

SERFF Tracking Number: NGLI-126488200 State: Arkansas
Filing Company: National Guardian Life Insurance Company State Tracking Number: 45092
Company Tracking Number: GROUP DENTAL - MET FORMS AND TLA TRUST
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: GROUP DENTAL - MET FORMS AND TLA TRUST
Project Name/Number: GROUP DENTAL - MET FORMS AND TLA TRUST/GROUP DENTAL - MET FORMS AND TLA TRUST

Filing at a Glance

Company: National Guardian Life Insurance Company

Product Name: GROUP DENTAL - MET FORMS AND TLA TRUST SERFF Tr Num: NGLI-126488200 State: Arkansas

TOI: H10G Group Health - Dental SERFF Status: Closed-Approved-Closed State Tr Num: 45092

Sub-TOI: H10G.000 Health - Dental Co Tr Num: GROUP DENTAL - MET FORMS AND TLA TRUST State Status: Approved-Closed

Filing Type: Form

Author: Mandi Schwarz Reviewer(s): Rosalind Minor
Date Submitted: 03/04/2010 Disposition Date: 03/08/2010
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GROUP DENTAL - MET FORMS AND TLA TRUST
Project Number: GROUP DENTAL - MET FORMS AND TLA TRUST
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 03/08/2010

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Trust, Other
Explanation for Other Group Market Type:
Multiple Employer Trust
State Status Changed: 03/08/2010
Created By: Mandi Schwarz
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Mandi Schwarz

Filing Description:

Group Dental Policy for Issue to Multiple Employer Trust
Group Policy NDNGRP2002-MET(R)
Group Certificate NDNGRP2002CT-MET (R)
Endorsement NDNGRP2002-END-AR

The above group dental policy/certificate forms are submitted for issuance to various Multiple Employer Trusts domiciled

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in your state. These are new forms, and are not intended to replace any previously approved forms.

These forms are designed to provide group dental insurance coverage to employees and their dependents of employers who participate in the Trust. We request approval of these forms for use with groups located in your state. In addition, we may issue the certificate to residents of your state on an out-of-state basis, i.e. when the group policy is issued in another state.

The forms will initially be used with the TLA Group Insurance Trust. This group has been approved as a licensed multiple employer trust in your state. The certificate and endorsement will initially be issued to residents of your state on an out-of-state basis as the TLA Group Insurance Trust is domiciled in Missouri.

A previously approved group application and enrollment form will be used with these forms.

Bracketed material is intended to be variable, and a Statement of Variability is attached to the filing.

Please do not hesitate to contact me if you need any additional information or clarification.

Company and Contact

Filing Contact Information

Mandi Schwarz, mcschwarz@nglic.com
2 East Gilman Street 608-443-5371 [Phone]
Madison , WI 53701 608-443-5365 [FAX]

Filing Company Information

National Guardian Life Insurance Company CoCode: 66583 State of Domicile: Wisconsin
P.O. Box 1191 Group Code: Company Type: LAH
Madison, WI 53701-1191 Group Name: State ID Number:
(800) 626-7931 ext. 5325[Phone] FEIN Number: 39-0493780

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Guardian Life Insurance Company	\$50.00	03/04/2010	34602656

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/08/2010	03/08/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	APPLICATION	Mandi Schwarz	03/04/2010	03/04/2010
Form	GROUP APPLICATION	Mandi Schwarz	03/04/2010	03/04/2010
Form	ENROLLMENT FORM	Mandi Schwarz	03/04/2010	03/04/2010

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Disposition

Disposition Date: 03/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	GROUP DENTAL INSURANCE	Approved-Closed	Yes
Form	GROUP DENTAL INSURANCE CERTIFICATE	Approved-Closed	Yes
Form	ENDORSEMENT	Approved-Closed	Yes
Form	APPLICATION	Approved-Closed	Yes
Form	GROUP APPLICATION	Approved-Closed	Yes
Form	ENROLLMENT FORM	Approved-Closed	Yes

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Amendment Letter

Submitted Date: 03/04/2010

Comments:

Under the Filing Description, I mistakenly indicating that a previously approved group application and enrollment form would be used with the forms submitted with this filing. Therefore, I have attached the group application and enrollment form to the Form Schedule tab for your review and approval. Additionally, I have attached the application to the trust for your review and approval.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
NVIGRP & NDNGRP 2002 MET APP	Application/EAPPLICATI nrollment Form	ON	Initial				0.000	NVIGRP & NDNGRP 2002 MET APP.pdf
NDVRX GRPAPP-MET 08-08	Application/EGROUP nrollment Form	APPLICATI ON	Initial				0.000	NDVRX GRPAPP-MET 08-08.pdf
NDVRX Enroll MET 08-08	Application/EENROLLME nrollment Form	NT FORM	Initial				0.000	NDVRX Enroll-MET 08-08.pdf

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Form Schedule

Lead Form Number: NDNGRP2002-MET(R)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/08/2010	NDNGRP2002-MET(R)	Policy/Contract/Certificate	GROUP DENTAL INSURANCE	Initial		41.600	NDNGRP2002-MET(R) revised 10-01-09.pdf
Approved-Closed 03/08/2010	NDNGRP2002CT-MET(R)	Certificate	GROUP DENTAL INSURANCE CERTIFICATE	Initial		42.500	NDNGRP2002CT-MET(R) revised 08-11-09.pdf
Approved-Closed 03/08/2010	NDNGRP2002-END-AR	Certificate Amendment, Insert Page, Endorsement or Rider	ENDORSEMENT	Initial		42.000	NDNGRP2002-END-AR Endorsement.pdf
Approved-Closed 03/08/2010	NVIGRP & NDNGRP2002 MET APP	Application/Enrollment Form	APPLICATION	Initial		0.000	NVIGRP & NDNGRP2002 MET APP.pdf
Approved-Closed 03/08/2010	NDVRX GRPAPP-MET 08-08	Application/Enrollment Form	GROUP APPLICATION	Initial		0.000	NDVRX GRPAPP-MET 08-08.pdf
Approved-Closed 03/08/2010	NDVRX Enroll MET 08-08	Application/Enrollment Form	ENROLLMENT FORM	Initial		0.000	NDVRX Enroll-MET 08-08.pdf



NATIONAL GUARDIAN LIFE INSURANCE COMPANY

GROUP DENTAL INSURANCE

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: [TPA Name and Address]

In return for the application, which is attached, and payment of premium as it becomes due, National Guardian Life Insurance Company (called "We," "Our," and "Us") agrees to pay the amount of insurance provided.

This Policy becomes effective at 12:01 a.m. Standard Time at the Policyholder's principal address shown on the application on the EFFECTIVE DATE shown below.

This Policy may be continued in effect by payment of premium at the rates We establish until the insurance ends as provided.

This Policy is governed by the laws of the jurisdiction shown below.

POLICYHOLDER: [ABC Trust]
GROUP POLICY NUMBER: [Group Number]
EFFECTIVE DATE: [January 1, 2002]
ANNIVERSARY DATE: [January 1, 2003]
JURISDICTION: [Missouri]
PREMIUM DUE DATE: [1st of every Month]
COVERAGE PROVIDED: [See Incorporated Certificate's Schedule of Benefits]

Signed for the Company:

Sherri Kliczak, Secretary

John Larson, President

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INCORPORATION OF PROVISIONS

All definitions, eligibility, benefits, exclusions, limitations, and other provisions of the Certificate(s) and rider(s) attached to the following pages are made a part of this Policy.

Second person pronouns in the Certificate(s) and rider(s) refer to an Employee of the class eligible for insurance under this Policy.

**CONTINUING INSURANCE ON ACTIVE EMPLOYEES
ABSENT FROM WORK**

Coverage may be continued on Active Employees absent from work subject to the following provisions. If an Active Employee is absent from work because of injury, sickness, approved leave of absence or temporary lay-off, or is placed on part-time employment, the Employer, acting on a basis which does not discriminate for or against any person, may consider the Active Employee as still employed until the Employer notifies Us differently or stops paying premiums for the Active Employee. However, in any event, insurance cannot be continued in this way for longer than the Maximum Continuation Period stated below.

FOR ABSENCE DUE TO:	MAXIMUM CONTINUATION PERIOD:
[Temporary Lay-Off]	One Year]
[Approved Leave of Absence]	One Year]
[Part-Time Employment]	One Year]
[Injury or Sickness]	One-year periods, each of which begins on the Anniversary Date of this Policy, subject to the following conditions: - the first period begins on the date the Active Employee stops Active Work due to injury or sickness and ends on the next following Anniversary Date of this Policy (up to six months); - request to continue insurance must be made by the Employer to Us within 31 days before each Anniversary Date.]

TERM OF POLICY AND RIGHT TO TERMINATE

This Policy is issued for an indefinite term, beginning on the Effective Date shown on the face page of the Policy. The Policy continues in force, so long as the premiums are paid when due, until terminated according to the following paragraphs:

The Policyholder may terminate this Policy by giving written notice to Us. Each Employer may also terminate coverage under this Policy by giving written notice to Us. Termination will be effective on the later of: (1) the date We receive the notice; or (2) the requested effective date.

