

SERFF Tracking Number: STAR-127077537 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number: 49108  
Company Tracking Number:  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Group dental policy  
Project Name/Number: /DN-2010-AR

## Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: Group dental policy

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: STAR-127077537 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 49108

Co Tr Num:

Author: Belle Lucas

Date Submitted: 06/22/2011

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 06/30/2011

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Project Number: DN-2010-AR

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association

Filing Status Changed: 06/30/2011

State Status Changed: 06/30/2011

Created By: Belle Lucas

Corresponding Filing Tracking Number:

Filing Description:

RE: DN-2010-AR, DN-2010CT-AR, et al (Dental Plan)

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Belle Lucas

The above group dental policy forms are submitted for your review and approval. These are new forms and are not intended to replace any previously approved group dental forms. This is a Me Too filing which was submitted and approved by National Guardian Life Insurance Company on February 24, 2010 under SERFF filing #NGLI-126449897. These forms are identical except for the standard changes made to the forms to be a Starmount filing.

These forms provide dental insurance benefits to the employees/members of eligible employer, union or association groups and their dependents. We request approval of these forms for use with groups located in your state. In addition,

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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 language in the forms has been developed to accommodate both employer and non-employer (i.e., association) groups.

Premiums may be paid by the member or policyholder or a combination. There is an initial contract period of 12 months. Premiums may be paid by the employee/member, employer or union, or a combination. There is no minimum or maximum issue age for these forms.

Benefits include reimbursement for the dental procedures listed in the attached Schedule of Covered Procedures. Note that 2 separate Schedules are attached to the filing, as follows:

DN-2010GRPCT SCP is used for plans where reimbursement is based on actual charges incurred or when there is a benefit difference for in-network vs. out-of-network providers.

DN-2010GRPCT SCP-SF is used for plans where benefits are based on a Scheduled Fee.

Endorsement form DN-2010-END-AR will be attached to each Certificate issued in Arkansas to provide the required coverage for Newborn and Adopted children.

A Statement of Variability is attached to the filing which explains bracketed information within the forms.

We will use our recently approved group master application (GRPAPP 03/11) and enrollment form (Enroll 03/11) in the solicitation of coverage which was approved under SERFF #STAR-127160664 on June 1, 2011.

The attached forms have been drafted to allow us to issue them to various non-employer groups. However, this initial filing is for the purpose of obtaining approval for use with employer groups only. The company understands its obligation to obtain approval of the forms for use with other types of groups, particularly with regard to associations.

For your information, the following previously approved optional benefit rider may be offered with these new forms:

Hearing Services Rider: Form DVGRP-HSR 07- approved 6/12/07.

Cosmetic Services Rider –Form DN-2007-CSR approved 1/19/07.

Please call or email me at 225-400-9282 or at bellel@starmountlife.com if you have any questions.

Sincerely,  
Belle Lucas  
Compliance Specialist

## Company and Contact

SERFF Tracking Number: STAR-127077537 State: Arkansas  
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**Filing Contact Information**

Belle Lucas, Compliance Specialist belle@starmountlife.com  
 P.O. Box 98100 225-926-2888 [Phone]  
 Baton Rouge, LA 70898

**Filing Company Information**

Starmount Life Insurance Company CoCode: 68985 State of Domicile: Louisiana  
 7800 Office Park Boulevard Group Code: Company Type:  
 Baton Rouge, LA 70809 Group Name: State ID Number:  
 (225) 926-2888 ext. [Phone] FEIN Number: 72-0977315

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	\$100.00	06/22/2011	48993326
Starmount Life Insurance Company	\$200.00	06/24/2011	49076714

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2011	06/30/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/23/2011	06/23/2011	Belle Lucas	06/24/2011	06/24/2011

*SERFF Tracking Number:*      *STAR-127077537*                      *State:*                      *Arkansas*  
*Filing Company:*              *Starmount Life Insurance Company*              *State Tracking Number:*      *49108*  
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*Product Name:*              *Group dental policy*  
*Project Name/Number:*      */DN-2010-AR*

## **Disposition**

Disposition Date: 06/30/2011

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	dental policy	Approved-Closed	Yes
Form	dental certificate	Approved-Closed	Yes
Form	endorsement	Approved-Closed	Yes
Form	schedule of covered procedures	Approved-Closed	Yes
Form	schedule of covered procedures-S fees	Approved-Closed	Yes
Form	schedule of benefits	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 06/23/2011

Submitted Date 06/23/2011

Respond By Date

Dear Belle Lucas,

This will acknowledge receipt of the captioned filing.

### Objection 1

- dental policy, DN-2010-AR (Form)
- dental certificate, DN-2010GRPCT-AR (Form)
- endorsement, DNGRP-END-AR 2010 (Form)
- schedule of covered procedures, DN-2010GRPCT-SCP (Form)
- schedule of covered procedures-S fees, DN-2010GRPCT-SCP-SF (Form)
- schedule of benefits, DN-2010GRPCT-SOB (Form)

### Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$300.00. Please submit an additional \$200.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/24/2011  
Submitted Date 06/24/2011

Dear Rosalind Minor,

### Comments:

Please see response below:

### Response 1

Comments: I have submitted an additional \$200 in filing fees. Thanks for the info.

