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Administrator: Starmount Life Insurance Company, 8485 Goodwood Blvd., P.O. Box 80139; Baton Rouge, LA 70898-0139

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") 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.

Chief Executive Officer

Secretary

NEED ASSISTANCE? If you have a question or wish to obtain information about Your coverage, or You require assistance in resolving a complaint, please contact us at 1-888-729-5433.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

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 or lawful Domestic Partner;
2. Your dependent child under age 25, who is your natural or adopted child, step-child, foster child, a child for whom you are a legal guardian or a child in Your court-ordered temporary or other custody and who is:
    a. dependent on You for support,
    b. living in Your household, or
    c. is a full-time or part-time student

    Coverage for such dependent child will last until at least the end of the calendar year in which the child reaches the age of 25
3. Your child who has reached age 25 and who is:
    a. primarily dependent upon You for support; 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.

Eligible Employee – Means an employee who works full time, having a normal workweek of at least 25 hours, and who has met any applicable waiting-period requirements or other requirements of this act.

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. This "customary charge" is based upon data developed by Ingenix for every dental procedure in every 3-digit zip code in the United States of America. Typically, We use between 80% and 90% of the Ingenix-developed charge, depending upon the plan selected by the Policyholder, to establish the "customary charge."
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 VII. 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 or Domestic Partner 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 or Domestic Partner carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other spouse's or Domestic Partner's coverage.

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 or Domestic Partnership;
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, Domestic Partnership, birth or adoption, coverage is effective on the date specified by the Policyholder. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn and Adopted Children: Newborn children are automatically covered under the terms of the policy from the moment of birth. In the case of a newborn adopted child, coverage begins at the moment of birth if You have entered into a written agreement to adopt the child prior to the birth of the child, whether or not the agreement is enforceable.

Adopted children, foster children and children in Your court-ordered temporary or other custody are covered from the date of Placement. Coverage for such children will be in effect until the 61st day following the date of birth or Placement, as the case may be. If You desire uninterrupted coverage for such children, You must notify Us within 60 days of the child's birth or the date of Placement. If timely notice is given within this 60-day period, We may not charge an additional premium for such coverage for the duration of the 60-day notice period. If timely notice is not given, We may charge an additional premium from the date of birth or the date of Placement. In either case, We may not deny coverage for a child due to Your failure to send us timely notice.

For purposes of this provision, "Placement" means: (1) your assumption of the physical custody of an adopted or foster child and the financial responsibility for the support and care of such child; (2) your assumption of a child placed in your custody pursuant to an interlocutory decree vesting temporary care of the child to you; or (3) your assumption of a child placed in your custody during the pendency of an adoption proceeding, whether or not a final decree of adoption is ultimately issued.

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.

Extension of Benefits: Termination of an Insured's coverage will be without prejudice to any covered loss incurred for which such Insured is collecting disability benefits that began prior to, and continued without interruption beyond, the date of termination. Such extension of benefits will continue for at least 90 days or until the maximum benefits payable for the loss is paid, whichever comes first.

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:** Coverage for a Late Entrant or a Re-enrollee will be limited to those procedures listed under Procedure Class A in the Schedule of Covered Procedures during the first 12 months after the Late Entrant's or Re-enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-enrollee's Eligible Dependents, if enrolled.
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 paid by 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
Dental Claims - P.O. Drawer 80139
Baton Rouge, LA 70898-0139

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: After receiving written proof of loss and premium payment, We will pay all benefits then due for dental claims. We will pay all claims or any portion of any claims within 45 days, or as required by Your state, after receipt of the Claim. If a claim or a portion of a claim is contested by Us, the Insured or their assignee shall be notified in writing, that the claim is contested or denied, within 45 days after receipt of the Claim by us. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested from the Insured or their assignee, We shall pay or deny the contested claim or portion of the contested claim, within 60 days. We shall not pay or deny any claim later than 120 days after receiving the claim. We will, upon request, provide to the Insured an estimate of the amount We will pay for a particular dental service.