After this policy has been in force for one year, We may terminate any and all of the insurance under this Policy, without cause, as of any premium due date, by giving written notice to the Policyholder at least 60 days prior to that date. We may also terminate an Employer's coverage under the Policy, after that Employer's coverage has been in effect for one year, by giving at least 60 days prior written notice to the Employer. After the first year, We may terminate an Employer's coverage with 31 days prior written notice if the Employer fails to maintain the following participation requirements:

- When Insureds are not required to contribute to the cost of their own insurance, there must be 100% participation.
- For groups of [2 to 10] Employees, [100%] participation is required in all circumstances for [both Employees and Eligible dependents].

- For groups of 11 or more Employees where benefits are funded by the Employees, [25%] participation is required in all circumstances for [both Employees and Eligible Dependents]. A minimum of [10] must enroll.
- Participation must not drop [25%] or more from the participation on the original effective date.
- For Dependent insurance, there must be 100% participation by all Insureds, when the Insured is not required to contribute to its cost.

Termination may take effect on an earlier date when both We and an Employer agree.

If coverage under this Policy terminates for any reason, with respect to all the Insureds or any class of Insureds of an Employer, the Employer will be liable to Us for all unpaid premium for the period during which the Policy was in force, with respect to those Insureds.

Insurance will end as provided above without the consent of, or notice to, any Insured, dependent, or beneficiary.

PREMIUMS

Each Employer is solely responsible for the premium for its Employees. Payment shall be made directly to Us at The Administrator's Office.

The payment of any premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under GRACE PERIOD.

The first premium is due on the Effective Date of each Employer's coverage under the Policy. Premiums after the first are due on the Premium Due Date agreed to by the Employer and Us. Upon agreement between an Employer and Us, the mode of premium payment may be changed as of any Premium Due Date.

When additional or increased insurance begins or insurance ends and such change is due to a change in the terms of this Policy, any adjustment in the premium will be made as of the date the change is effective. Otherwise, any adjustment in premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if premiums are payable other than monthly).

PREMIUM CALCULATION

The total premium for insurance coverage under this Policy is obtained by multiplying the number of Insureds in each class times the applicable premium rates then in effect and adding the results.

CHANGES IN PREMIUM RATES

We have the right to change the premium rates after the Initial Term for each Employer, and not more than once in any six-month period following their Initial Term. We will notify the Policyholder in writing at least forty-five days before any increase in premium rates.

Changes in Premium Rates: All rate guarantees are subject to the following provisions:

- The plan of benefits outlined in the Certificate of Coverage and eligibility remains unchanged.
- There are no additions or deletions of subsidiaries or affiliates.
- The census, volume or geographic distribution does not change by [25%] or more.
- The employer contribution to premiums is not reduced.

AGGREGATE PREMIUM

The aggregate premium due on any Premium Due Date is the sum of the amounts determined in accord with the provision(s) of this Policy entitled PREMIUM CALCULATION.

GRACE PERIOD

A Grace Period of 31 days (without interest charge) will be granted for the payment of any premium due after the first. This Policy will continue in effect during this period unless the Employer has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the premium is not paid by the end of the Grace Period, all insurance under this Policy will end on the last day of the Grace Period. The Employer will owe Us all premiums then due and unpaid including the premium for the Grace Period.

If an Employer gives Us written notice that insurance under this Policy is to be ended during the Grace Period, all insurance will end on the date We receive the written notice or the date specified, if later.

The Policyholder will owe Us the pro-rata premium for the time the insurance was in effect during the Grace Period.

GENERAL PROVISIONS ENTIRE CONTRACT

The entire contract consists of this Policy, the Policyholder application, the application of each Employer, the Certificate and the applications (if any) made by the persons insured under this Policy.

A copy of the Policyholder's application and each Employer application is attached to this Policy on the date it is signed.

All statements made in the applications which are made a part of this Policy are representations and not warranties.

No statement made by an Insured under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured or to His Beneficiary, if any.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the Policy and no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the Policy.

INCONTESTABILITY

This Policy will be incontestable, except for non-payment of premium, after it has been in force for one year.

No statement made by a person insured under this Policy relating to His being insurable will be used to void the insurance for which the statement was made after it has been in force for one year during His lifetime. In order to be used, that statement must be in writing and signed by the Insured.

CHANGES IN POLICY

The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by Our President or Our Secretary.

Any changes will be made without the consent of, or notice to, any Insured or Beneficiary, if any.

No agent has authority to make this Policy or to change, alter or amend any of its terms or provisions in any way.

AGE MISSTATED

If the age of any Insured under this Policy has been misstated, there will be a fair adjustment between the Employer and Us. As the basis for adjustment, We will recompute the premium for the true age of that person and the right amount of His insurance as provided by this Policy.

CONFORMITY WITH LAW

If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

POLICY NON-PARTICIPATING

This Policy is not entitled to share in the surplus earnings of Our company.

INFORMATION TO BE FURNISHED BY POLICYHOLDER

The Policyholder, and each Employer, will furnish Us with all information which pertains to this Policy. Failure to furnish Us with such information without good and sufficient cause will permit Us to terminate this Policy. We may inspect at all reasonable times (while this Policy is in effect and thereafter until all rights and payments have been made) any records of the Policyholder, or Employer, which have a bearing on the insurance or premiums.

CLERICAL ERROR

Clerical error (whether by the Policyholder, Employer or Us) in keeping records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

POLICYHOLDER NOT AGENT

The Policyholder will in no event be considered Our agent for any purpose under this Policy.

ASSIGNMENT

No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us at Our Home Office.

INDIVIDUAL CERTIFICATE

We will issue Certificates to each Employer for delivery to each Employee insured under this Policy that state the insurance protection to which He is entitled and to whom the benefits are payable. The word Certificates will include Certificate riders and Certificate supplements, if any.



NATIONAL GUARDIAN LIFE INSURANCE COMPANY
(called "We", "Our", and "Us")

GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: [TPA Name and Address]

certifies that it has issued a Group Dental Policy (the Policy) to the Policyholder. The policy provides the benefits described on the following pages for the Insured Employee (called "You" or "Your") and any Insured Dependents under the Policy. Persons become insured under the Policy as provided on a following page.

The Employer and its Group 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 and replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your dental benefits. The exact provisions and terms, including eligibility, premium payments, and continuation of coverage, are contained in the Policy. The benefits and provisions described herein are subject in all respects to the terms and conditions of the Policy.

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

Sherri Kliczak, Secretary

John Larson, President

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PART I. DEFINITIONS

Active Employee - An Actively At Work Employee of the Employer named in the Schedule of Benefits.

At Work and Actively At Work - Performing in the customary manner all the regular duties of Your occupation for Your Employer, on a full-time basis as defined on the Schedule of Benefits, at the customary place of employment or business, or at some location to which the employment requires You to travel.

Calendar Year Plan - Benefits begin anew on January 1 or each Calendar Year. If You enrolled other than on January 1 of a given Calendar Year, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Calendar Year with full 12-month benefits becoming effective on January 1 of the next 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.

Contracting Provider Program Directory - The list which consists of selected dentists who:

- are located in Your area; and
- have been selected by Us to be Contracting Providers and part of the Contracting Provider Program. These Contracting Providers agree to accept Our Contracting Provider Program Table of Maximum Allowed Charges as payment in full for services rendered. The list will be periodically updated.

Contracting Provider - A dentist who has been selected by Us for inclusion in the Contracting Provider Program. These Contracting Providers agree to accept Our Contracting Provider Program Table of Maximum Allowed Charges as payment in full for services rendered.

Contracting Provider Program - Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Contracting Providers. When dental care is given by Contracting Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

Contracting Provider Program Table of Maximum Allowed Charges - Our fee agreement with a Contracting Provider in which such Contracting Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

Co-Pay - The fixed amount that each Insured pays for each dental appointment. The Co-Pay amount is deducted from the Covered Expenses from each dental appointment before any insurance benefit is determined.

Covered Expense - The lesser of the following for a Covered Procedure: (1) the actual charge; (2) the Usual, Customary and Reasonable charge; (3) the Scheduled Fee, if applicable; or (4) the fee shown in the Contracting Provider Program Table of Maximum Allowable Charges.

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:

- a. licensed dentist who is acting within the scope of his or her license;
- b. licensed physician performing dental services within the scope of his or her license; or
- c. licensed dental hygienist acting under the supervision and direction of a dentist.

Deductible - The amount shown on the Schedule of Benefits for each coverage category. This amount applies to an Insured and must be satisfied once each Certificate Year (or lifetime, when applicable) before benefits are payable for Covered Expenses. If, in any one Certificate Year, there are [3] Insured's under Your certificate and each of these [3] Insured's have met their individual Deductible, then no Deductible will be required for any other Insured during that same Certificate Year, unless the Deductible shown on the Schedule of Benefits is listed as "unlimited". The Deductibles will be satisfied in order of the Procedure Class if all services are incurred on the same date (that is, to Covered Expenses with Procedure Class of B and then C). The Procedure Class for each Covered Procedure is shown in the Schedule of Covered Procedures.

Domestic Partner - means two people in a relationship that satisfy the following. Each person:

1. is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
2. is the sole Domestic Partner of the other partner and not have had another domestic partner in the last 12 months;
3. is not related to the other partner by adoption or blood;

4. share the same permanent address for at least 12 consecutive months and intend to so indefinitely;
5. share joint financial responsibility for basic living expenses and welfare of the other partner;
6. meets (or agrees to meet) the requirements of any applicable federal, state or local laws or ordinances for Domestic Partnerships; and
7. demonstrates financial interdependence by submission of proof of four (4) of the following:
 - a. a Domestic Partnership agreement;
 - b. a joint mortgage or lease;
 - c. an execution of wills naming each other as executor and/or beneficiary;
 - d. a durable property and health care powers of attorney;
 - e. a joint title to an automobile, or joint bank account or credit account; or
 - f. evidence of other joint financial responsibility to establish economic interdependency under the circumstances of the particular case.]

