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AlwaysCare℠

Underwriter
Starmount Life Insurance Company
7800 Office Park Blvd, P.O. Box 98100
Baton Rouge, LA 70898-9100

Administrator
AlwaysCare Benefits, Inc.
7800 Office Park Blvd., P.O. Box 80139
Baton Rouge, LA 70898-9100

This Certificate explains the dental insurance coverage under the Group Policy (the Policy) issued to the Policyholder. The Policy provides the benefits for the Insured Member (called "You" or "Your") 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

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.

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 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 21 years old and is dependent on You; or
   b. is less than 24, 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 retardation 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 24; or
   d. is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (a), (b) or (c) above.

A 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.

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 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 medications, 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
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 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.

Time of Payment Of Claims: Benefits payable under this Certificate for any loss incurred will be paid within 30 days following Our receipt of written proof of loss, 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.

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.

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.

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
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.

Continuation of Coverage During Military Service: If You leave employment to perform service in the uniformed services You will have the right to maintain Your coverage under the Policy during such service by furnishing to Your employer a sum equal to that which would have been deducted from Your compensation for such coverage. Upon timely receipt of Your contributions, the employer will provide Us with those contributions plus an amount equal to what the employer would have contributed during the period of service in the uniformed services. You are responsible for notifying Your employer of Your election to continue coverage under the Policy at the time You enter service in the uniformed services.

Reinstatement Following Service in the Unformed Services: If Your coverage under the Policy lapses because You left employment to perform service in the uniformed services, You will have the right to reapply for coverage after release. Provided the Policy is still in force, Your coverage will be reinstated upon Your re-enrollment, including the coverage of Your Dependents previously covered, without any clause or restriction because of a preexisting condition.

Consent of Beneficiary: Consent of the beneficiary (if any) will not be requisite to surrender or assignment of benefits payable under this Certificate, nor to change of beneficiary, nor to any other changes in Your coverage.

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; and (2) 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

* Procedure Class

A Preventive/Diagnostic
B Basic
C Major
D Orthodontia
E Not Covered
F Other

Type of Maximum Reimbursement:

PMAC – Participating Provider Maximum Allowable Charge
MAC – Maximum Allowable Charge (based on "Customary Charge")
SF – Scheduled Fee

¶ Limitations

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 12 films per 36 months
(d) Limited to Dependent Children under age 19
(e) Maximum of 1 procedure per 12 months
(f) Limited to Dependent Children under age 14
(g) Limited to Dependent Children under age 12
(h) Maximum of 1 procedure per 24 months
(j) Applications made to permanent molar teeth only
(k) Maximum of 2 procedures per arch per 24 months
(l) Maximum of 1 per 5 year period per tooth
(m) Maximum of 1 each quadrant per 12 months
(n) Maximum of 1 each quadrant per 24 months
(o) Maximum of 1 each tooth per 24 months
(p) Subject to a yearly and a lifetime maximum
(q) Maximum of 1 each quadrant per 36 months
(r) Replacement of existing only if in place for 12 months (insured under age 19)
(s) Replace existing only if in place for 36 months (insured over age 19)
(t) Benefits will be based on the benefit for the corresponding non-cosmetic restoration.
(u) Maximum 1 time per tooth
(v) Maximum of 1 per lifetime
(w) Only in conjunction with listed complex oral surgery procedures and subject to review.
(x) Limited to Dependent Children under age 16
(y) Maximum of 1 per 24 months for age 17 +
(z) Maximum of 1 per 12 months for age 16 & under
(aa) Limited to those age 25+
(bb) 6 months must have passed since initial placement
(cc) Maximum of 1 per 7 year period
(dd) Maximum of 1 per 10 year period
(ee) Maximum of 1 per 3 year period
(ff) Maximum of 1 per 4 year period
(gg) Maximum of 1 per 5 year period
(hh) In lieu of a 3 unit bridge when a 3 unit bridge has been approved for coverage
(ii) Maximum of 2 procedures per 12 months
(jj) Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion.
(kk) 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.
(ll) 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.