### Related Objection 1

Applies To:

- dental policy, DN-2010-AR (Form)
- dental certificate, DN-2010GRPCT-AR (Form)
- endorsement, DNGRP-END-AR 2010 (Form)
- schedule of covered procedures, DN-2010GRPCT-SCP (Form)
- schedule of covered procedures-S fees, DN-2010GRPCT-SCP-SF (Form)
- schedule of benefits, DN-2010GRPCT-SOB (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$300.00. Please submit an additional \$200.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

*SERFF Tracking Number:*      *STAR-127077537*                      *State:*                      *Arkansas*  
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*TOI:*                      *H10G Group Health - Dental*              *Sub-TOI:*                      *H10G.000 Health - Dental*  
*Product Name:*              *Group dental policy*  
*Project Name/Number:*      */DN-2010-AR*

No Rate/Rule Schedule items changed.

Rosalind, let me know if you need anything else.

Thanks,  
Belle Lucas  
225-400-9282

Sincerely,  
Belle Lucas

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## Form Schedule

### Lead Form Number: DN-2010-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/30/2011	DN-2010-AR	Policy/Cont ract/Fraternal Certificate	dental policy	Initial		44.300	DN-2010-AR.pdf
Approved-Closed 06/30/2011	DN-2010GRPC T-AR	Certificate	dental certificate	Initial		41.700	DN-2010GRPCT-AR.pdf
Approved-Closed 06/30/2011	DNGRP-END-AR 2010	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	endorsement	Initial		45.000	DNGRP END-AR 2010.pdf
Approved-Closed 06/30/2011	DN-2010GRPC T-SCP	Schedule Pages	schedule of covered procedures	Initial		46.500	DN-2010GRPCT-SCP.pdf
Approved-Closed 06/30/2011	DN-2010GRPC T-SCP-SF	Schedule Pages	schedule of covered procedures-S fees	Initial		44.300	DN-2010GRPCT-SCP-SF.pdf
Approved-Closed 06/30/2011	DN-2010GRPC T-SOB	Schedule Pages	schedule of benefits	Initial		56.000	DN-2010GRPCT-SOB.pdf



**STARMOUNT LIFE INSURANCE COMPANY**  
8485 Goodwood Blvd., Baton Rouge, LA 70806-7878

**GROUP DENTAL INSURANCE MASTER POLICY**

Underwritten by: Starmount Life Insurance Company  
8485 Goodwood Blvd., Baton Rouge, LA 70806-7878  
P.O. Box 98100  
Baton Rouge, LA 70898-9100

Administrator: [TPA Name and TPA Logo  
TPA Address  
City, State, Zip]

In return for the application, which is attached, and payment of premium as it becomes due, Starmount Life Insurance Company (called "We," "Our," and "Us") agrees to pay the benefits described in the Policy.

This Policy is issued to the Policyholder. It takes effect at 12:01 a.m. at the Policyholder's principal address shown on the application on the Policy Effective Date. The Effective Date is shown on the Policy Schedule.

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

**The following are made part of this Policy: the provisions of the attached Certificates; all riders; all endorsements; and all amendments issued on and after the Effective Date.**

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

**POLICYHOLDER:** [Group Name]  
**GROUP POLICY NUMBER:** [Group Number]  
**POLICY EFFECTIVE DATE:** [November 1, 2010]  
**ANNIVERSARY DATE:** [November 1, 2011]  
**JURISDICTION:** [Louisiana]  
**PREMIUM DUE DATE:** [1<sup>st</sup> of every Month]  
**COVERAGE PROVIDED:** [See Incorporated Certificate's Schedule of Benefits]  
**INITIAL TERM:** [12 Months]

Jeffrey G. Wild, Secretary

Erich Sternberg, President

**NON-PARTICIPATING**

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**[PART I: PROVISIONS SPECIFIC TO EMPLOYER GROUPS**

**A. DEFINITIONS:** The following Definitions apply in addition to those contained in the attached Certificate:

**Active Employee** – Means an Actively At Work Employee of the Employer named as the Policyholder.

**Active Work and Actively at Work** – Means that You are performing all of the usual and customary duties of Your job on a full-time basis for the Policyholder, as defined in the Certificate Schedule of Benefits. This must be done at the Policyholder’s customary place of employment or business, or at some location to which the employment requires You to travel.

**B. 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.

<b>FOR ABSENCE DUE TO:</b>	<b>MAXIMUM CONTINUATION PERIOD:</b>
[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:
	<ol style="list-style-type: none"> <li>1. 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 (6) months);</li> <li>2. request to continue insurance must be made by the Employer to Us within thirty-one (31) days before each Anniversary Date.]</li> </ol>

**PART [II]: WHEN INSURANCE UNDER THIS POLICY ENDS**

By giving the Policyholder written notice at least sixty (60) days in advance, We have the right to end coverage under this policy at the end of the Initial Term or on any Premium Due Date after participation drops below the following requirements:

1. [When Members are not required to contribute to the cost of their own insurance, there must be 100% participation.]
2. [For groups of [two (2) or more] Members where benefits are funded by the Members, [20%] participation is required in all circumstances.]
3. [Participation must not drop [25%] or more from the participation on the original effective date.]

All insurance or any part may be ended on any date by mutual agreement between the Policyholder and Us.

After the Initial Term, the Policy shall continue on a [twelve (12) month basis]. It will automatically renew on the first day of each renewal period unless either We or the Policyholder has given to the other at least sixty 60 days advance written notice of cancellation.

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

## **PART [III]: PREMIUMS**

**A. PAYMENT OF PREMIUMS:** The premiums due under this Policy are payable in advance directly to Us at the Administrator's Office. The first premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the face page of this Policy.

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 the GRACE PERIOD provision.

**B. PREMIUM ADJUSTMENTS:** 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).

Upon agreement between the Policyholder and Us, the mode of premium payment may be changed as of any Premium Due Date.

**C. 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.

**D. CHANGES IN PREMIUM RATES:** We have the right to change the premium rates on any premium due date after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in any twelve (12) month period. We will notify the Policyholder in writing at least sixty (60) days before any increase in premium rates.

