a court of competent jurisdiction in the parish where You live or have Your domicile, excepting a justice of the peace court.

H. Extension of Benefits
Termination of Your coverage will be without prejudice to any claim for continuous loss that commenced while such coverage was in force; however, the payment of benefits after the termination date will be predicated upon continuing loss for which benefits were payable prior to such termination date and limited to the payment of the maximum benefits payable for such loss.

I. Extension of Time Limitations
If any limitation of the Policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on the Policy is less than that permitted by law of the state, district or territory in which the You reside at the time coverage is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

J. Overpayments
If we pay a benefit and it is later shown that a lesser amount should have been paid, We will be entitled to a refund of the excess. This applies to payments made to You, to a Covered Dependent, or to the provider of the Covered Services or Materials.

PART XI. COORDINATION OF BENEFITS (COB)
This provision applies when an Insured has vision coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. Allowable Expense: An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

2. Coordination of Benefits: Taking other Plans into account when We pay benefits.

3. Plan: Any plan, including this one that provides benefits or services for vision services on either a group or individual basis. “Plan” includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). “Plan” shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.
4. **Primary Plan**: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

**B. BENEFIT COORDINATION**

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured’s Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured’s benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

**C. THE ORDER OF BENEFIT DETERMINATION**

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

   a. **Non-dependent/Dependent**: A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced**: For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

   c. **Dependent Child/Separated or Divorced Parents**: If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

      i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;

      ii. The Plan of the parent with custody of the child;

      iii. The Plan of the spouse of the parent with custody; and

      iv. The Plan of the parent without custody of the child.

   d. **Dependent Child/Joint Custody**: If the joint custody court decree does not specifically state which parent is responsible for the child’s medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee’s dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. **Right to Receive and Release Needed Information**

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. **Right to Make Payments To Another Plan**

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. **Right to Recovery**

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

**PART XII. GRIEVANCE PROCEDURE**

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

**AlwaysCare Benefits, Inc.**
**Grievance Committee**
**P.O. Box 80139**
**Baton Rouge, LA 70898-0139**

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving
the grievance.
PART XII. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid as required by the law of the state in which the Policy is issued. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

PART XIV: REPLACEMENT OF EXISTING COVERAGE

This provision applies when the Policy replaces coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the Prior Plan. Coverage under this Policy will not be considered as replacement coverage unless the Policyholder’s coverage under this Policy takes effect within 60 days after coverage under the Prior Plan ends.

In the absence of this provision, an Insured who was covered by the Prior Plan at the date of discontinuance might not qualify for coverage under this Policy because the person is not actively at work or is confined in a hospital.

Each such person will be insured under this Policy if:

(a) the person was insured under the Prior Plan, including coverage under the Prior Plan’s extension of benefits provision, on the date the Policyholder’s coverage with the prior plan ended;
(b) the prior plan covered more than fifteen (15) people; and
(c) the person is a Member of an Eligible Class under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the Prior Plan pursuant to any extension of benefits provision.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Starmount Life Insurance Company, Inc. and AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company) (collectively “Starmount”) are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How Starmount May Use or Disclose Your Health Information

1. **Payment Functions.** Starmount may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. **Health Care Operations.** Starmount may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. **Required by Law.** As required by law, Starmount may use and disclose your health information. Starmount may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. **Public Health.** As required by law, Starmount may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. **Coroners, Medical Examiners and Funeral Directors.** Starmount may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Health and Safety.** Starmount may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. **Government Functions.** Starmount may disclose your health information for military, national security, prisoner and government benefits purposes.
9. **Worker’s Compensation.** Starmount may disclose your health information as necessary to comply with worker’s compensation or similar laws.

10. **Disclosures to Plan Sponsors.** Starmount may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

**When Starmount May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, Starmount will not use or disclose your health information without written authorization from you. If you do authorize Starmount to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**Statement of Your Health Information Rights**

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. Starmount is not required to agree to the restrictions that you request.