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
Attn: Grievance Committee
P.O. Drawer 98100
Baton Rouge, LA 70898-9100

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 five (5) years from the time written proof of loss is required to be furnished.

Change of Beneficiary: The Insured can change the beneficiary at any time by giving Us written notice. The beneficiary's consent is not required for this or any other change in the Insured's coverage under the policy, unless the designation of the beneficiary is irrevocable

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

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
Comprehensive Oral Exam	A	(0)	(a)	PMAC	PMAC
Periodic Oral Exam	A	(0)	(a)	PMAC	PMAC
Problem Focused Exam	B	(0)	(e)	PMAC	PMAC
Emergency Palliative Treatment	B	(0)	(e)	PMAC	PMAC
Single Film	A	(0)		PMAC	PMAC
Additional Films	A	(0)		PMAC	PMAC
Intra-Oral Occlusal Film	A	(0)		PMAC	PMAC
Panoramic Film	A	(0)	(h)	PMAC	PMAC
Full Mouth X-Ray	B	(0)	(h)	PMAC	PMAC
Bitewing – Single Film, or	A	(0)	(e)	PMAC	PMAC
Bitewing – Two Films, or	A	(0)	(e)	PMAC	PMAC
Bitewing – Four Films	A	(0)	(e)	PMAC	PMAC
Prophylaxis	A	(0)	(a)	PMAC	PMAC
Adjunctive Pre-Diagnostic Oral Cancer Screening	A	(0)	(e) (jj)	Up to $45	Up to $45
Topical Application of Fluoride	A	(0)	(e) (x)	PMAC	PMAC
Sealant	A	(0)	(b) (x) (j)	PMAC	PMAC
Space Maintainer – Fixed Unilateral	A	(0)	(x) (o)	PMAC	PMAC
Space Maintainer – Fixed Bilateral	A	(0)	(x) (o)	PMAC	PMAC
Space Maintainer – Removable Unilateral	A	(0)	(x) (o)	PMAC	PMAC
Space Maintainer – Removable Bilateral	A	(0)	(x) (o)	PMAC	PMAC
FILLINGS					
One Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
Two Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
Three Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
Four + Surface Amalgam	B	(0)	(r) (s)	PMAC	PMAC
One Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Two Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Three Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Four + Surface or Incisal Resin – Anterior	B	(0)	(r) (s)	PMAC	PMAC
Protective Restoration	B	(0)	(o)	PMAC	PMAC
ORAL SURGERY					
Extraction, erupted tooth or exposed root	B	(0)		PMAC	PMAC
Coronal Remnants	B	(0)		PMAC	PMAC
Surgical Extraction	B	(0)		PMAC	PMAC
Impacted (soft tissue)	B	(0)		PMAC	PMAC
Impacted (partial bony)	B	(0)		PMAC	PMAC
Impacted (complete bony)	B	(0)		PMAC	PMAC
Surgical Removal of Root	B	(0)		PMAC	PMAC
Alveoplasty (with extraction) – per quadrant	B	(0)		PMAC	PMAC
Alveoplasty (without extraction) – per quadrant	B	(0)		PMAC	PMAC
Incision and Drainage of Abscess – Intraoral	B	(0)		PMAC	PMAC
General Anesthesia/Intravenous Sedation	B	(0)	(w)	PMAC	PMAC
CROWN AND BRIDGE REPAIR					
Inlay Recementation	B	(0)	(bb)	PMAC	PMAC
Crown Recementation	B	(0)	(bb)	PMAC	PMAC
Bridge Repair	B	(0)	(bb)	PMAC	PMAC
Crown Repair	B	(0)	(bb)	PMAC	PMAC
Bridge Recementation	B	(0)	(bb)	PMAC	PMAC