Any premium rate guarantees are subject to the following provisions:

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

**E AGGREGATE PREMIUM:** The aggregate premium due on any Premium Due Date is the sum of the amounts determined in accordance with the PREMIUM CALCULATION provision.

**F. GRACE PERIOD:** A Grace Period of thirty (31) days (without interest charge) is granted for the payment of any premium due after the first. This Policy will continue in effect during this period unless the Policyholder 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 Policyholder will owe Us all premiums then due and unpaid including the premium for the Grace Period.

If the Policyholder 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.

## **PART [IV]: GENERAL PROVISIONS**

**A. ENTIRE CONTRACT:** The entire contract consists of:

1. this Policy;
2. the application of the Policyholder;
3. the provisions shown in the Certificate;
4. the Insured enrollment forms; and
5. riders and endorsements, if any, adding or changing the provisions of the Policy or Certificate.

A copy of the Policyholder's application is attached to this Policy on the date it is signed. All statements made in the applications, in the absence of fraud, 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.

**B. INCONTESTABILITY:** This Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

**C. 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.

**D. AGE MISSTATED:** If the age of any Insured under this Policy has been misstated, there will be a fair adjustment between the Policyholder 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.

**E. 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.

**F. POLICY NON-PARTICIPATING:** This Policy is not entitled to share in the surplus earnings of Our company.

**G. INFORMATION TO BE FURNISHED BY POLICYHOLDER:** The Policyholder 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 which have a bearing on the insurance or premiums.

**H. CLERICAL ERROR:** Clerical error (whether by the Policyholder 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.

**I. POLICYHOLDER NOT AGENT:** The Policyholder will in no event be considered Our agent for any purpose under this Policy.

**J. 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.

**K. INDIVIDUAL CERTIFICATE:** We will issue to the Policyholder for delivery to each person insured under this Policy Certificates 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.

**L. ADDITIONAL INSUREDS:** The following will be added to the group originally insured:

1. All new persons becoming eligible to and applying for insurance in such group or class, including new members of a family; and
2. Any persons required to be provided coverage under federal law who apply for insurance in such group or class.

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

## PART [V]: CLAIM PROVISIONS

**A. NOTICE OF CLAIM:** Written notice of claim must be given within thirty (30) days after a loss occurs, or as soon as reasonably possible. The notice must be given to the Administrator. Claims should be sent to:

Starmount Life Insurance Company  
[c/oTPA Name and Address]

**B. CLAIM FORMS:** When the Administrator receives notice of claim that does not contain all necessary information or is not on an appropriate claim form, forms for filing proof of loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within fifteen (15) days, 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.

**C. 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.

**D. PAYMENT OF CLAIMS:** Benefits will be paid to the Insured unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at the Insured's death will be paid to the Insured's 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 the insurance amount to such beneficiary's court appointed guardian.

**E. 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.



## GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by: Starmount Life Insurance Company  
(called "We," "Our," and "Us")  
8485 Goodwood Blvd.  
P.O. Box 98100  
Baton Rouge, LA 70806

Administrator: [TPA Name and TPA Logo  
TPA Address  
City, State, Zip]

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

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

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

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

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

Jeffrey G. Wild, Secretary

Erich Sternberg, President

**NON-PARTICIPATING**

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## PART I. DEFINITIONS

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

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

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

**Co-Pay** - The fixed amount that an Insured is required to pay directly to a Participating Provider for Covered Expenses. The Co-Pay may vary by Procedure Code. If a Co-Pay applies, it is shown on the Schedule of Benefits.

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

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

**Covered Procedure** - The procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for performed dental treatment to an Insured while His coverage under this Certificate is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a:

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

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

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

**Eligible Dependent** - Means a person listed below:

1. Your spouse; [or lawful Domestic Partner]
2. Your unmarried dependent child under age [18-30], who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
- [3. Your unmarried child age [Insert same age as in 2, above] or older but less than age [21,22, 23, 24, 25, 26, 27, 28, 29 or 30] who is:
  - a. Not regularly employed on a full-time basis;
  - b. Primarily dependent upon You for support and maintenance; and
  - c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.]
- [4.] Your unmarried child who has reached age [Insert same age as in 2, above] and who is:
  - a. primarily dependent upon You for support and maintenance; and
  - b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

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

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

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

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

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

**Insured** – Means You and each Covered Dependent.

**Insured Member**– Means a person:

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

**[Late Entrant** - Any Member or Eligible Dependent enrolling outside the Policyholder's initial Eligibility Period as indicated in the Schedule of Benefits. Benefits may be limited for Late Entrants as noted under Part VII., A under Limitations.]

**Maximum Reimbursement** – An amount used to determine the Covered Expense. There are 4 types of Maximum Reimbursement, depending on the plan issued:

1. **Maximum Allowable Charge (MAC)**: The MAC may be used if a dentist who is a Non-Participating Provider performs a Covered Procedure. The amount of the MAC is equal to the lesser of: (a) the dentist's actual charge; or (b) the "customary charge" for the dental service or supply. We determine the "customary charge" from within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area.
2. **Participating Provider Maximum Allowable Charge (PMAC)**: The PMAC may be used if a dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the dentist has agreed with Us to accept as payment in full for a dental service or supply.
3. **Scheduled Fee (SF)**: Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the dentist. The Scheduled Fee for a Participating Provider may be different than the Scheduled Fee for a Non-Participating Provider.
4. **Indemnity**: The Maximum Allowable Charge (MAC), as explained in (1,) above, is used to determine the amount payable for a Covered Procedure. However, the MAC will be the same, regardless of whether a Participating Provider or Non-Participating Provider is used.