Eligible Dependent - Means a person listed below:

1. Your spouse [or lawful Domestic Partner];
2. Your unmarried dependent child under age 25, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian.
3. Your unmarried child who has reached age 25 and who is:
 - a. primarily dependent upon You for support and maintenance; and
 - b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

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

Employee - The individual employed by the Employer.

Employer - The entity for whose Employees dental care benefits are being provided, that has been approved by Us to participate under the Policy issued to the Policyholder.

He, Him and His - May also mean She, Her and Hers.

Initial Term - The [12 month] period following the Employer's initial effective date. Rates are guaranteed not to change during this period.

In-Network Benefits - The dental benefits provided under this Certificate for covered dental services that are provided by a Contracting Provider.

Insured - The Insured Employee and each Insured Dependent.

Late Entrant - Any Employee or Eligible Dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits are limited for Late Entrants under Part VI. Limitations.

Non-Contracting Provider - A dentist who is not a Contracting Provider.

Out-of-Network Benefits - The dental benefits provided under this Certificate for covered dental services that are not provided by a dentist who is a Contracting Provider.

Physical Examination - We may, at Our own expense, have the right and opportunity to have an Insured examined as often as reasonably necessary while his claim is pending.

Policyholder - The Trust that contracts with Us on behalf of the participating Employers.

Policy Year Plan - Benefits begin immediately on the Employer's effective date and renew 12 months following the initial effective date. For persons enrolled other than on the Employer's initial effective date or a subsequent Policy anniversary, benefit maximums will be adjusted or prorated according to the amount of time remaining in the Policy Year with full 12-month benefits becoming effective on the next Policy anniversary of the next Calendar Year.

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.

Scheduled Fee - The maximum fee charge allowable, as defined by the "Procedure Fee Schedule," if attached to this Certificate.

The 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.

Usual, Customary and Reasonable ("UCR") - The lesser of: (a) the reasonable charges the provider charges for a dental service or supply; or (b) the customary charge for the dental service or supply. We will determine the customary charge from within the range of charges made for such dental service or supply by other providers of similar training and experience in that general geographic area.

Waiting Period - The amount of time which coverage must be in force before benefits may become payable for Covered Procedures.

PART II. INDIVIDUAL EFFECTIVE DATES

A. Active Employee

To be eligible for coverage under the Policy an Employee must satisfy the following Eligibility Requirements:

- a. he must be in an Eligible Class as defined on the Schedule of Benefits; he must be At Work as an Employee of the Employer. (Coverage will be delayed if the Employee is confined for medical care or treatment in an institution or at home on the day which would ordinarily be his effective date. This delay will end and coverage which will then become effective on the day following his return to Actively-At-Work status as an Employee.)

The effective date of an Employee's coverage is determined as follows:

- a. When no Employee contributions are required, the Employee's effective date will be the later of:
 - (i) the Employer's Effective Date; or
 - (ii) the day coinciding with the date that the Employee meets all of the Eligibility Requirements.
- b. When Employee contributions are required, the Employee's effective date will be the later of:
 - (i) the Employer's Effective Date; or
 - (ii) the day coinciding with:
 - ◆ the date the Employee meets all of the Eligibility Requirements, if written application is made on or prior to the date that the Employee meets all of the Eligibility Requirements;
 - ◆ the date of the written application, if made within 31 days following the date that the Employee meets all of the Eligibility Requirements;
 - ◆ the effective date prescribed for the next following period of open enrollment as has been agreed to by the Employer and Us, if written application is made more than 31 days after the date that the Employee meets all of the Eligibility Requirements; or
 - ◆ the date of written application, if made within 31 days following the date that the Employee has a change in life status as determined by the Employer's flexible benefit plan.

No insurance will become effective unless the Employer makes the first premium payment for his insurance while living and within 31 days of his effective date.

B. Eligible Dependents

An Eligible Dependent will be covered on the later of:

- a. the date the Dependent meets all of the requirements of an Eligible Dependent, if written application is made on or prior to the date that the Dependent is an Eligible Dependent;
- b. the date of the written application, if made within 31 days following the date that the Dependent meets all of the requirements of an Eligible Dependent;
- c. the effective date prescribed for the next following period of open enrollment as has been agreed to by the Employer and Us, if written application is made more than 31 days after the date that the Dependent meets all of the requirements of an Eligible Dependent; or
- d. the date of written application, if made within 31 days following the date that the Employee has a change in life status as determined by the Employer's flexible benefit plan.

Newborn Coverage: Any child born to an Insured is covered from the moment of birth to 31 days or until released from the hospital. In order to continue coverage beyond the initial 31 day period, the Insured must notify Us orally or in writing. Upon notification, We will provide the Insured with all forms and instructions necessary to enroll the newborn child. The enrollment form along with the

additional premium must be submitted to Us within 31 days after the date of birth in order to continue coverage. We will allow the Insured an additional 10 days from the date the forms and instructions are provided by Us in which to enroll the newborn child.

Adopted Children: A child is covered from: 1) the date of birth if a petition for adoption is filed within 31 days of birth; or 2) from the date of placement of the child for the purpose of adoption if a petition for adoption is filed within 31 days of placement of the child. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with the 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 III. INDIVIDUAL TERMINATION DATES

A. All Insureds

Coverage of all Insureds will automatically terminate on the earliest of the following dates:

- a. the date that the Policy terminates;
- b. the date that the Employer's coverage terminates under the Policy;
- c. the date that You are no longer a full-time Employee;
- d. the date that You die;
- e. on any premium due date, if the full payment for Your insurance is not made within 31 days following the premium due date.

B. Insured Dependents

An Insured Dependent's coverage will terminate on the earliest of the following dates:

- a. the date that Your insurance terminates;
- b. the last day of the month for which premium has not been paid for the Insured Dependent;
- c. the day immediately preceding the date on which that dependent is no longer an Eligible Dependent. With respect to a Dependent child, attainment of the limiting age shall not cause termination of coverage of such child while the child is and continues to be both: (a) incapable of self-sustaining employment by reason of mental or physical handicap; and (b) who becomes so incapacitated prior to the attainment of age twenty-five (25) so long as the employee's coverage remains in force and so long as the dependent remains in such condition. We may require, at reasonable intervals during the 2 years following the dependent child's attainment of the limiting age, subsequent proof of that child's incapacity and dependency. After that 2-year period, We may require proof not more than once a year.

PART IV. INDIVIDUAL PREMIUMS

Any reference to age shall refer to the Insured's attained age on any premium due date. The first premium due date shall be the Employer's Effective Date.

We reserve the right to change the premium rates on any premium due date on or after the Initial Term and will not increase them more than once in a 6 month period thereafter. Written notice must be provided 45 days in advance of any change to the Employer.

Changes in Premium Rates: All rates are subject to terms outlined in the Policy.

PART V. DESCRIPTION OF COVERAGE

1. Covered Dental Expenses: All dental treatments that are covered under this Certificate are listed in the Schedule of Covered Procedures. The Schedule shows the following for each Covered Procedure:

- a. the Procedure Class;
- b. any applicable Waiting Period; and
- c. any applicable limitations.

For each Procedure Class, the Schedule of Benefits shows any applicable:

- a. Deductible Amount;
- b. Calendar Year or Policy Year Maximum Annual Benefit;
- c. Maximum Lifetime Benefit; and
- d. Insurance Percentage.

Benefits are determined by applying the applicable Insurance Percentage to the Covered Expense, after satisfaction of any Deductible. The Insurance Percentage is determined based on the length of time that You have been covered under the Certificate.

The Covered Procedure must start and be completed while the Insured's coverage is in force, except as provided in the Replacement of Existing Coverage provision.

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.

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: For Orthodontic Dental Services see Class D, in the Schedule of Covered Procedures for start and completion dates.

2. 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.

3. 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 Contracting Provider or a Non Contracting Provider. Benefits under this Certificate are determined and payable in either case. The Insured will generally incur less out-of-pocket cost if a Contracting Provider is chosen.

4. Pre-Estimate: If the charge for any treatment is expected to exceed \$300, We recommend that a dental treatment plan be submitted to Us for review before treatment begins. An estimate of the benefits payable will be sent to You and Your dentist.

In addition to a dental treatment plan, before orthodontic treatment begins, We may request any of the following information to help determine benefits payable for orthodontic services:

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

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets You or Your Dependent know in advance approximately what portion of the expenses will be considered covered dental expenses by Us.

5. Alternate Benefit Provision: Recognizing that many dental problems can be solved in more than one way, We will pay an amount equal to that applicable for that generally accepted treatment which, in Our sole judgment, will provide adequate dental care at the lowest cost. In determining Our liability, We will be guided by nationally established standards of the dental profession.

If You pursue a more expensive course of treatment, this coverage may pay the equivalent of the least expensive treatment for that condition according to generally accepted standards of care. This payment may be applied toward a more expensive course of treatment.

6. Services Performed Outside the U.S.A.: Any claims submitted for procedures performed outside the U.S.A. must be supplied in English, must use American Dental Association (ADA) codes, and must be in U.S. Dollar currency. Reimbursement will be based on the [50th percentile] Usual Customary & Reasonable Fees or applicable Fee Schedule amounts for the Policyholder's zip code.