DENTURE REPAIR					
Repair Denture Base	B	(0)	(e) (bb)	PMAC	PMAC
Repair Teeth – per tooth	B	(0)	(e) (bb)	PMAC	PMAC
Repair Partial Base	B	(0)	(e) (bb)	PMAC	PMAC
Repair Partial Framework	B	(0)	(e) (bb)	PMAC	PMAC
Repair Broken Clasp	B	(0)	(e) (bb)	PMAC	PMAC
Add Tooth to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	PMAC
Add Clasp to Existing Partial Denture	B	(0)	(e) (bb)	PMAC	PMAC
Replace Teeth – per tooth	B	(0)	(e) (bb)	PMAC	PMAC
Reline Upper Denture	B	(0)	(h) (bb)	PMAC	PMAC
Reline Lower Partial Denture	B	(0)	(h) (bb)	PMAC	PMAC
Reline Upper Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Reline Lower Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Reline Upper Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Reline Lower Partial Denture (Lab)	B	(0)	(h) (bb)	PMAC	PMAC
Rebase Complete Denture – Upper	B	(0)	(h) (bb)	PMAC	PMAC
Rebase Complete Denture – Lower	B	(0)	(h) (bb)	PMAC	PMAC
Rebase Partial Denture – Lower	B	(0)	(h) (bb)	PMAC	PMAC
Tissue Conditioning – Upper	B	(0)	(k) (bb)	PMAC	PMAC
Tissue Conditioning – Lower	B	(0)	(k) (bb)	PMAC	PMAC
PERIODONTICS (Non-surgical)					
Scaling and Root Planing–per quadrant	C	(12)	(n)	PMAC	PMAC
Periodontal Debridement (full mouth)	C	(12)	(v)	PMAC	PMAC
Periodontal Maintenance Procedure	C	(12)	(a)	PMAC	PMAC
ENDODONTICS					
Vital Pulpotomy – primary teeth only	C	(12)	(f)	PMAC	PMAC
Root Canal – Anterior	C	(12)		PMAC	PMAC
Root Canal – Bicuspid	C	(12)		PMAC	PMAC
Root Canal – Molar	C	(12)		PMAC	PMAC
Apicoectomy – Anterior	C	(12)	(u)	PMAC	PMAC
Apicoectomy – Molar	C	(12)	(u)	PMAC	PMAC
Retrograde Filling	C	(12)	(u)	PMAC	PMAC
Root Amputation	C	(12)	(u)	PMAC	PMAC
MISCELLANEOUS					
Occlusal Guard	E				
PERIODONTICS (Surgical)					
Gingivectomy – per quadrant	C	(12)	(n)	PMAC	PMAC
Gingivectomy – per tooth	C	(12)	(o)	PMAC	PMAC
Gingival Curettage – Surgical – per quadrant. or	C	(12)	(n)	PMAC	PMAC
Osseous Surgery – per quadrant	C	(12)	(n)	PMAC	PMAC
Soft Tissue Grafts	C	(12)	(n)	PMAC	PMAC
Gingival Flap Surgery	C	(12)	(n)	PMAC	PMAC