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

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

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

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

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

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

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

1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated and is subject to change without notice.

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

**Policy Year Plan** - Benefits begin immediately on the Policyholder's effective date and renew 12 months following the initial effective date.

**[Re-enrollee** - Any Insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits are limited for Re-enrollees under Part VII. Limitations.]

**You or Your** – The Insured Member.

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

## **PART II. ELIGIBILITY AND ENROLLMENT**

### **A. ELIGIBILITY**

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

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

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

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

### **B. ENROLLMENT**

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

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

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

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

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

1. Marriage; [or Domestic Partnership];
2. Divorce or legal separation;
3. Birth or adoption of a child;

4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

### **PART III. INDIVIDUAL EFFECTIVE DATES**

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

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

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

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

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

### **PART IV. INDIVIDUAL TERMINATION DATES**

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

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

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

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

### **PART V. INDIVIDUAL PREMIUMS**

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

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

The Schedule of Benefits shows the method of premium payment.

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

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

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a [twelve (12)] month period. We will give the Policyholder written notice at least sixty (60) days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

## **PART VI. DESCRIPTION OF COVERAGE**

### **A. COVERED DENTAL EXPENSES**

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

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

We then pay the Insurance Percentage of the Covered Expense, minus any Co-Pay. The Insurance Percentage is shown in the Table of Insurance Percentages on the Schedule of Benefits.

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

The benefit is subject to the following:

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

### **B. WHEN A COVERED PROCEDURE IS STARTED AND COMPLETED**

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

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

### **C. HOW TO SUBMIT EXPENSES**

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

### **D. CHOICE OF PROVIDERS**

An Insured may choose a dentist of his choice. An Insured may choose the services of a dentist who is either a

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

Note: If this is an Indemnity plan, there is no difference in payment between a Participating and Non-Participating Provider.

#### **E. PRE-ESTIMATE**

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

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

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

#### **F. ALTERNATE BENEFIT PROVISION**

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

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

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

### **PART VII. LIMITATIONS AND EXCLUSIONS**

#### **A. LIMITATIONS**

**[1.] [LIMITATION FOR LATE ENTRANTS OR RE-ENROLLEES:** [Members that waive coverage at initial enrollment (within thirty-one (31) days of effective date) or in the new Member eligibility period will have a twelve (12) month waiting period applied to all basic, major, and orthodontia services upon re-applying.] [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 [six (6)][twelve (12)][eighteen (18)][twenty-four (24)] months after the Late Entrant's or Re-Enrollee's Effective Date. The limited coverage also applies to the Late Entrant's or Re-Enrollee's Eligible Dependents, if enrolled.]

**[2.] [MISSING TEETH LIMITATION:** We will not pay benefits for replacement of teeth missing on an Insured's effective date of insurance under this Certificate for the purpose of the initial placement of a full denture, partial denture fixed bridge or implant. 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, fixed bridge or implant 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 or implant will be considered a Covered Procedure if the placement includes the initial replacement of a functioning natural tooth extracted while an Insured is covered under the policy. However, the following restrictions will apply:
  - (i) Benefits will only be paid for the replacement of the teeth extracted while an Insured is covered under the policy or under the "Prior Extraction" clause;
  - (ii) benefits will not be paid for the replacement of other teeth which were missing on the Insured's effective date.
  - (iii) missing teeth limitation will be waived after Insured has been covered under this group's plan for [one (1)] [three (3)] [five (5)] continuous years unless it is a replacement of an existing unserviceable prosthesis.]

**[3.] [Other Limitations:** Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations.] [Coverage is limited to two prophylaxis and/or two periodontal maintenance procedures, subject to a maximum total of no more than two (2) procedures per twelve (12) month period.] [Coverage is limited to one (1) full mouth radiograph or panoramic film per limitation period listed in the Schedule of Covered procedures.] [On any given day, more than seven (7) periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph. Additional limitations are noted in the Schedule of Covered Procedures.]]

## B. EXCLUSIONS

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

1. any service or supply not shown on the Schedule of Covered Procedures;
2. any procedure begun after an Insured's insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty (30) days after an Insured's insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations or congenital missing teeth;
6. the replacement of lost or discarded or stolen appliances;
7. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
8. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
9. replacement of implants, crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
10. appliances, services or procedures relating to: (a) the change or maintenance of vertical dimension; (b) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (c) splinting; (d) correction of attrition, abrasion, erosion or abfraction; (e) bite registration or (f) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
12. orthognathic surgery;
13. prescribed medications, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or

- accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
  19. for orthodontic treatment;
  20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
  21. any procedure We determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
  22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured's household;
  23. expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage);
  24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the "Payment of Claims" provision;
  25. procedures started but not completed;
  26. any duplicate device or appliance;
  27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures as defined by Us, plus the services of anesthesiologists;
  28. the replacement of 3<sup>rd</sup> molars;
  29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

#### **PART VIII. CLAIM PROVISIONS**

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

Starmount Life Insurance Company  
[c/oTPA 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 a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss.