2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. Starmount is not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, Starmount may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that Starmount amend your health information. Starmount is not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. Starmount will provide one list per 12 month period free of charge; Starmount may charge you for additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

**Starmount’s Obligations Under This Notice**

**Starmount is required by law to:**

1. Maintain the privacy of your health information.
2. Provide you with a notice of its legal duties and privacy practices with respect to your health information.

3. Abide by the terms of this Notice.

4. Notify you if Starmount is unable to agree to a requested restriction on how your information is used or disclosed.

5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

Starmount reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that Starmount maintains. Revised Notices will be distributed to you by mail.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer  
Starmount Life Insurance Company  
7800 Office Park Boulevard  
Baton Rouge, LA 70809-7603

You may also file a complaint with the Secretary of the Department of Health and Human Services. Starmount will not retaliate against you in any way for filing a complaint.

**Effective Date of This Notice: April 14, 2003.**
A Federal law, usually called COBRA, requires that most employers sponsoring group dental and vision plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. Both you and your spouse should take the time to read this notice carefully.

You have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of employment (for reasons other than gross misconduct on your part), or because your employer files for reorganization under Chapter XI of the Bankruptcy Law while you are retired.

If you are the spouse of an employee covered by this employer, you have the right to choose continuation coverage for yourself if you lose your group health coverage for any of the following five reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becomes entitled to Medicare; or
5. Your spouse's employer files for reorganization under Chapter XI of the Bankruptcy Law while your spouse is retired.

In the case of a dependent child of an employee covered by the plan, he or she has the right to continuation coverage if group health coverage is lost for any of the following six reasons:

1. The death of a parent;
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;
3. Parents' divorce or legal separation;
4. A parent becomes entitled to Medicare;
5. The dependent ceases to be a "dependent child" under the Group Health Plan; or
6. The parent's employer files for reorganization under Chapter XI of the Bankruptcy Law while the parent is retired.
Under COBRA, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the happening of any such event. If notice is not received within that 60 day period, the dependent will not be entitled to choose continuation coverage. The employer has the responsibility to notify Starmount Life Insurance Company of the employee's death, termination of employment, or reduction in hours or Medicare entitlement.

When the employer is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have at least 60 days from the date you would lose coverage, because of one of the events described above, to inform the employer that you want continuation coverage.

If you do not choose continuation coverage, your group dental and vision insurance coverage will end.

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for 3 years unless you lost your group health coverage because of a termination of employment or reduction of hours. In that case, the required continuation coverage period is 18 months. If, during that 18-month period, another event takes place that would also entitle a dependent spouse or child (other than a spouse or child who became covered after continuation coverage became effective) to his or her own continuation coverage, (for example, the former employee dies, is divorced or legally separated, or be entitled to Medicare, or a dependent ceases to be a "dependent child" under the dental and vision plan the continuation coverage may be extended. However, in no case will any period of continuation coverage be more than 36 months.

If you are entitled to 18 months of continuation coverage, and if you are determined to be disabled under the terms of the Social Security Act as of the date your employment terminated (or the date your hours, were reduced), you are eligible for an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the employer within 60 days after you receive a determination of disability from the Social Security Administration, provided notice is given before the end of the initial 18 months of continuation coverage. During the additional 11 months of continuation coverage, your premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

However, the new law also provides that your continuation coverage may be cut short for any of the following four reasons:

1. The employer no longer provides group dental and/or vision coverage to any of its employees;
2. The premium for your continuation coverage is not paid in a timely fashion;
3. You become covered under another group health plan, unless that other plan contains an exclusion or limitation with respect to any pre-existing condition affecting you or a covered dependent; or
4. You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you may have to pay all or part of the premium for your continuation coverage. You will have an initial grace period of 45 days starting with the date you choose continuation coverage to pay any premiums; and after that initial 45 day grace period, you will have a grace period of at least 30 days to pay any subsequent premiums. COBRA also says that, at the end of the 18 month, 29 month or 3 year
continuation coverage period, you must be allowed to enroll in any individual conversion health plan which may be provided under the plan.