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
Comprehensive or Periodic Oral Exam	A	(0)	(ii)	PMAC	MAC
Problem Focused Exam	B	(0)	(e)	PMAC	MAC
Comprehensive Periodontal Exam	A	(0)	(e)	PMAC	MAC
Emergency Palliative Treatment	A	(0)	(e)	PMAC	MAC
Single Film	A	(0)		PMAC	MAC
Additional Films	A	(0)		PMAC	MAC
Intra-Oral Occlusal Film	A	(0)		PMAC	MAC
Panoramic Film or Full Mouth X-Ray	A	(0)	(h)	PMAC	MAC
Bitewing – Single Film, or	A	(0)	(e)	PMAC	MAC
Bitewing – Two Films, or	A	(0)	(e)	PMAC	MAC

Bitewing – Four Films	A	(0)	(e)	PMAC	MAC
Prophylaxis	A	(0)	(ii) (kk)	PMAC	MAC
Adjunctive Pre-Diagnostic Oral Cancer Screening	A	(0)	(e) (jj)	Up to $45	Up to $45
Prophylaxis	A	(0)	(a)	PMAC	MAC
Topical Application of Fluoride	A	(0)	(e) (x)	PMAC	MAC
Sealant	B	(0)	(b) (x) (j)	PMAC	MAC
Space Maintainer – Fixed Unilateral	B	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Fixed Bilateral	B	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Removable Unilateral	B	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Removable Bilateral	B	(0)	(x) (o)	PMAC	MAC
FILLINGS					
One Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Two Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Three Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Four + Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
One Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Two Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Three Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Four + Surface or Incisal Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Sedative Fillings	B	(0)	(o)	PMAC	MAC
ORAL SURGERY					
Extraction, erupted tooth or exposed root	B	(0)		PMAC	MAC
Coronal Remnants	B	(0)		PMAC	MAC
Surgical Extraction	B	(0)		PMAC	MAC
Impacted (soft tissue)	B	(0)		PMAC	MAC
Impacted (partial bony)	B	(0)		PMAC	MAC
Impacted (complete bony)	B	(0)		PMAC	MAC
Surgical Removal of Root	B	(0)		PMAC	MAC
Alveoplasty (with extraction) – per quadrant	B	(0)		PMAC	MAC
Alveoplasty (without extraction) – per quadrant	B	(0)		PMAC	MAC
Incision and Drainage of Abscess – Intraoral	B	(0)		PMAC	MAC
General Anesthesia/Intravenous Sedation	B	(0)	(w)	PMAC	MAC
CROWN AND BRIDGE REPAIR					
Inlay Recementation	B	(0)	(bb)	PMAC	MAC
Crown Recementation	B	(0)	(bb)	PMAC	MAC
Bridge Repair	B	(0)	(bb)	PMAC	MAC
Crown Repair	B	(0)	(bb)	PMAC	MAC
Bridge Recementation	B	(0)	(bb)	PMAC	MAC
DENTURE REPAIR					
Repair Denture Base	B	(0)	(e) (bb)	PMAC	MAC
Repair Teeth – per tooth	B	(0)	(e) (bb)	PMAC	MAC
Repair Partial Base	B	(0)	(e) (bb)	PMAC	MAC
Repair Partial Framework	B	(0)	(e) (bb)	PMAC	MAC
Repair Broken Clasp	B	(0)	(e) (bb)	PMAC	MAC
Add Tooth to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	MAC
Add Clasp to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	MAC
Replace Teeth – per tooth	B	(0)	(e) (bb)	PMAC	MAC
Reline Upper Denture	B	(0)	(h) (bb)	PMAC	MAC
Reline Lower Partial Denture	B	(0)	(h) (bb)	PMAC	MAC
Reline Upper Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Reline Lower Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Reline Upper Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Reline Lower Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	MAC
Rebase Complete Denture – Upper	B	(0)	(h) (bb)	PMAC	MAC
Rebase Complete Denture – Lower	B	(0)	(h) (bb)	PMAC	MAC
Rebase Partial Denture – Lower	B	(0)	(h) (bb)	PMAC	MAC