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

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

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

**Time Payment Of Claims:** Benefits will be payable immediately upon receipt of acceptable Proof of Loss.

**Recovery Of Overpayments:** We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or

5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

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

## **[PART IX. COORDINATION OF BENEFITS (COB)]**

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

### **A. DEFINITIONS RELATED TO COB**

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.
2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.
3. **Plan:** Any plan, including this one that provides benefits or services for dental expenses on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.
4. **Primary Plan:** The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.
5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

### **B. BENEFIT COORDINATION**

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

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

### **C. THE ORDER OF BENEFIT DETERMINATION**

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
  - a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.
  - b. **Dependent Child/Parents Not Separated or Divorced.** For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

- c. **Dependent Child/Separated or Divorced Parents.** If two (2) or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
  - i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
  - ii. The Plan of the parent with custody of the child;
  - iii. The Plan of the spouse of the parent with custody; and
  - iv. The Plan of the parent without custody of the child.
- d. **Dependent Child/Joint Custody.** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
- e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

#### **D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

#### **E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN**

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

#### **F. RIGHT TO RECOVERY**

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

### **PART [X]. GRIEVANCE PROCEDURE**

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

Starmount Life Insurance Company  
[c/oTPA 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.

#### **PART [XI]. GENERAL PROVISIONS**

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

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

#### **[PART XII. TAKEOVER BENEFITS**

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

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to Starmount Life.

New hires with prior-like dental coverage (lapse in coverage must be less than sixty-three (63) days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e., one page benefit summary, certificate of creditable coverage, etc.).

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

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

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

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

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

1. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the Prior Plan; and

2. orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
3. orthodontic treatment is continued while Your covered dependent is insured under this Certificate.

If You submit the required proof, the maximum benefit for orthodontic treatment will be the lesser of this Certificate's Overall Maximum Benefit for Class D Orthodontic Services or the Prior Plan's ortho maximum benefit. The ortho maximum benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

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

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

**Prior Extractions:** If: (1) treatment is performed due to an extraction which occurred before the effective date of this coverage while an Insured was covered under the Prior Plan; and (2) the replacement of the extracted tooth must take place within [twelve (12)] [twenty-four (24)] [thirty-six (36)] [forty-eight (48)] [sixty (60)] months of extraction; and (3) treatment would have been covered under the Policyholder's Prior Plan; We will apply the expenses to this plan as long as they are Covered Expenses under both this Certificate and the Prior Plan.

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

1. Extension of Benefits under Prior Plan. We will not pay benefits for treatment if:
  - (a) the Prior Plan has an Extension of Benefits provision;
  - (b) the treatment expenses were incurred under the Prior Plan; and
  - (c) the treatment was completed during the extension of benefits.
2. No Extension of Benefits under Prior Plan. We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:
  - (a) the Prior Plan has no extension of benefits when that plan terminates;
  - (b) the treatment expenses were incurred under the Prior Plan; and
  - (c) the treatment was completed while insured under this Certificate.
3. Treatment Not Completed during Extension of Benefits. We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan and during the extension if:
  - (a) the Prior Plan has an extension of benefits;
  - (b) the treatment expenses were incurred under the Prior plan; and
  - (c) the treatment was not completed during the Prior Plan's extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.]



**STARMOUNT LIFE INSURANCE COMPANY**  
8485 Goodwood Blvd., Baton Rouge, LA 70806-7878

**GROUP DENTAL INSURANCE MASTER POLICY**

Underwritten by: Starmount Life Insurance Company  
8485 Goodwood Blvd., Baton Rouge, LA 70806-7878  
P.O. Box 98100  
Baton Rouge, LA 70898-9100

Administrator:[TPA Name and TPA Logo  
TPA Address  
City, State, Zip]

**ENDORSEMENT**

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

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 91<sup>st</sup> 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.

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.

Jeffrey G. Wild, Secretary

Erich Sternberg, President

## PART [XIII]. SCHEDULE OF COVERED PROCEDURES

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

### Key for Schedule of Covered Procedures

* Procedure Class	Type of Maximum Reimbursement:
[A Preventive/Diagnostic]	[PMAC – Participating Provider Maximum Allowable Charge]
[B Basic]	[MAC – Maximum Allowable Charge (based on “Customary Charge”)]
[C Major]	[SF – Scheduled Fee]
[D Orthodontia]	[Indemnity]
[E Not Covered]	
[F Other]	

### ¶ Limitations

[(a) Maximum of 1 procedure per 6 months]	[(dd) Maximum of 1 per 10 year period]
[(b) Maximum of 1 procedure per 36 months]	[(ee) Maximum of 1 per 3 year period]
[(c) Maximum of 4 films per 12 months]	[(ff) Maximum of 1 per 4 year period]
[(d) Limited to Dependent Children under age 19]	[(gg) Maximum of 1 per 5 year period]
[(e) Maximum of 1 procedure per 12 months]	[(hh) In lieu of a single tooth replacement when a 2 or 3 unit bridge has been approved for coverage]
[(f) Limited to Dependent Children under age 14]	[(ii) Maximum of 2 procedures per 12 months]
[(g) Limited to Dependent Children under age 12]	[(jj) Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion]
[(h) Maximum of 1 procedure per 24 months]	[(kk) One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient’s physician and claim narrative from dentist must be submitted at the time of claim.]
[(i) Limited to Dependent Children under age 19]	[(ll) Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient’s physician and claim narrative must be submitted at the time of the claim.]
[(j) Applications made to permanent molar teeth only]	[(mm) Covered only if provided on different date of service than other covered treatment or exam]
[(k) Maximum of 2 procedures per arch per 24 months]	[(nn) Subject to review]
[(l) Maximum of 1 per 5 year period per tooth]	[(oo) In lieu of Topical Application of Fluoride for a child]
[(m) Maximum of 1 each quadrant per 12 months]	[(pp) Limited to 2 oral evaluation procedures, in any combination (D0120, D0150, D9310) per 12 month period]
[(n) Maximum of 1 each quadrant per 24 months]	
[(o) Maximum of 1 each tooth per 24 months]	
[(p) Subject to a yearly and a lifetime maximum]	
[(q) Maximum of 1 each quadrant per 36 months]	
[(r) Replacement of existing only if in place for 12 months (insured under age 19)]	
[(s) Replace existing only if in place for 36 months (insured over age 19)]	
[(t) Benefits will be based on the benefit for the corresponding non-cosmetic restoration.]	
[(u) Maximum 1 time per tooth or site]	
[(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 when existing appliance/restoration is not serviceable]	