CROWN					
Crown Resin – resin with high noble metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Resin – resin with noble metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Resin – resin with predominately base metal	C	(12)	(l) (t)	PMAC	PMAC
Crown – porcelain/ceramic substrate	C	(12)	(l) (t)	PMAC	PMAC
Crown - porcelain fused to high noble metal	C	(12)	(l) (t)	PMAC	PMAC
Crown – porcelain fused to noble metal	C	(12)	(l) (t)	PMAC	PMAC
Crown –porcelain fused to predominantly base metal	C	(12)	(l) (t)	PMAC	PMAC
Crown – full cast high noble metal	C	(12)	(l) (t)	PMAC	PMAC
Crown – ¾ cast high noble metal	C	(12)	(l) (t)	PMAC	PMAC
Crown – full cast noble metal	C	(12)	(l) (t)	PMAC	PMAC
Crown – full cast predominantly base metal	C	(12)	(l)	PMAC	PMAC
Crown Prefabricated Stainless Steel	C	(12)	(l)	PMAC	PMAC
Cast Post and Core – In Addition to Crown	C	(12)	(l)	PMAC	PMAC
Prefabricated Post and Core – In Addition to Crown	C	(12)	(l)	PMAC	PMAC
BRIDGE					
Pontic Cast High Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Pontic Cast Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Pontic Cast Predominantly Base Metal	C	(12)	(l)	PMAC	PMAC
Pontic Porcelain Fused to High Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Pontic Porcelain Fused to Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Pontic Porcelain Fused to Predominantly Base Metal	C	(12)	(l) (t)	PMAC	PMAC
Pontic Resin with High Noble Metal	C	(12)	(l)	PMAC	PMAC
Pontic Resin with Noble Metal	C	(12)	(l)	PMAC	PMAC
Pontic Resin with Predominantly Base Metal	C	(12)	(l)	PMAC	PMAC
Crown Resin with High Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Resin with Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Resin with Predominantly Base Metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Porcelain Fused to Noble / High Noble Metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Porcelain Fused to Predominantly Base Metal	C	(12)	(l) (t)	PMAC	PMAC
Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal	C	(12)	(l)	PMAC	PMAC
Crown ¾ Cast High Noble Metal	C	(12)	(l)	PMAC	PMAC
Crown Full Cast Noble Metal	C	(12)	(l)	PMAC	PMAC
Crown Full Cast Predominantly Base Metal	C	(12)	(l)	PMAC	PMAC
Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	C	(12)	(l)	PMAC	PMAC
Core Build-up for Retainer, (including any pins)	C	(12)	(l)	PMAC	PMAC
Core Build-up (including any pins)	C	(12)	(l)	PMAC	PMAC
Inlay	C	(12)	(l)	PMAC	PMAC
Onlay	C	(12)	(l)	PMAC	PMAC
Veneers – excluding cosmetic; restorative only	C	(12)	(l)	PMAC	PMAC
DENTURES					
Complete Upper Denture	C	(12)	(l)	PMAC	PMAC
Complete Lower Denture	C	(12)	(l)	PMAC	PMAC
Immediate Upper Denture	C	(12)	(l)	PMAC	PMAC
Immediate Lower Denture	C	(12)	(l)	PMAC	PMAC
Upper Partial – Resin Base	C	(12)	(l)	PMAC	PMAC
Lower Partial – Resin Base	C	(12)	(l)	PMAC	PMAC
Upper Partial – Cast Metal Framework with Resin Base	C	(12)	(l)	PMAC	PMAC
Lower Partial – Cast Metal Framework with Resin Base	C	(12)	(l)	PMAC	PMAC
Removable Unilateral Partial Denture	C	(12)	(l)	PMAC	PMAC
Denture Adjustment – Upper	B	(0)	(a) (bb)	PMAC	PMAC

Denture Adjustment – Lower	B	(0)	(a) (bb)	PMAC	PMAC
Partial Adjustment – Upper	B	(0)	(a) (bb)	PMAC	PMAC
Partial Adjustment – Lower	B	(0)	(a) (bb)	PMAC	PMAC
OTHER				PMAC	PMAC
Endosteal Implants (with applicable crown – subject to alternate benefit provision)	C	(12)	(u)	PMAC	PMAC
Cosmetic	E				
TMJ	E				
ORTHODONTIA **					
Initial Orthodontic Examination	D	(12)	(d)	PMAC	PMAC
Initial Placement of Braces or Appliances	D	(12)	(d)	PMAC	PMAC
Continuing Treatment for Braces or Appliances	D	(12)	(d)	PMAC	PMAC

** **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 Takeover Benefits 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-insurance 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:	PEO Pro Services Inc - Low Plan
Policyholder's Address:	14286 Beach Blvd #19-176 Jacksonville Beach, FL 32250
Effective Date:	December 1, 2019
Initial Term:	24 Months
Eligible Classes:	ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK
Eligibility Period:	Immediately following Date of Hire
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
$1000	$1000	$1000

Out-of- Network

Year 1	Year 2	Year 3 & Forward
$1000	$1000	$1000

Waiting Periods	See Schedule of Covered Procedures

TABLE OF INSURANCE PERCENTAGES:

Certificate Year 1	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A – Preventive Services	100%	80%	Yes	None/None
Class B – Basic Services	80%	50%	Yes	None/None
Class C – Major Services	0%	0%	Yes	None/None
Class D – Ortho Services	0%	0%	No	None/$1,000