Tissue Conditioning – Upper	B	(0)	(k) (bb)	PMAC	MAC
Tissue Conditioning – Lower	B	(0)	(k) (bb)	PMAC	MAC
Denture Adjustment Maxillary – Upper	B	(0)	(a) (bb)	PMAC	MAC
Denture Adjustment Mandibular – Lower	B	(0)	(a) (bb)	PMAC	MAC
Partial Adjustment Maxillary – Upper	B	(0)	(a) (bb)	PMAC	MAC
Partial Adjustment Mandibular – Lower	B	(0)	(a) (bb)	PMAC	MAC
PERIODONTICS (Non-surgical)					
Scaling and Root Planing–per quadrant	C	(6)	(n)	PMAC	MAC
Periodontal Debridement (full mouth)	C	(6)	(v)	PMAC	MAC
Periodontal Maintenance Procedure	C	(6)	(ii) (kk)	PMAC	MAC
ENDODONTICS					
Vital Pulpotomy – primary teeth only	C	(6)	(f)	PMAC	MAC
Root Canal – Anterior	C	(6)		PMAC	MAC
Root Canal – Bicuspid	C	(6)		PMAC	MAC
Root Canal – Molar	C	(6)		PMAC	MAC
Apicoectomy – Anterior	C	(6)	(u)	PMAC	MAC
Apicoectomy – Molar	C	(6)	(u)	PMAC	MAC
Retrograde Filling	C	(6)	(u)	PMAC	MAC
Root Amputation	C	(6)	(u)	PMAC	MAC
MISCELLANEOUS					
Occlusal Guard	E				
PERIODONTICS (Surgical)					
Gingivectomy or gingivoplasty – per quadrant	C	(6)	(n)	PMAC	MAC
Gingivectomy or gingivoplasty – per tooth	C	(6)	(o)	PMAC	MAC
Gingival Flap Procedure – per quadrant, or	C	(6)	(n)	PMAC	MAC
Osseous Surgery – per quadrant	C	(6)	(n)	PMAC	MAC
Pedicle Soft Tissue Graft	C	(6)	(n)	PMAC	MAC
Free Soft Tissue Graft	C	(6)	(n)	PMAC	MAC
Subepithelial Connective Tissue Graft	C	(6)	(n)	PMAC	MAC
CROWN					
Crown Resin – resin with high noble metal	C	(6)	(l) (t)	PMAC	MAC
Crown Resin – resin with noble metal	C	(6)	(l) (t)	PMAC	MAC
Crown Resin – resin with predominately base metal	C	(6)	(l) (t)	PMAC	MAC
Crown – porcelain/ceramic substrate	C	(6)	(l) (t)	PMAC	MAC
Crown - porcelain fused to high noble metal	C	(6)	(l) (t)	PMAC	MAC
Crown – porcelain fused to noble metal	C	(6)	(l) (t)	PMAC	MAC
Crown –porcelain fused to predominantly base metal	C	(6)	(l) (t)	PMAC	MAC
Crown – full cast high noble metal	C	(6)	(l) (t)	PMAC	MAC
Crown – ¾ cast high noble metal	C	(6)	(l) (t)	PMAC	MAC
Crown – full cast noble metal	C	(6)	(l) (t)	PMAC	MAC
Crown – full cast predominantly base metal	C	(6)	(l)	PMAC	MAC
Crown Prefabricated Stainless Steel	C	(6)	(l)	PMAC	MAC
Cast Post and Core – In Addition to Crown	C	(6)	(l)	PMAC	MAC
Prefabricated Post and Core – In Addition to Crown	C	(6)	(l)	PMAC	MAC
Inlay	C	(6)	(l)	PMAC	MAC
Onlay	C	(6)	(l)	PMAC	MAC
Veneers – excluding cosmetic; restorative only	C	(6)	(l)	PMAC	MAC
BRIDGE					
Pontic Cast High Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Pontic Cast Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Pontic Cast Predominantly Base Metal	C	(6)	(l)	PMAC	MAC
Pontic Porcelain Fused to High Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Pontic Porcelain Fused to Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Pontic Porcelain Fused to Predominantly Base Metal	C	(6)	(l) (t)	PMAC	MAC
Pontic Resin with High Noble Metal	C	(6)	(l)	PMAC	MAC
Pontic Resin with Noble Metal	C	(6)	(l)	PMAC	MAC