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	[Maximum Reimbursement] [Co-Pay]	
				In-Network [PMAC] [Co-Pay]	Out-of-Network [PMAC] [MAC]
[Comprehensive or Periodic Oral Exam]	[A]	[(0-24)]	[(pp)]	[PMAC] [\$0-\$9,999]	[MAC] [\$0-\$9,999]
[Oral Evaluation – Patient under 3 yrs of age]	[A]	[(0-24)]	[(pp)]	[PMAC]	[MAC]
[Problem Focused Exam]	[B]	[(0-24)]	[(e)]	[PMAC]	[MAC]
[Re-evaluation – Limited Problem Focused (not post-op visit), benefited for accidental injury monitoring only]	[B]	[(0-24)]	[(e)]	[PMAC]	[MAC]
[Comprehensive Periodontal Exam]	[A]	[(0-24)]	[(e)]	[PMAC]	[MAC]
[Emergency Palliative Treatment]	[A]	[(0-24)]	[(e)]	[PMAC]	[MAC]
[Professional Consultation]	[A]	[(0-24)]	[(pp)]	[PMAC]	[MAC]
[Office visit for observation (during regularly scheduled hours) – no other services performed]	[A]	[(0-24)]	[(v)]	[PMAC]	[MAC]
[Single Film]	[A]	[(0-24)]	[]	[PMAC]	[MAC]
[Additional Films]	[A]	[(0-24)]	[]	[PMAC]	[MAC]
[Intra-Oral Occlusal Film]	[A]	[(0-24)]	[]	[PMAC]	[MAC]
[Extraoral – First Film (by report)]	[A]	[(0-24)]	[]	[PMAC]	[MAC]
[Extraoral – Each Additional Film (by report)]	[A]	[(0-24)]	[]	[PMAC]	[MAC]
[Bitewings (single or multiple films)]	[A]	[(0-24)]	[(c) (e)]	[PMAC]	
[Panoramic Film or Full Mouth X-Ray]	[A]	[(0-24)]	[(h)]	[PMAC]	[MAC]
[Prophylaxis – Adult (age 14 and above)]	[A]	[(0-24)]	[(ii) (kk) [(ll)]]	[PMAC]	[MAC]
[Prophylaxis – Child]	[A]	[(0-24)]	[(f) (ii) (kk) [(ll)]]	[PMAC]	[MAC]
[Adjunctive Pre-Diagnostic Oral Cancer Screening]	[A]	[(0)]	(e) (jj)	[Up to \$45]	[Up to \$45]
[Accession of Tissue, Gross Exam including report]	[A]	[(0-24)]	[(nn)]	[PMAC]	[MAC]
[Accession of Tissue, Gross and Micro Exam including report]	[A]	[(0-24)]	[(nn)]	[PMAC]	[MAC]
[Accession of Tissue, Gross and Micro Exam (including assessment of surgical margins) including report]	[A]	[(0-24)]	[(nn)]	[PMAC]	[MAC]
[Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report]	[A]	[(0-24)]	[(e) (jj)]	[PMAC]	[MAC]
[Topical Application of Fluoride – Child]	[A]	[(0-24)]	[(e) (x)]	[PMAC]	[MAC]
[Topical Application of Fluoride – Adult]	[A]	[(0-24)]	[(e)]	[PMAC]	[MAC]
[Topical Fluoride Varnish]	[A]	[(0-24)]	[(e) (x) (oo)]	[PMAC]	[MAC]
[Sealant]	[A]	[(0-24)]	[(b) (x) (j)]	[PMAC]	[MAC]
[Space Maintainer – Fixed Unilateral]	[A]	[(0-24)]	[(x) (o)]	[PMAC]	[MAC]
[Space Maintainer – Fixed Bilateral]	[A]	[(0-24)]	[(x) (o)]	[PMAC]	[MAC]
[Space Maintainer – Removable Unilateral]	[A]	[(0-24)]	[(x) (o)]	[PMAC]	[MAC]
[Space Maintainer – Removable Bilateral]	[A]	[(0-24)]	[(x) (o)]	[PMAC]	[MAC]
[Recementation of Space Maintainer]	[A]	[(0-24)]	[(x) (o) (bb)]	[PMAC]	[MAC]