PART VI. LIMITATIONS

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 24 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.

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 You are covered under the policy. However, the following restrictions will apply:
 - (i) the extracted tooth will not be considered a Covered Procedure if it was an abutment to an existing prosthesis;
 - (ii) benefits will only be paid for the replacement of the teeth extracted while an Insured is covered under the policy;
 - (iii) benefits will not be paid for the replacement of other teeth which were missing on the Insured's effective date.

[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.]

PART VII. EXCLUSIONS

No benefits are payable under the Policy for the procedures listed below. Additionally, the procedures listed below will not be recognized toward satisfaction of any Deductible amount.

1. 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 Your or Your Dependent(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 replacement of lost or discarded or stolen appliances;
6. replacement of bridges unless the bridge is more than [5] years old and cannot be made serviceable;
7. replacement of full or partial dentures unless the prosthetic appliance is more than [5] years old and cannot be made serviceable;
8. replacement of crowns, inlays or onlays unless the prior restoration is more than [5] years old and cannot be made serviceable;
9. appliances, services or procedures relating to: (I) the change or maintenance of vertical dimension; (ii) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (iii) splinting; (iv) correction of attrition, abrasion, erosion or abfraction; (v) bite registration or (vi) bite analysis;
10. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
11. orthognathic surgery;
12. prescribed drugs, premedication or analgesia;
13. any instruction for diet, plaque control and oral hygiene;
14. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
15. 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;
16. 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);
17. for treatment of malignancies, cysts and neoplasms;
18. for orthodontic treatment unless otherwise listed as a Covered Procedure;
19. charges for failure to keep a scheduled visit or for the completion of any claim forms;
20. 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;
21. service or supply rendered by someone who is related to an Insured by blood (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;
22. expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law ;

23. 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 Payment of Claims in Part VIII. Claim Provisions;
24. procedures begun but not completed;
25. any duplicate device or appliance;
26. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures, plus the services of anesthetists or anesthesiologists except for (1) a child under the age of five and (2) a person who is severely disabled or (3) a person who has a medical or behavior condition which requires hospitalization or general anesthesia when dental care is provided;
27. the replacement of 3rd molars;
28. 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:

National Guardian Life Insurance Company
c/o [Administrator Name and Address]

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 request for missing information. If these forms are not sent within fifteen (15) days, the claimant will meet the proof of loss requirements if the Plan 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 Payment of Claims: Benefits payable under this policy will be paid either immediately or within thirty (30) days upon receipt of written proof of loss.

Legal Actions: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the Policy and no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the Policy.

Coordination of Benefits

Coordination of Benefits (COB) applies to This Plan when an Insured Person has health care coverage under more than one Plan. **Plan** and **This Plan** are defined below. This provision will only apply for the duration of Your employment with the Employer.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- a. Shall not be reduced when This Plan determines its benefits before another Plan; but
- b. May be reduced when another Plan determines its benefits first.

1. Definitions

- a. **Plan** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - (1) Group insurance or group-type coverage (including, but not limited to, group, group-type and individual automobile No-Fault" coverage), whether insured or uninsured. This includes

prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

- (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under 1 or 2 is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- b. **This Plan** is the part of the Policy that provides benefits for health care expenses.
- c. **Primary Plan/Secondary Plan:** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

- d. **Allowable Expense** means a Medically Necessary, Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the Insured for whom claim is made.

When benefits are reduced under a Primary Plan because an Insured does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense.

- e. **Claim Determination Period** means a Policy Year. However, it does not include any part of a year during which an Insured has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

2. **Order of Benefit Determination Rules**

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- a. The other Plan has rules coordinating its benefits with those of This Plan; and
- b. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

- a. Non-Dependent/Dependent - The benefits of the Plan which covers the Insured as an Employee, member or subscriber are determined before those of the Plan which covers the Insured as a Dependent; except that: if the Insured is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is
 - (1) Secondary to the Plan covering the Insured as a Dependent and
 - (2) Primary to the Plan covering the Insured as other than a Dependent (e.g. a retired Employee),then the benefits of the Plan covering the Insured as a dependent are determined before those of the Plan covering that Insured Person as other than a Dependent.
- b. Dependent Child/Parents Not Separated or Divorced - Except as stated in Paragraph 3 below, when This Plan and another Plan cover the same child as a dependent of different persons, called parents:
 - (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in "1" immediately above, and if, as a result the plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- c. Dependent Child/Separated or Divorced - If two or more Plans cover an Insured as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (1) First, the Plan of the parent with custody of the child;
 - (2) Then, the Plan of the spouse of the parent with custody;
 - (3) Finally, the Plan of the parent not having custody of the child.
 However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- d. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall follow the order of benefit determination rules outlined in Paragraph 2.
- e. Active/Inactive Employee - The benefits of a plan which covers an Insured as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Insured as a laid off or retired Employee. The same would hold true if an Insured is a Dependent of a person covered as a retiree and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- f. Continuation Coverage - If an Insured whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - (1) First, the benefits of a Plan covering the Insured as an Employee, member or subscriber (or as that Insured);
 - (2) Second, the benefits under the continuation coverage.
 If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- g. Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Insured for the shorter term.

3. **Effect On the Benefits of This Plan**

This Section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this Section.

The benefits of This Plan will be reduced when the sum of:

- a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

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

Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or health benefit Plan administrator with whom We coordinate benefits.

5. **Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment

made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. **Right to Recovery**

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

- a. The persons We have paid or for whom We have paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. This may only be recovered if it is within twelve (12) months from the date the claim was paid by Us.

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:

National Guardian Life Insurance Company
c/o [Administrator Name and Address]

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.

IX. REPLACEMENT OF EXISTING COVERAGE

The following takeover provisions are applicable when there is a group dental plan in force at the time of application.

Waiting Period Credit. When We immediately take over an entire dental group from another carrier, those persons insured by the prior carrier's plan on the day immediately prior to the takeover effective date will receive waiting period credit for the number of continuous uninterrupted months of coverage they had under the prior carrier, if they are eligible for coverage on the effective date of Our plan. The waiting period credit does not apply to new Employees, dependent add-ons, or 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 Employer's previous plan during the current Calendar Year. Any benefits paid under the Employer's previous policy 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, except for orthodontic services, paid under the Policyholder's previous policy 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 Employer's prior plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

- a. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the prior plan;
- b. orthodontic treatment was started and bands or appliances were inserted while insured under the prior plan; and
- c. 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 maximum benefit. The maximum benefit payable under this Certificate will be reduced by the amount paid or payable under the prior plan.

Verification. The Employer'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 Employer's previous plan.

Prior Carrier's Responsibility. The prior carrier is responsible for costs for procedures begun prior to the effective date.

Prior Extractions. If treatment is dentally necessary due to an extraction which occurred before the effective date of this coverage but while an Insured was covered under the prior plan and treatment would have been covered under the Employer's prior plan, We will apply the Coverage for Treatment in Progress provision as stated below and consider expenses as follows:

- a. the replacement of the extracted tooth must take place within 12 months of extraction; and
- b. expenses must be covered dental expenses under this Certificate and the prior plan.

Coverage for Treatment in Progress. If an Insured was covered under the prior plan on the day before the prior plan was replaced by this Certificate, We will pay benefits for any program of dental treatment already in progress on the effective date of this Certificate as stated below. However, the expenses must be covered dental expenses under this Certificate and the prior plan.

- a. **Extension of Benefits under Prior Plan. We will not pay benefits for treatment if:**
 - (i) the prior plan has an Extension of Benefits provision;
 - (ii) the treatment expenses were incurred under the prior plan; and
 - (iii) the treatment was completed during the extension of benefits.
- b. **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:**
 - (i) the prior plan has no extension of benefits when that plan terminates;
 - (ii) the treatment expenses were incurred under the prior plan; and
 - (iii) the treatment was completed while insured under this Certificate.
- c. **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:**
 - (i) the prior plan has an extension of benefits;
 - (ii) the treatment expenses were incurred under the prior plan; and
 - (iii) 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.