If you have any questions about COBRA, please contact the employer. Also, if you have changed marital status, if a dependent ceases to be a "dependent child" under the plan, or if you or your spouse have a changed address, please notify the employer.
STARMOUNT LIFE INSURANCE COMPANY
PRIVACY NOTICE AND NOTICE OF INSURANCE INFORMATION PRACTICES
2004

This Notice Describes How Medical and Financial Information About You May Be Used and Disclosed.  Please Review This Notice Carefully.

Starmount Life Insurance Company and its insurance affiliates are committed to protecting your privacy and the confidentiality of information we collect from you or about you in compliance with Gramm-Leach-Bliley (GLB) law.

We are required by law to maintain the privacy of your protected health and financial information.  This notice outlines our duties and practices in this regard.

How We Collect Information: We get most information from you or anyone you have authorized to provide the information.  Information is obtained from your application for insurance, from other related forms or through a verification phone call with you.  If additional information is needed, we may obtain it from your independent sales agent, physicians, hospitals, or other medical personnel, your employer, other transactions with our company or its affiliates, other insurers, the Medical Information Bureau or consumer reporting agencies.

Information collected may relate to your personal characteristics, employment, health, avocations, finances, as well as transactions with us or our affiliates.  The information we collect might include name, address, Social Security number, telephone number, date of birth, medical and family history and dependent information.  It may also include type and plan of insurance, other insurance you own, claim data, the amount of insurance premiums, or any other information.

How We Protect Information: Starmount Life Insurance Company and its affiliates maintain physical, electronic and procedural safeguards to protect the information we have obtained about you and to assist us in preventing unauthorized access to that information.

Electronic records are protected by multiple computer software products that use security features such as passwords, encryption, user identification numbers, and personal identification numbers to guard against unauthorized access.  Our internal systems contain electronic firewalls and other security measures designed to prevent unauthorized access to our electronic records.  We also employ surveillance software to determine if any abnormal activity occurs.  Electronic points of entry, as well as databases, servers, e-mail and workstations are generally protected by virus detection/removal software.

We train all employees on our Privacy Policy and the importance of the privacy and confidentiality of all information we collect.

How We Use and Disclose Information: We may disclose any information we collect when we believe it is necessary for us to conduct or service our business or where disclosure is permitted or required by law.  For example, information may be disclosed while you are insured, or after your insurance terminates, to:

- Anyone to whom you have authorized us to disclose the information;
- Your independent sales agent;
- Claims adjusters to process your claims;
- Underwriters to accept or reject your request for insurance;
- Investigators and attorneys;
- Consultants, Third-party administrators, PPO Networks, and Health care clearinghouses; Data processing firms and billing firms;
- Our affiliated companies, business associates, other insurance companies and reinsurers;
- Persons or organizations that conduct audits and scientific research, including actuarial or underwriting studies;
- Persons/entities performing general administrative and claim processing activities for us; and
- Insurance regulators, courts or government agencies or others as may be permitted or required by law.

Information may also be shared with our affiliates so that they may offer you other products and services.  We may also provide information to others outside Starmount Life Insurance Company with whom we have a joint marketing agreement.  For example, we may have a joint marketing agreement with another insurer to enable us to offer you that company’s insurance products.  Any person or entity with whom we share information must maintain the same high standards of privacy and confidentiality that we require of our own employees and affiliates.

We do not make disclosures of information to any other companies that may want to sell their products or services to you.  We will not sell any information to a catalog company.  We do not disclose information subject to the Fair Credit Reporting Act.

Other disclosures will be made only with your written authorization, which you may revoke at any time.

Right to Access and Correct Information: You have a right to inspect and copy your protected health information.  You have a right to ask for an accounting of any disclosures of information.  We may impose a reasonable fee for this service where permitted.  You may ask us to correct or change our records regarding your information.  If we agree, we will make the correction/change.  If we do not agree, you may submit a short statement of dispute, which
we will include in any future disclosure of information. You can contact us by phone at 225-926-2888 or by mail to E. Sternberg, Starmount Life Insurance Company, 7800 Office Park Boulevard, Baton Rouge, LA 70809-7603, or e-mail Erich@StarmountLife.com.