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	[Maximum Reimbursement] [Co-Pay]	
				In-Network [PMAC] [Co-Pay]	Out-of-Network [PMAC] [MAC]
(per Space Maintainer)]					
[Removal of fixed Space Maintainer]	[A]	[(0-24)]	[(x) (o)]	[PMAC]	[MAC]
<b>FILLINGS</b>					
[One Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Two Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Three Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Four + Surface Amalgam]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[One Surface Resin – Anterior]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Two Surface Resin – Anterior]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Three Surface Resin – Anterior]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[One Surface Resin – Posterior]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Two Surface Resin – Posterior]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Three Surface Resin – Anterior]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Four + Surface or Incisal Resin – Anterior]	[B]	[(0-24)]	[(r) (s)]	[PMAC]	[MAC]
[Sedative Fillings]	[B]	[(0-24)]	[(o)]	[PMAC]	[MAC]
<b>ORAL SURGERY</b>					
[Extraction, erupted tooth or exposed root]	[B]	[(0-24)]	[]	[PMAC]	[MAC]
[Coronal Remnants]	[B]	[(0-24)]	[]	[PMAC]	[MAC]
[Surgical Extraction]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Impacted (soft tissue)]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Impacted (partial bony)]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Impacted (complete bony)]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Surgical Removal of Root]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Alveoplasty (with extraction) – per quadrant]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Alveoplasty (without extraction) – per quadrant]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Incision and Drainage of Abscess – Intraoral]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Frenectomy (by report, for periodontal purposes only)]	[C]	[(0-24)]	[(u) (v)]	[PMAC]	[MAC]
[General Anesthesia/Intravenous Sedation]	[C]	[(0-24)]	[(w)]	[PMAC]	[MAC]
<b>CROWN AND BRIDGE REPAIR</b>					
[Inlay Recementation]	[B]	[(0-24)]	[(bb)]	[PMAC]	[MAC]
[Crown Recementation]	[B]	[(0-24)]	[(bb)]	[PMAC]	[MAC]
[Bridge Repair]	[B]	[(0-24)]	[(bb)]	[PMAC]	[MAC]
[Crown Repair]	[B]	[(0-24)]	[(bb)]	[PMAC]	[MAC]
[Bridge Recementation]	[B]	[(0-24)]	[(bb)]	[PMAC]	[MAC]
<b>DENTURE REPAIR</b>					
[Repair Denture Base]	[B]	[(0-24)]	[(e) (bb)]	[PMAC]	[MAC]
[Repair Teeth – per tooth]	[B]	[(0-24)]	[(e) (bb)]	[PMAC]	[MAC]
[Repair Partial Base]	[B]	[(0-24)]	[(e) (bb)]	[PMAC]	[MAC]
[Repair Partial Framework]	[B]	[(0-24)]	[(e) (bb)]	[PMAC]	[MAC]
[Repair Broken Clasp]	[B]	[(0-24)]	[(e) (bb)]	[PMAC]	[MAC]
[Add Tooth to Existing Partial Denture]	[B]	[(0-24)]	[(e) (bb)]	[PMAC]	[MAC]
[Add Clasp to Existing Partial Denture]	[B]	[(0-24)]	(e) (bb)]	[PMAC]	[MAC]

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	[Maximum Reimbursement] [Co-Pay]	
				In-Network [PMAC] [Co-Pay]	Out-of-Network [PMAC] [MAC]
[Replace Teeth – per tooth]	[B]	[(0-24)]	[(e) (bb)]	[PMAC]	[MAC]
[Reline Upper Denture]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Reline Lower Partial Denture]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Reline Upper Denture (Lab)]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Reline Lower Denture (Lab)]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Reline Upper Partial Denture (Lab)]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Reline Lower Partial Denture (Lab)]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Rebase Complete Denture – Upper]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Rebase Complete Denture – Lower]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Rebase Partial Denture – Lower]	[B]	[(0-24)]	[(h) (bb)]	[PMAC]	[MAC]
[Tissue Conditioning – Upper]	[B]	[(0-24)]	[(k) (bb)]	[PMAC]	[MAC]
[Tissue Conditioning – Lower]	[B]	[(0-24)]	[(k) (bb)]	[PMAC]	[MAC]
[Denture Adjustment Maxillary – Upper]	[B]	[(0-24)]	[(a) (bb)]	[PMAC]	[MAC]
[Denture Adjustment Mandibular – Lower]	[B]	[(0-24)]	[(a) (bb)]	[PMAC]	[MAC]
[Partial Adjustment Maxillary – Upper]	[B]	[(0-24)]	[(a) (bb)]	[PMAC]	[MAC]
[Partial Adjustment Mandibular – Lower]	[B]	[(0-24)]	[(a) (bb)]	[PMAC]	[MAC]
<b>PERIODONTICS (Non-surgical)</b>					
[Scaling and Root Planning–per quadrant]	[C]	[(0-24)]	[(n)]	[PMAC]	[MAC]
[Periodontal Debridement (full mouth)]	[C]	[(0-24)]	[(v)]	[PMAC]	[MAC]
[Periodontal Maintenance Procedure]	[C]	[(0-24)]	[(ii) (kk) [(ll)]]	[PMAC]	[MAC]
<b>ENDODONTICS</b>					
[Vital Pulpotomy – primary teeth only]	[C]	[(0-24)]	[(f)]	[PMAC]	[MAC]
[Pulpal Therapy – posterior primary teeth only (subject to alternate benefit provision)]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Root Canal – Anterior]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Root Canal – Bicuspid]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Root Canal – Molar]	[C]	[(0-24)]	[]	[PMAC]	[MAC]
[Apicoectomy – Anterior]	[C]	[(0-24)]	[(u)]	[PMAC]	[MAC]
[Apicoectomy – Bicuspid]	[C]	[(0-24)]	[(u)]	[PMAC]	[MAC]
[Apicoectomy – Molar]	[C]	[(0-24)]	[(u)]	[PMAC]	[MAC]
[Retrograde Filling]	[C]	[(0-24)]	[(u)]	[PMAC]	[MAC]
[Root Amputation]	[C]	[(0-24)]	[(u)]	[PMAC]	[MAC]
<b>MISCELLANEOUS</b>					
[Occlusal Guard]	[E]	[(0-24)]	[]	[PMAC]	[MAC]
<b>PERIODONTICS (Surgical)</b>					
[Gingivectomy or Gingivoplasty – per quadrant]	[C]	[(0-24)]	[(n)]	[PMAC]	[MAC]
[Gingivectomy or gingivoplasty – per tooth]	[C]	[(0-24)]	[(o)]	[PMAC]	[MAC]
[Gingival Flap Procedure – per quadrant]	[C]	[(0-24)]	[(n)]	[PMAC]	[MAC]
[Osseous Surgery – per quadrant]	[C]	[(0-24)]	[(n)]	[PMAC]	[MAC]
[Pedicle Soft Tissue Grafts]	[C]	[(0-24)]	[(n)]	[PMAC]	[MAC]
[Free Soft Tissue Graft]	[C]	[(0-24)]	[(n)]	[PMAC]	[MAC]