Pontic Resin with Predominantly Base Metal	C	(6)	(l)	PMAC	MAC
Crown Resin with High Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Crown Resin with Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Crown Resin with Predominantly Base Metal	C	(6)	(l) (t)	PMAC	MAC
Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Crown Porcelain Fused to Noble / High Noble Metal	C	(6)	(l) (t)	PMAC	MAC
Crown Porcelain Fused to Predominantly Base Metal	C	(6)	(l) (t)	PMAC	MAC
Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal	C	(6)	(l)	PMAC	MAC
Crown ¾ Cast High Noble Metal	C	(6)	(l)	PMAC	MAC
Crown Full Cast Noble Metal	C	(6)	(l)	PMAC	MAC
Crown Full Cast Predominantly Base Metal	C	(6)	(l)	PMAC	MAC
Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	C	(6)	(l)	PMAC	MAC
Core Build-up for Retainer, (including any pins)	C	(6)	(l)	PMAC	MAC
Core Build-up (including any pins)	C	(6)	(l)	PMAC	MAC
DENTURES					
Complete Upper Denture	C	(6)	(l)	PMAC	MAC
Complete Lower Denture	C	(6)	(l)	PMAC	MAC
Immediate Upper Denture	C	(6)	(l)	PMAC	MAC
Immediate Lower Denture	C	(6)	(l)	PMAC	MAC
Maxillary (Upper) Partial – Resin Base	C	(6)	(l)	PMAC	MAC
Mandibular (Lower) Partial – Resin Base	C	(6)	(l)	PMAC	MAC
Maxillary (Upper)Partial – Cast Metal Framework with Resin Base	C	(6)	(l)	PMAC	MAC
Mandibular (Lower) Partial – Cast Metal Framework with Resin Base	C	(6)	(l)	PMAC	MAC
Removable Unilateral Partial Denture	C	(6)	(l)	PMAC	MAC
OTHER					
Endosteal Implants (with applicable crown - subject to alternate benefit provision)	C	(6)	(hh)	PMAC	MAC
Cosmetic	E				
TMJ	E				
ORTHODONTIA *					
Initial Orthodontic Examination	D	(6)	(d) (p)	PMAC	MAC
Initial Placement of Braces or Appliances	D	(6)	(d) (p)	PMAC	MAC
Continuing Treatment for Braces or Appliances	D	(6)	(d) (p)	PMAC	MAC

*** 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:	East Baton Rouge Parish Schools
Policyholder's Address:	1050 South Foster Drive Baton Rouge, LA 70806
Effective Date:	January 1, 2006
Revised Date:	**January 1, 2010**
Initial Term:	12 Months
Eligible Classes:	ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK
Eligibility Period:	1 Month from 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 Calendar Year Plan.
Deductible:	In-Network $50 Individual Deductible. Maximum Individual Deductible per Family: 3 Applies to Classes: B, C Out-of-Network $50 Individual Deductible. Maximum Individual Deductible per Family: 3 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
$1,500	$1,500	$1,500

Out-of-Network

Year 1	Year 2	Year 3 & Forward
$1,500	$1,500	$1,500

Waiting Periods	See Schedule of Covered Procedures

TABLE OF INSURANCE PERCENTAGES:

For the first 12 months that this plan is in effect, the following covered percentages apply:

	Insurance Percentage In-Network	Insurance Percentage Out-of Network	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	100%	100%	Yes	None/None
Class B	80%	80%	Yes	None/None
Class C	0%	0%	Yes	None/None
Class D	0%	0%	Yes	$500/$1,000

*Class C and D covered following six month waiting period

Certificate Year 2:

	Insurance Percentage In-Network	Insurance Percentage Out-of Network	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	100%	100%	Yes	None/None
Class B	80%	80%	Yes	None/None
Class C	50%	50%	Yes	None/None
Class D	50%	50%	Yes	$500/$1,000

Certificate Year 3 and later:

	Insurance Percentage In-Network	Insurance Percentage Out-of Network	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	100%	100%	Yes	None/None
Class B	80%	80%	Yes	None/None
Class C	50%	50%	Yes	None/None
Class D	50%	50%	Yes	$500/$1,000

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

Summary of the Louisiana Life and Health Insurance Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy holders 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 insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent.

COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

Louisiana Life and Health
Insurance Guaranty Association
P. O. Drawer 44126
Baton Rouge, Louisiana 70804

Louisiana Department of Insurance
P. O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. On the back of this page is a brief summary of the Law's coverage, exclusions and limits. This summary does not cover all provisions of the Law nor does it in any way change any person's right or obligations under the Law or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

(over)

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

(1) 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);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by the prospectus:

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contract holder;

(6) employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;

(8) any obligation that does not arise under the express written terms of the policy or contract;

(9) any policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or Part D coverage.

Other exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Law, Louisiana Revised Statutes R.D. 22.2081 *et seq*.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more that what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000, no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the association will not pay more than $100,000 in cash surrender values, $500,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

STARMOUNT LIFE INSURANCE COMPANY PRIVACY NOTICE
January 2003

WE CARE ABOUT YOUR PRIVACY!

In compliance with Gramm-Leach-Bliley (GLB), this describes the privacy policy and practices followed by Starmount Life Insurance Co. ("Starmount").

Your privacy is a high priority for us and it will be treated with the highest degree of confidentiality. In order to provide insurance and services, we collect certain information. However, we are committed to maintaining the privacy of this information in accordance with law. Individuals with access to personal information about customers or former customers are required to follow this policy.

NON-PUBLIC INFORMATION COLLECTED.

- Information we receive from you on insurance and annuity applications, claim forms or other forms such as your name, address, date and location of birth, marital status, sex, social security number, medical information, beneficiary information, etc.
- Information about your transactions with us, our affiliates or others such as premium payment history, tax information, investment information, and accounting information; and
- Information we receive from consumer reporting agencies, such as your credit history.

NON-PUBLIC INFORMATION DISCLOSED.

- We may provide the non-public information we collect to affiliated or nonaffiliated persons or entities involved in the underwriting, processing, servicing and marketing of your Starmount insurance products. We will not provide this information to any other nonaffiliated third party unless we have a written agreement that requires such third party to protect the confidentiality of this information.
- We may have to provide the above described non-public information to authorized persons or entities to comply with a subpoena or summons by government authorities and to respond to judicial process or regulatory authori-ties having jurisdiction over our company for examination, compliance or other purposes as required by law.
- We do not disclose non-public personal information about customers or former customers to anyone except as permitted or required by law.

CONFIDENTIALITY AND SECURITY OF YOUR NON-PUBLIC PERSONAL INFORMATION.

- We restrict access of non-public personal information about you to only those who need to know that information to underwrite, process, service or market Starmount insurance and services.
- We maintain physical, electronic, and procedural safeguards that comply with government standards to guard non-public personal information.
- If we become aware that an item of personal information may be materially inaccurate, we will make a reasonable effort to re-verify its accuracy and correct any error as appropriate.
- If you prefer we not disclose nonpublic personal information about you to nonaffiliated third parties, write us at the address below.

INFORMATION ABOUT FORMER CUSTOMERS.

Non-public information about our former Clients is maintained by Starmount on a confidential and secure basis. If any such disclosure is made, it would be for reasons and under the conditions described in this notice. We do not disclose any non-public personal information about our former customers to anyone except as permitted or required by law.

FOR QUESTIONS, write E. Sternberg at: Starmount Life Insurance Co., 7800 Office Park Blvd., Baton Rouge, LA 70809; 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.

Starmount Life Insurance Company

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 Name of Employer;

(3) Parents' divorce or legal separation;

(4) A parent becomes entitled to Medicare;

(5) The dependent ceases to be a "dependent child" under Name of 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
Baton Rouge, Louisiana 70809

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 January 1, 2006.

Policyholder Status:
This is an in-force group renewing coverage and adding this rider. Carryover Benefits will be accumulated based on the claim activity from the first complete Benefit Year this rider was in-force.

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: $700
- Carryover Benefit: $350
- Carryover Account Limit: $1,250

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:
Calendar Year Plans: If this plan's dental coverage first becomes effective in October, November or December, this rider will not apply until January 1 of the first full Calendar Year. And, if the effective date of an Insured's dental coverage is in October, November or December, this rider will not apply to the Insured until January 1 of the next Calendar Year. In either case:

- Only claims incurred on or after January 1 will count toward the Threshold Limit*;* and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Calendar 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 Sternberg,
Chairman and
Chief Executive Officer