Certificate Year 2	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A – Preventive Services	100%	80%	Yes	None/None
Class B – Basic Services	80%	50%	Yes	None/None
Class C – Major Services	50%	30%	Yes	None/None
Class D – Ortho Services	50%	50%	No	None/$1,000

Certificate Year 3 & Later	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
Class A – Preventive Services	100%	80%	Yes	None/None
Class B – Basic Services	80%	50%	Yes	None/None
Class C – Major Services	50%	30%	Yes	None/None
Class D – Ortho Services	50%	50%	No	None/$1,000

Takeover Benefits: Do takeover benefits apply for Employees who currently have dental coverage? No

Plan Type: ☐ Indemnity: No participating provider network

☑ Participating Provider Program:

√ In and Out-of-Network Benefits
☐ In-Network Benefit only

☐ Scheduled Plan

Starmount Life Insurance Company

8485 Goodwood Blvd., PO Box 98100
Baton Rouge, LA 70806-7878

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 December 1, 2019

Policyholder Status:
This is a new group with no prior Carryover Benefits provision in place.

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. In addition, the Insured must have at least one cleaning and one routine exam per 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: $1000

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 on any date other than January 1, this rider will not become effective 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*;*
- Requirement of 1 cleaning and 1 exam incurred after January 1; 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 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:

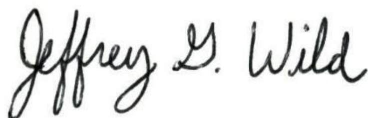
- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit*;* and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

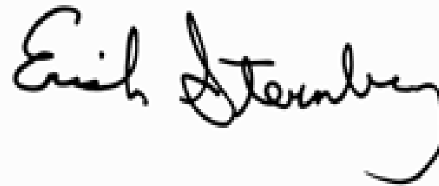
Definitions:

- "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, C, and D, (Orthodontia) and must include 1 exam and 1 cleaning.
- "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 includes all claims processed under all Procedure Classes.

This Rider takes effect on the date shown on Page 1 of this 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 at 8485 Goodwood Blvd., Baton Rouge, LA 70806-7878.





Jeffrey G. Wild, Secretary **Erich Sternberg, Chief Executive Officer**

STARMOUNT LIFE INSURANCE COMPANY
8485 GOODWOOD BOULEVARD, BATON ROUGE, LA 70806-7878
AMENDMENT
AGE LIMITS FOR COVERED DEPENDENT CHILDREN

Attached to Policy/Certificate No.: 00703721/DN-2007CT-FL

The Policy/ Certificate to which this Amendment is attached are amended as follows, unless already so stated:

Extension of Age Limit for Covered Dependent Children:

Coverage for any unmarried Covered Dependent child may be extended beyond any limiting age stated in the Policy/Certificate. Such child must be dependent on You for income tax purposes. This extension is available for any unmarried child, regardless of student status. Such coverage may be extended until the last day of the Calendar Year in which the child attains the age of 26.

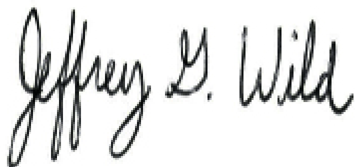
(The limiting age will not apply to a child who, at the time of the limiting age, is incapable of self-support by reason of mental retardation, mental illness or disorder or physical handicap, provided the incapacitated child is unmarried and dependent on an individual insured under the Policy/Certificate.)

To extend coverage for a Covered Dependent to age 26 You must send Us a written notice of Your request and pay any additional required premium. This must be done within 31 days after the dependent's limiting age stated in the policy/certificate to which this Amendment is attached.

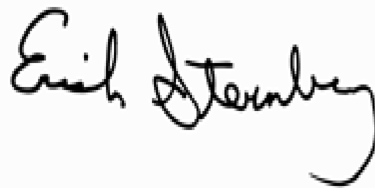
This Endorsement takes effect on December 1, 2019, and expires on the same date as the policy/certificate to which it is attached.

There are no other changes to the policy/certificate.

In witness whereof, the Company has caused this Amendment to be signed by its Chief Executive Officer and Secretary.



Secretary



Chief Executive Officer