X. 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	§ Waiting Periods
A Preventive/Diagnostic	(i) None
B Basic	(ii) 3 months
C Major	(iii) 6 months
D Orthodontia	(iv) 12 months
E Not Covered	(v) 18 months
	(vi) 24 months

¶ Limitations

- | | |
|--|---|
| <ul style="list-style-type: none"> (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 | <ul style="list-style-type: none"> (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 |
|--|---|

Procedures	Procedure Class*	Waiting Period§	¶Limitation
Comprehensive Oral Exam or	[A]	[(i)]	[(a)]
Periodic Oral Exam	[A]	[(i)]	[(a)]
Problem Focused Exam	[B]	[(i)]	[(e)]
Emergency Palliative Treatment	[A]	[(i)]	[(e)]
Single Film	[A]	[(i)]	
Additional Films	[A]	[(i)]	
Intra-Oral Occlusal Film	[A]	[(i)]	
Panoramic Film, or	[A]	[(i)]	[(h)]
Full Mouth X-Ray	[A]	[(i)]	[(h)]
Bitewing – Single Film, or	[A]	[(i)]	[(y) (z)]
Bitewing – Two Films, or	[A]	[(i)]	[(y) (z)]
Bitewing – Four Films	[A]	[(i)]	[(y) (z)]
Prophylaxis	[A]	[(i)]	[(a)]
Topical Application of Fluoride	[A]	[(i)]	[(e) (x)]
Sealant	[A]	[(i)]	[(b) (x) (j)]
Space Maintainer – Fixed Unilateral	[A]	[(i)]	[(x) (o)]
Space Maintainer – Fixed Bilateral	[A]	[(i)]	[(x) (o)]
Space Maintainer – Removable Unilateral	[A]	[(i)]	[(x) (o)]
Space Maintainer – Removable Bilateral	[A]	[(i)]	[(x) (o)]
FILLINGS			
One Surface Amalgam – Primary	[B]	[(i)]	[(r) (s)]

Procedures	Procedure Class*	Waiting Period§	¶Limitation
Two Surface Amalgam – Primary	[B]	[(i)]	[(r) (s)]
Three Surface Amalgam – Primary	[B]	[(i)]	[(r) (s)]
Four + Surface Amalgam – Primary	[B]	[(i)]	[(r) (s)]
One Surface Amalgam – Permanent	[B]	[(i)]	[(r) (s)]
Two Surface Amalgam – Permanent	[B]	[(i)]	[(r) (s)]
Three Surface Amalgam – Permanent	[B]	[(i)]	[(r) (s)]
Four + Surface Amalgam – Permanent	[B]	[(i)]	[(r) (s)]
One Surface Resin – Anterior	[B]	[(i)]	[(r) (s)]
Two Surface Resin – Anterior	[B]	[(i)]	[(r) (s)]
Three Surface Resin – Anterior	[B]	[(i)]	[(r) (s)]
Four + Surface or Incisal Resin – Anterior	[B]	[(i)]	[(r) (s)]
One Surface Resin – Posterior Primary	[B]	[(i)]	[(r) (s) (t)]
Two Surface Resin – Posterior Primary	[B]	[(i)]	[(r) (s) (t)]
Three + Surface Resin – Posterior Primary	[B]	[(i)]	[(r) (s) (t)]
One Surface Resin – Posterior Permanent	[B]	[(i)]	[(r) (s) (t)]
Two Surface Resin – Posterior Permanent	[B]	[(i)]	[(r) (s) (t)]
Three + Surface Resin – Posterior Permanent	[B]	[(i)]	[(r) (s) (t)]
Four + Surface Resin – Posterior Permanent	[B]	[(i)]	[(r) (s) (t)]
Sedative Fillings	[B]	[(i)]	[(o)]
ORAL SURGERY			
Simple Extraction	[B]	[(i)]	
Additional Extraction	[B]	[(i)]	
Root Removal Exposed	[B]	[(i)]	
Surgical Extraction	[B]	[(i)]	
Impacted (soft tissue)	[B]	[(i)]	
Impacted (partial bony)	[B]	[(i)]	
Impacted (complete bony)	[B]	[(i)]	
Surgical Removal of Root	[B]	[(i)]	
Alveolectomy (with extraction) – per quadrant	[B]	[(i)]	
Alveolectomy (without extraction) – per quadrant	[B]	[(i)]	
Incision and Drainage of Abscess – Intraoral	[B]	[(i)]	
General Anesthesia/Intravenous Sedation	[B]	[(i)]	[(w)]
CROWN AND BRIDGE REPAIR			
Inlay Recementation	[B]	[(i)]	[(bb)]
Crown Recementation	[B]	[(i)]	[(bb)]
Bridge Repair	[B]	[(i)]	[(bb)]
Crown Repair	[B]	[(i)]	[(bb)]
Bridge Recementation	[B]	[(i)]	[(bb)]
DENTURE REPAIR			
Repair Denture Base	[B]	[(i)]	[(e) (bb)]
Repair Teeth – per tooth	[B]	[(i)]	[(e) (bb)]
Repair Partial Base	[B]	[(i)]	[(e) (bb)]
Repair Partial Framework	[B]	[(i)]	[(e) (bb)]
Repair Broken Clasp	[B]	[(i)]	[(e) (bb)]
Add Tooth to Existing Partial Denture	[B]	[(i)]	[(e) (bb)]
Add Clasp to Existing Partial Denture	[B]	[(i)]	[(e) (bb)]
Replace Teeth – per tooth	[B]	[(i)]	[(e) (bb)]
Reline Upper Denture	[B]	[(i)]	[(h) (bb)]
Reline Lower Partial Denture	[B]	[(i)]	[(h) (bb)]
Reline Upper Denture (Lab)	[B]	[(i)]	[(h) (bb)]

Procedures	Procedure Class*	Waiting Period§	¶Limitation
Reline Lower Denture (Lab)	[B]	[(i)]	[(h) (bb)]
Reline Upper Partial Denture (Lab)	[B]	[(i)]	[(h) (bb)]
Reline Lower Partial Denture (Lab)	[B]	[(i)]	[(h) (bb)]
Rebase Complete Denture – Upper	[B]	[(i)]	[(h) (bb)]
Rebase Complete Denture – Lower	[B]	[(i)]	[(h) (bb)]
Rebase Partial Denture – Lower	[B]	[(i)]	[(h) (bb)]
Tissue Conditioning – Upper	[B]	[(i)]	[(k) (bb)]
Tissue Conditioning – Lower	[B]	[(i)]	[(k) (bb)]
PERIODONTICS (Non-surgical)			
Scaling and Root Planing–per quadrant	[B]	[(i)]	[(n) (aa)]
Periodontal Debridement (full mouth)	[B]	[(i)]	[(v)]
Periodontal Maintenance Procedure	[B]	[(i)]	[(a)]
ENDODONTICS			
Vital Pulpotomy – primary teeth only	[B]	[(i)]	[(f)]
Root Canal – Anterior, or	[B]	[(i)]	
Root Canal – Bicuspid, or	[B]	[(i)]	
Root Canal – Molar	[B]	[(i)]	
Apicoectomy – Anterior, or	[B]	[(i)]	[(u)]
Apicoectomy – Molar	[B]	[(i)]	[(u)]
Retrograde Filling	[B]	[(i)]	[(u)]
Root Amputation	[B]	[(i)]	[(u)]
MISCELLANEOUS			
Occlusal Guard	[E]	[(i)]	
PERIODONTICS (Surgical)			
Gingivectomy – per quadrant	[B]	[(i)]	[(n)]
Gingivectomy – per tooth	[B]	[(i)]	[(o)]
Gingival Curettage – Surgical – per quadrant, or	[B]	[(i)]	[(n)]
Osseous Surgery – per quadrant	[B]	[(i)]	[(n)]
Soft Tissue Grafts	[B]	[(i)]	[(n)]
Gingival Flap Surgery	[B]	[(i)]	[(n)]
CROWN			
Crown Resin – resin with high noble metal	[C]	[(iv)]	[(l) (t)]
Crown Resin – resin with noble metal	[C]	[(iv)]	[(l) (t)]
Crown Resin – resin with predominately base metal	[C]	[(iv)]	[(l) (t)]
Crown – porcelain/ceramic substrate	[C]	[(iv)]	[(l) (t)]
Crown - porcelain fused to high noble metal	[C]	[(iv)]	[(l) (t)]
Crown – porcelain fused to noble metal	[C]	[(iv)]	[(l) (t)]
Crown –porcelain fused to predominantly base metal	[C]	[(iv)]	[(l) (t)]
Crown – full cast high noble metal	[C]	[(iv)]	[(l) (t)]
Crown – ¾ cast high noble metal	[C]	[(iv)]	[(l) (t)]
Crown – full cast noble metal	[C]	[(iv)]	[(l) (t)]
Crown – full cast predominantly base metal	[C]	[(iv)]	[(l)]
Crown Prefabricated Stainless Steel	[C]	[(iv)]	[(l)]
Cast Post and Core – In Addition to Crown	[C]	[(iv)]	[(l)]
Prefabricated Post and Core – In Addition to Crown	[C]	[(iv)]	[(l)]
BRIDGE			
Pontic Cast High Noble Metal	[C]	[(iv)]	[(l) (t)]
Pontic Cast Noble Metal	[C]	[(iv)]	[(l) (t)]

Procedures	Procedure Class*	Waiting Period§	¶Limitation
Pontic Cast Predominantly Base Metal	[C]	[(iv)]	[(l)]
Pontic Porcelain Fused to High Noble Metal	[C]	[(iv)]	[(l) (t)]
Pontic Porcelain Fused to Noble Metal	[C]	[(iv)]	[(l) (t)]
Pontic Porcelain Fused to Predominantly Base Metal	[C]	[(iv)]	[(l) (t)]
Pontic Resin with High Noble Metal	[C]	[(iv)]	[(l)]
Pontic Resin with Noble Metal	[C]	[(iv)]	[(l)]
Pontic Resin with Predominantly Base Metal	[C]	[(iv)]	[(l)]
Crown Resin with High Noble Metal	[C]	[(iv)]	[(l) (t)]
Crown Resin with Noble Metal	[C]	[(iv)]	[(l) (t)]
Crown Resin with Predominantly Base Metal	[C]	[(iv)]	[(l) (t)]
Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal	[C]	[(iv)]	[(l) (t)]
Crown Porcelain Fused to Noble / High Noble Metal	[C]	[(iv)]	[(l) (t)]
Crown Porcelain Fused to Predominantly Base Metal	[C]	[(iv)]	[(l) (t)]
Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal	[C]	[(iv)]	[(l)]
Crown ³ / ₄ Cast High Noble Metal	[C]	[(iv)]	[(l)]
Crown Full Cast Noble Metal	[C]	[(iv)]	[(l)]
Crown Full Cast Predominantly Base Metal	[C]	[(iv)]	[(l)]
Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	[C]	[(iv)]	[(l)]
Core Build-up for Retainer, (including any pins)	[C]	[(iv)]	[(l)]
Core Build-up (including any pins)	[C]	[(iv)]	[(l)]
Inlay	[C]	[(iv)]	[(l)]
Onlay	[C]	[(iv)]	[(l)]
Veneers – excluding cosmetic; restorative only	[C]	[(iv)]	[(l)]
DENTURES			
Complete Upper Denture	[C]	[(iv)]	[(l)]
Complete Lower Denture	[C]	[(iv)]	[(l)]
Immediate Upper Denture	[C]	[(iv)]	[(l)]
Immediate Lower Denture	[C]	[(iv)]	[(l)]
Upper Partial – Resin Base	[C]	[(iv)]	[(l)]
Lower Partial – Resin Base	[C]	[(iv)]	[(l)]
Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	[C]	[(iv)]	[(l)]
Core Build-up for Retainer, (including any pins)	[C]	[(iv)]	[(l)]
Core Build-up (including any pins)	[C]	[(iv)]	[(l)]
Inlay	[C]	[(iv)]	[(l)]
Onlay	[C]	[(iv)]	[(l)]
Veneers – excluding cosmetic; restorative only	[C]	[(iv)]	[(l)]
Upper Partial – Cast Metal Base	[C]	[(iv)]	[(l)]
Lower Partial – Cast Metal Base	[C]	[(iv)]	[(l)]
Removable Unilateral Partial Denture	[C]	[(iv)]	[(l)]
Denture Adjustment – Upper	[C]	[(iv)]	[(a) (bb)]
Denture Adjustment – Lower	[C]	[(iv)]	[(a) (bb)]
Partial Adjustment – Upper	[C]	[(iv)]	[(a) (bb)]
Partial Adjustment – Lower	[C]	[(iv)]	[(a) (bb)]
ORTHODONTIA *			
Initial Orthodontic Examination	[D]	[(i)]	[(d) (p)]
Initial Placement of Braces or Appliances	[D]	[(i)]	[(d) (p)]
Continuing Treatment for Braces or Appliances	[D]	[(i)]	[(d) (p)]

*** Orthodontic Dental Services**

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 Effect of Prior Plan 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 co-insurance percentage amount shown in the Schedule 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. Those who receive orthodontic 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 equal quarterly installments over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and quarterly installments will be determined as follows:

1. We will determine the lesser of the Reasonable and Customary charge and the orthodontist's fee and multiply that amount by the co-insurance rate 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 will be the maximum benefit payable. An initial amount of 25% of the 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 maximum benefit payable will be divided by the number of quarters that orthodontic treatment will continue to determine the amount which will be payable for each subsequent quarter of orthodontic treatment. The subsequent quarterly 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 maximum benefit payable has been paid, no further benefits will be paid.]

PART XI. SCHEDULE OF BENEFITS

Employer: [Group Name]

Employer's Address: [Address]

Effective Date: [August 1, 2001]

Initial Term: [12 Months]

Eligible Classes: [ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK AFTER COMPLETING 60 DAYS OF SERVICE]

Mode of Premium Payment: [MONTHLY]

Certificate Year: Your Certificate Year is on a [Calendar Year Plan or a Policy Year Plan].

Deductible:
 In Network:
 [\$50] per Insured Person per [Certificate Year]. Maximum per family: [3/Unlimited]
 Applies to Classes: [B, C]

 Out of Network:
 [\$50] per Insured Person per [Certificate Year]. Maximum per family: [3/Unlimited]
 Applies to Classes: [B, C]

Co-Pay: [0]

Certificate Year Maximum Benefit:
 Per Insured Person

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 & Forward</u>
[\$0-\$5,000]	[\$0-\$5,000]	[\$0-\$5,000]

Waiting Periods See schedule of covered procedures

ORTHODONTIA (CLASS D)
 In addition to Maximum Annual Benefit [No]
 Coverage Applies to [Dependent Children to Age [19-25] Only]

COVERED INSURANCE PERCENTAGES:

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

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

For the second year of this plan, the following covered percentages apply:

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

For the third year and all subsequent years, the following covered percentages apply:

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

Do takeover benefits apply for Employees who currently have dental coverage? [Yes]

- Covered Dental Expenses: Lesser of Dentist's actual charge or Usual, Customary or Reason ("UCR") Charge]
- Lesser of Dentist's actual charge or appropriate Fee Schedule amount]
- Lesser of Dentist's actual charge or Contracting Providers Program Maximum Allowed charge]

[PART XII. Procedure Fee Schedule

Procedures	“Scheduled Fee”	Procedures	“Scheduled Fee”
Initial Oral Exam (150)	[\$0-\$5,000]	Alveolectomy (with extraction) – per quadrant (7310)	[\$0-\$5,000]
Periodic Oral Exam (120)	[\$0-\$5,000]	Alveolectomy (without extraction) – per quadrant (7320)	[\$0-\$5,000]
Emergency Oral Exam (140)	[\$0-\$5,000]	Incision and Drainage of Abscess – Intraoral (7510)	[\$0-\$5,000]
Emergency Palliative Treatment (9110)	[\$0-\$5,000]	General Anesthesia (with surgery) (9220/9221)	[\$0-\$5,000]
Single Film (220)	[\$0-\$5,000]	Intravenous Sedation (9241/9242)	[\$0-\$5,000]
Additional Films (230)	[\$0-\$5,000]	CROWN AND BRIDGE REPAIR	
Intra-Oral Occlusal Film (240)	[\$0-\$5,000]	Inlay Recementation (2910)	[\$0-\$5,000]
Panoramic Film, or (330)	[\$0-\$5,000]	Crown Recementation (2920)	[\$0-\$5,000]
Full Mouth X-Ray (210)	[\$0-\$5,000]	Bridge Repair (6980)	[\$0-\$5,000]
Bitewing – Single Film, or (270)	[\$0-\$5,000]	Crown Repair (2980)	[\$0-\$5,000]
Bitewing – Two Films, or (272)	[\$0-\$5,000]	Bridge Recementation (6930)	[\$0-\$5,000]
Bitewing – Four Films (274)	[\$0-\$5,000]	DENTURE REPAIR	
Prophylaxis (1110)	[\$0-\$5,000]	Repair Denture Base (5510)	[\$0-\$5,000]
Prophylaxis with Fluoride – Child, or (1120)	[\$0-\$5,000]	Repair Teeth – per tooth (5520)	[\$0-\$5,000]
Topical Application of Stannous Fluoride– Child (1203)	[\$0-\$5,000]	Repair Partial Base(5610)	[\$0-\$5,000]
Sealant or Preventive Resin Restoration–per tooth or quadrant (1351)	[\$0-\$5,000]	Repair Partial Framework (5620)	[\$0-\$5,000]
Space Maintainer – Fixed Unilateral (1510)	[\$0-\$5,000]	Repair Broken Clasp (5630)	[\$0-\$5,000]
Space Maintainer – Fixed Bilateral (1515)	[\$0-\$5,000]	Add Tooth to Existing Partial Denture (5650)	[\$0-\$5,000]
Space Maintainer – Removable Unilateral (1520)	[\$0-\$5,000]	Add Clasp to Existing Partial Denture (5660)	[\$0-\$5,000]
Space Maintainer – Removable Bilateral (1525)	[\$0-\$5,000]	Replace Teeth – per tooth (5640)	[\$0-\$5,000]
FILLINGS		Reline Upper Denture (5730)	[\$0-\$5,000]
One Surface Amalgam – Primary (2110)	[\$0-\$5,000]	Reline Lower Denture (5731)	[\$0-\$5,000]
Two Surface Amalgam – Primary (2120)	[\$0-\$5,000]	Reline Upper Partial Denture (5740)	[\$0-\$5,000]
Three Surface Amalgam – Primary (2130)	[\$0-\$5,000]	Reline Lower Partial Denture (5741)	[\$0-\$5,000]
Four + Surface Amalgam – Primary (2131)	[\$0-\$5,000]	Reline Upper Denture (Lab) (5750)	[\$0-\$5,000]
One Surface Amalgam – Permanent (2140)	[\$0-\$5,000]	Reline Lower Denture (Lab) (5751)	[\$0-\$5,000]
Two Surface Amalgam – Permanent (2150)	[\$0-\$5,000]	Reline Upper Partial Denture (Lab) (5760)	[\$0-\$5,000]
Three Surface Amalgam – Permanent (2160)	[\$0-\$5,000]	Reline Lower Partial Denture (Lab) (5761)	[\$0-\$5,000]
Four + Surface Amalgam – Permanent (2161)	[\$0-\$5,000]	Rebase Complete Denture – Upper (5710)	[\$0-\$5,000]
One Surface Resin – Anterior (2330)	[\$0-\$5,000]	Rebase Complete Denture – Lower (5711)	[\$0-\$5,000]
Two Surface Resin – Anterior (2331)	[\$0-\$5,000]	Rebase Partial Denture – Upper (5720)	[\$0-\$5,000]
Three Surface Resin – Anterior (2332)	[\$0-\$5,000]	Rebase Partial Denture – Lower (5721)	[\$0-\$5,000]
Four + Surface or Incisal Resin – Anterior (2335)	[\$0-\$5,000]	Tissue Conditioning – Upper (5850)	[\$0-\$5,000]
One Surface Resin – Posterior Primary (2380)	[\$0-\$5,000]	Tissue Conditioning – Lower (5851)	[\$0-\$5,000]
Two Surface Resin – Posterior Primary (2381)	[\$0-\$5,000]	PERIODONTICS (Non-surgical)	
Three + Surface Resin – Posterior Primary (2382)	[\$0-\$5,000]	Scaling and Root Planing–per quadrant (4341)	[\$0-\$5,000]
One Surface Resin – Posterior Permanent (2385)	[\$0-\$5,000]	Periodontal Debridement (full mouth) (4355)	[\$0-\$5,000]
Two Surface Resin – Posterior Permanent (2386)	[\$0-\$5,000]	Periodontal Maintenance Procedure (4910)	[\$0-\$5,000]
Three + Surface Resin – Posterior Permanent (2387)	[\$0-\$5,000]	ENDODONTICS	
Sedative Fillings (2940)	[\$0-\$5,000]	Vital Pulpotomy – primary teeth only (3220)	[\$0-\$5,000]
ORAL SURGERY	[\$0-\$5,000]	Root Canal – Anterior, or (3310)	[\$0-\$5,000]
Simple Extraction (7110)	[\$0-\$5,000]	Root Canal – Bicuspid, or (3320)	[\$0-\$5,000]
Additional Extraction (7120)	[\$0-\$5,000]	Root Canal – Molar (3330)	[\$0-\$5,000]
Root Removal Exposed (7130)	[\$0-\$5,000]	Apicoectomy – Anterior, or (3410)	[\$0-\$5,000]
Surgical Extraction (7210)	[\$0-\$5,000]	Apicoectomy – Bicuspid, or (3421)	[\$0-\$5,000]
Impacted (soft tissue) (7220)	[\$0-\$5,000]	Apicoectomy – Molar (3425)	[\$0-\$5,000]
Impacted (partial bony) (7230)	[\$0-\$5,000]	Apicoectomy – Additional Root (3426)	[\$0-\$5,000]

Procedures	“Scheduled Fee”	Procedures	“Scheduled Fee”
ORAL SURGERY (Continued)		ENDODONTICS (Continued)	
Impacted (complete bony) (7240)	[\$0-\$5,000]	Retrograde Filling (3430)	[\$0-\$5,000]
Surgical Removal of Root (7250)	[\$0-\$5,000]	Root Amputation (3450)	[\$0-\$5,000]
PERIODONTICS (Surgical)		Crown Retainer Porcelain Precious (6750)	[\$0-\$5,000]
Gingivectomy – per quadrant (4210)	[\$0-\$5,000]	Crown Retainer Porcelain Semi-precious (6752)	[\$0-\$5,000]
Gingivectomy – per tooth (4211)	[\$0-\$5,000]	Crown Retainer Porcelain Non-precious (6751)	[\$0-\$5,000]
Gingival Curettage – Surgical – per quadrant, or (4220)	[\$0-\$5,000]	Crown Retainer Full Cast Precious (6790)	[\$0-\$5,000]
Osseous Surgery – per quadrant (4260)	[\$0-\$5,000]	Crown Retainer ¾ Cast Precious (6780)	[\$0-\$5,000]
Soft Tissue Grafts (4270)	[\$0-\$5,000]	Crown Retainer Full Cast Semi-precious (6792)	[\$0-\$5,000]
Gingival Flap Surgery (4240)	[\$0-\$5,000]	Crown Retainer Full Cast Non-precious (6791)	[\$0-\$5,000]
		Cast Post and Core (plus Fixed Partial Retainer) (6970)	[\$0-\$5,000]
CROWN AND BRIDGE			
Crown Resin – Precious (2720)	[\$0-\$5,000]	Prefabricated Post and Core (plus Fixed Partial Retainer) (6972)	[\$0-\$5,000]
Crown Resin – Semi-precious (2722)	[\$0-\$5,000]	Core Build-up for Retainer (including any pins) (6973)	[\$0-\$5,000]
Crown Resin – Non-precious (2721)	[\$0-\$5,000]	Crown Build-up (including pins) (2950)	[\$0-\$5,000]
Crown Porcelain (2740)	[\$0-\$5,000]	Veneers – excluding cosmetic; restorative only (2960)	[\$0-\$5,000]
Crown Porcelain with Precious (2750)	[\$0-\$5,000]	DENTURES	
Crown Porcelain with Semi-precious (2752)	[\$0-\$5,000]	Complete Upper Denture (5110)	[\$0-\$5,000]
Crown Porcelain with Non-precious (2751)	[\$0-\$5,000]	Complete Lower Denture (5120)	[\$0-\$5,000]
Crown Full Precious (2790)	[\$0-\$5,000]	Immediate Upper Denture (5130)	[\$0-\$5,000]
Crown ¾ Precious (2810)	[\$0-\$5,000]	Immediate Lower Denture (5140)	[\$0-\$5,000]
Crown Full Semi-precious (2792)	[\$0-\$5,000]	Upper Partial – Resin Base (5211)	[\$0-\$5,000]
Crown Full Non-precious (2791)	[\$0-\$5,000]	Lower Partial – Resin Base (5212)	[\$0-\$5,000]
Crown Prefabricated Stainless Steel (2930)	[\$0-\$5,000]	Upper Partial – Cast Metal Base (5213)	[\$0-\$5,000]
Crown Prefabricated Resin (2932)	[\$0-\$5,000]	Lower Partial – Cast Metal Base (5214)	[\$0-\$5,000]
Post and Core – Cast (2952)	[\$0-\$5,000]	Removable Unilateral Partial Denture (5281)	[\$0-\$5,000]
Post and Core – Prefabricated (2954)	[\$0-\$5,000]	Denture Adjustment – Upper (5410)	[\$0-\$5,000]
Pontic Cast Precious (6210)	[\$0-\$5,000]	Denture Adjustment – Lower (5411)	[\$0-\$5,000]
Pontic Cast Semi-precious (6212)	[\$0-\$5,000]	Partial Adjustment – Upper (5421)	[\$0-\$5,000]
Pontic Cast Non-precious (6211)	[\$0-\$5,000]	Partial Adjustment – Lower (5422)	[\$0-\$5,000]
Pontic Porcelain Precious (6240)	[\$0-\$5,000]	ORTHODONTIA *	
Pontic Porcelain Semi-precious (6242)	[\$0-\$5,000]	Initial Orthodontic Examination	[\$0-\$5,000]
Pontic Porcelain Non-precious (6241)	[\$0-\$5,000]	Initial Placement of Braces or Appliances	[\$0-\$5,000]
Pontic Plastic Precious (6250)	[\$0-\$5,000]	Continuing Treatment for Braces or Appliances	[\$0-\$5,000]
Pontic Plastic Semi-precious (6252)	[\$0-\$5,000]		
Pontic Plastic Non-precious (6251)	[\$0-\$5,000]		

]



National Guardian Life Insurance Company

Two East Gilman Street, PO Box 1191, Madison, WI 53701

ENDORSEMENT

The Policy and Certificate to which this endorsement is attached are amended as follows:

1. Under Individual Effective Dates, the provisions entitled Newborn Coverage and Adopted Children are hereby deleted and the following provisions are added:

Newborn Children: Newborn children are automatically covered under the terms of the policy from the moment of birth. Coverage for newborn will be in effect until the 91st day following the date of such event. If You desire uninterrupted coverage for a newborn child, You must notify Us within 91 days of the child's birth.

Adopted Children: Coverage for adopted children will begin on the date of the filing of Your petition for adoption if You apply for such coverage within sixty (60) days after the filing of the petition. However, coverage will begin from the moment of birth of the adopted child if Your application for coverage is filed within sixty (60) days after the birth of the minor.

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

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

Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of our liability will be paid immediately upon receipt of due written proof.

The endorsement is effective on the later of the policy effective date or the certificate effective date to which it is attached.

There are no other changes to the policy or certificate.

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

Sherri Kliczak, Secretary

John Larson, President

APPLICATION
to
National Guardian Life Insurance Company
Administered by [TPA Name, Address, Telephone Number and Fax Number]

Group Policy: [12345]

Policyholder: [ABC Trust]

Address: [Address]

The Policyholder hereby applies to National Guardian Life Insurance provided by the Group Policy and approves and accepts the Group Policy with the signature below. The Group Policy takes effect on the date specified on the face page of the Group Policy.

Dated At: _____

On: _____

Signed for the Policyholder

By: _____
(Signature and Title)

Agent: _____
(Must be a Resident Licensed Agent where required by law)

Group, Attn: _____ Phone: (____) _____
 Broker or Agent

The Employer agrees to participate in the [National Guardian Life Insurance Company's Employer/Employee Group Insurance Plan Trust]. The Employer acknowledges that as an "employer," the Employer is establishing this [dental] [vision] [prescription drug] plan. Neither National Guardian Life nor the policyholder/trustee is acting as a "sponsor" as defined in ERISA. Employer agrees that any compliance with ERISA that is applicable to the Employer is the responsibility of the Employer.

[Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan.] [I understand and agree if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status]. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized National Guardian Life Insurance Co. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement. I acknowledge that I have read the applicable Fraud Warning statement printed on this form.

Signed by Employer:

_____/_____/_____
Name Title Date

Agent's Signature _____ Agent's Name (Printed) _____

NGL Agent # _____ Agent State License # _____

Date

Fraud Warning:

[Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty [(in Georgia, Kansas, Nebraska, Texas and Oregon may be guilty)] of insurance fraud.]

[In Arkansas and Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

In Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

In California: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

In District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

In Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In Kansas: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of committing a fraudulent insurance act.

In Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

In Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

In New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

In New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

In Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

In Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

In Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

Enrollment/Change Form
[DENTAL] / [VISION] / [OUTPATIENT PRESCRIPTION INSURANCE]

Underwritten by National Guardian Life Insurance Company
 [Administered by: TPA Name
 TPA Address]



Please print and complete all sections.

GROUP EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)					
Group Employer Name		Group Number	Location	Effective Date	Date of Hire
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Employee Last Name	First Name	M.I.	Date of Birth	Social Security Number
Home Street Address		City/State/Zip	Home Phone ()	Work Phone ()	
Email Address				Cell Phone ()	

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)					
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No

[NOTE for Dental: Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.]

[NOTE for Vision: Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for 12 months.]]

[I elect the following coverage(s):

- | | | |
|---|---|---|
| <input type="checkbox"/> Dental | <input type="checkbox"/> Vision | <input type="checkbox"/> Outpatient Prescription Drug |
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee Only |
| <input type="checkbox"/> Employee + Spouse | <input type="checkbox"/> Employee + Spouse | <input type="checkbox"/> Employee + Spouse |
| <input type="checkbox"/> Employee + Child(ren) | <input type="checkbox"/> Employee + Child(ren) | <input type="checkbox"/> Employee + Child(ren) |
| <input type="checkbox"/> Employee Family | <input type="checkbox"/> Employee Family | <input type="checkbox"/> Employee Family |
| <input type="checkbox"/> Waived due to other coverage | <input type="checkbox"/> Waived due to other coverage | <input type="checkbox"/> Waived due to other coverage |
| <input type="checkbox"/> Waive | <input type="checkbox"/> Waive | <input type="checkbox"/> Waive]] |

Do you or any of your dependents have other [dental] [or vision] [or prescription drug] insurance? Yes No

If yes, please give: Policyholder _____ and Insurance Company _____.

[Declination of coverage must be accompanied by the Employee's signature. I acknowledge that I have read the Fraud Warning statement printed on the reverse side of this form.

Employee Signature: _____ Date: _____

Fraud Warning:

[Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty [(in Georgia, Kansas, Nebraska, Texas and Oregon may be guilty)] of insurance fraud.]

[In Arkansas and Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

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In Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

In District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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In Kansas: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of committing a fraudulent insurance act.

In Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

In Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

In New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

In New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

In Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

In Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

In Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

SERFF Tracking Number: NGLI-126488200 State: Arkansas
 Filing Company: National Guardian Life Insurance Company State Tracking Number: 45092
 Company Tracking Number: GROUP DENTAL - MET FORMS AND TLA TRUST
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: GROUP DENTAL - MET FORMS AND TLA TRUST
 Project Name/Number: GROUP DENTAL - MET FORMS AND TLA TRUST/GROUP DENTAL - MET FORMS AND TLA TRUST

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/08/2010
Comments:		
Attachments:		
AR - Required Certification - Title 19.pdf		
AR - Required Certification - Reg 49.pdf		
AR - Certification of Readability - 2002 MET Forms.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	03/08/2010
Comments:		
Group Application - NDVRX GRPAPP 4/08 Approved 06/03/08 (SERFF Tr Num: NGLI-125659536)		
Enrollment Form - NDVRX ENROLL 4/08 Approved 06/03/08 (SERFF Tr Num: NGLI-125659536)		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved-Closed	03/08/2010
Comments:		
Attachments:		
Variable Data - Policy.pdf		
Variable Data - Certificate.pdf		



**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

I, **Mark Neidinger**, an officer of *National Guardian Life Insurance Company*, hereby certify that, to the best of my information, knowledge and belief the attached filing is in compliance with Rule and Regulation 19 regarding Unfair Sex Discrimination in the Sale of Insurance.

A handwritten signature in black ink, appearing to read "Mark Neidinger", written over a horizontal line.

March 4, 2010

Signature

Date

Mark Neidinger

Associate General Counsel – Company Officer

Individual responsible for this filing:

Name: Mandi Schwarz

Title: Paralegal

Phone #: (608) 443-5371

Email: mcschwarz@nglic.com



**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

I, **Mark Neidinger**, an officer of *National Guardian Life Insurance Company*, hereby certify the following:

- Our company is in compliance with Arkansas Code Ann. 23-79-138. The required notice providing information on the Arkansas Department of Insurance is automatically included with each policy issued in the state of Arkansas.
-
- Similarly, the required Life and health Guaranty Association Notice is automatically included with each policy issued in Arkansas, in compliance with Regulation 49.

A handwritten signature in black ink, appearing to read "Mark Neidinger".

March 4, 2010

Signature

Date

Mark Neidinger

Associate General Counsel – Company Officer

Individual responsible for this filing:

Name: Mandi Schwarz

Title: Paralegal

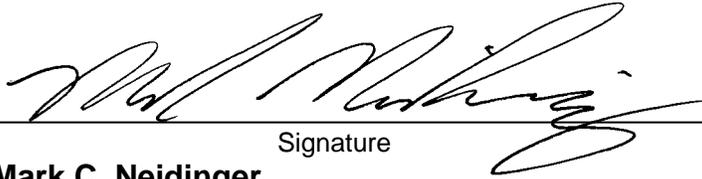
Phone #: (608) 443-5371

Email: mcschwarz@nglic.com

CERTIFICATION OF READABILITY

I, Mark C. Neidinger, an officer of National Guardian Life Insurance Company, certify that the Flesch scores for the submitted forms are listed below:

Forms	Flesch Scores
NDNGRP2002-MET(R)	41.6
NDNGRP2002CT-MET(R)	42.5
NDNGRP2002-END-AR	42



Signature

March 4, 2010

Date

Mark C. Neidinger

Associate General Counsel and Company Officer

**GROUP DENTAL PRODUCT
DEFINITION OF VARIABLE TEXT**

GROUP POLICY FORM – NDNGRP2002-MET(R):

Page 1:

1. The Administrator's logo may be added or changed.
2. The Administrator's name and address may be changed as needed.
3. Company officer names and signatures may change.
4. The information on the Schedule will be completed with information specific to the group issued, i.e. Name of Policyholder, Policy Number, Effective Date, etc.

Page 3 – CONTINUING INSURANCE ON ACTIVE EMPLOYEES ABSENT FROM WORK:

1. The Maximum Continuation Periods are bracketed to allow changes based on a specific employer's rules with regard to insurance on active employees absent from work.

Page 3 – TERM OF POLICY AND RIGHT TO TERMINATE

1. The information is bracketed to allow changes based on a specific employer's rules with regard to employee participation requirements.

Page 4 – CHANGES IN PREMIUM RATES

1. The information is bracketed to allow changes based on a specific employer's rules with regard to premium rate changes.

**GROUP DENTAL PRODUCT
DEFINITION OF VARIABLE TEXT**

CERTIFICATE FORM – NDNGRP2002CT-MET(R):

Page 1:

1. The Administrator's logo may be added or changed.
2. The Administrator's name and address may be changed as needed.

PART I. DEFINITIONS:

1. Definition of Deductible: The range for the number of insureds is 1-10. This number will coincide with the variability under "Deductible" in the Schedule of Benefits
2. Definition of Domestic Partner may be deleted entirely.
3. Definition of Eligible Dependent: The words [or lawful Domestic Partner] may be deleted entirely.
4. Definition of Initial Term: The words [12 month] may be either 12 month or 24 month.

PART VI. LIMITATIONS:

1. The provision "Other Limitations" may be deleted in its entirety.

PART VII. EXCLUSION

1. The bracketed information in this section may be any number of years greater than or equal to 1.

PART VIII. CLAIM PROVISIONS:

1. Under the "Notice of Claim" provision, the Administrator's name and address may be changed as needed.
2. Under the "Grievance Procedure" provision, the Administrator's name and address may be changed as needed.

PART X. SCHEDULE OF COVERED PROCEDURES:

1. All items are bracketed so that Covered Procedures may be deleted, and Procedure Classes, Waiting Periods, and Limitations may be revised. All of possibilities for the variable data in the chart under this section are listed in the key.
2. Below the Schedule of Covered Procedures, the entire [Orthodontic Dental Services] provision may be deleted if the plan does not provide orthodontia benefits.

PART XI. SCHEDULE OF BENEFITS

All plan information is bracketed to allow for completion based on the benefits elected by the Policyholder.

1. Under the "Deductible" provision, the range for the deductible is \$0 - \$999 and the [Certificate Year] variable term may either be Certificate Year, Calendar Year or Policy Year.
2. Under the "Certificate Year Maximum Benefit" provision, the range for the maximum benefit is \$0 - \$5,000.
3. Under the "Covered Insurance Percentages" provision, the percentage range for In-Network and Out-of-Network is 0%-100%. The Maximum Annual/Lifetime Benefits range is None or from \$0-\$9,999.

PART XII. PROCEDURE FEE SCHEDULE

1. The "Scheduled Fee" amounts for any of the listed procedures under this section may range from \$0-\$5,000.
2. The Fee Schedule may be deleted entirely if it is not applicable to the plan being issued.