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	[Maximum Reimbursement] [Co-Pay]	
				In-Network [PMAC] [Co-Pay]	Out-of-Network [PMAC] [MAC]
[Subepithelial Connective Tissue Graft]	[C]	[(0-24)]	[(n)]	[PMAC]	[MAC]
<b>CROWN</b>					
[Crown Resin – resin with high noble metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Resin – resin with noble metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Resin – resin with predominately base metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown – porcelain/ceramic substrate]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown - porcelain fused to high noble metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown – porcelain fused to noble metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown –porcelain fused to predominantly base metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown – full cast high noble metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown – ¾ cast high noble metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown – Full cast high noble metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown – full cast predominantly base metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Crown Prefabricated Stainless Steel]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Cast Post and Core – In Addition to Crown]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Prefabricated Post and Core – In Addition to Crown]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Resin-based composite crown, anterior]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Resin-based composite – one surface, posterior]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Resin-based composite – two surfaces, posterior]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Resin-based composite – three surfaces, posterior]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Resin-based composite – four or more surfaces, posterior]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Lengthening]	[C]	[(0-24)]	[(nn) (u) (v)]	[PMAC]	[MAC]
[Inlay]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Onlay]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Veneers – excluding cosmetic; restorative only]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
<b>BRIDGE</b>					
[Pontic Cast High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Pontic Cast Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Pontic Cast Predominantly Base Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Pontic Porcelain Fused to High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Pontic Porcelain Fused to Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Pontic Porcelain Fused to Predominantly Base Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	[Maximum Reimbursement] [Co-Pay]	
				In-Network [PMAC] [Co-Pay]	Out-of-Network [PMAC] [MAC]
[Pontic Resin with High Noble Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Pontic Resin with Noble Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Pontic Resin with Predominantly Base Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Crown Resin with High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Resin with Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Resin with Predominantly Base Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Porcelain Fused to Noble / High Noble Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Porcelain Fused to Predominantly Base Metal]	[C]	[(0-24)]	[(l) (t)]	[PMAC]	[MAC]
[Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Crown ¾ Cast High Noble Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Crown Full Cast Noble Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Crown Full Cast Predominantly Base Metal]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Core Build-up for Retainer, (including any pins)]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Core Build-up (including any pins)]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Pin Retention – per tooth, in addition to restoration]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
<b>DENTURES</b>					
[Complete Upper Denture]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Complete Lower Denture]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Immediate Upper Denture]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Immediate Lower Denture]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Maxillary (Upper) Partial – Resin Base]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Mandibular (Lower) Partial – Resin Base]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Maxillary (Upper) Partial – Cast Metal Framework with Resin Base]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Mandibular (Lower) Partial – Cast Metal Framework with Resin Base]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
[Removable Unilateral Partial Denture]	[C]	[(0-24)]	[(l)]	[PMAC]	[MAC]
<b>OTHER</b>					
[Endosteal Implants]	[C]	[(0-24)]	[(hh) (v)]	[PMAC]	[MAC]
[Cosmetic]	[E]	[(0-24)]	[(p) (u)]	[PMAC]	[MAC]
[TMJ]	[E]	[(0-24)]	[(p)]	[PMAC]	[MAC]
<b>[ORTHODONTIA **]</b>					
[Initial Orthodontic Examination]	[D]	[(0-24)]	[(d) (p)]	[PMAC]	[MAC]
[Initial Placement of Braces or Appliances]	[D]	[(0-24)]	[(d) (p)]	[PMAC]	[MAC]
[Continuing Treatment for Braces or	[D]	[(0-24)]	[(d) (p)]	[PMAC]	[MAC]

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	[Maximum Reimbursement]	
				[Co-Pay]	
				In-Network [PMAC] [Co-Pay]	Out-of-Network [PMAC] [MAC]
Appliances including retention]					
[Interceptive Orthodontic Treatment]	[D]	[(0-24)]	[(d) (p)]	[PMAC]	[MAC]

**[\* Orthodontia Services**

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

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

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

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

**PART [XIII]. SCHEDULE OF COVERED PROCEDURES**

SUBJECT TO THE WAITING PERIOD, POLICY YEAR DEDUCTIBLE, POLICY YEAR BENEFIT MAXIMUM, PERCENTAGE OF COVERED DENTAL EXPENSES LISTED IN THE POLICY SCHEDULE, AND THE LIMITATIONS AND EXCLUSIONS SECTION OF THE POLICY, WE WILL PAY THE FOLLOWING BENEFITS UP TO THE COVERED DENTAL EXPENSE AMOUNT WHEN A CHARGE IS INCURRED FOR A COVERED DENTAL PROCEDURE THAT OCCURS WHILE COVERAGE IS IN FORCE.

The following is a complete list of Covered Dental Procedures, applicable limitations, and Scheduled Amounts. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

**¶ Limitations**

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Limited to Dependent Children under age 19
(d) Maximum of 1 procedure per 12 months
(e) Maximum of 1 procedure per 12 months per provider
(f) Maximum of 1 procedure per 24 months
(g) Applications made to permanent molar teeth only
(h) Maximum of 2 procedures per arch per 24 months
(i) Maximum of 1 per 5 year period per tooth
(j) Maximum of 1 each quadrant per 12 months
(k) Maximum of 1 each quadrant per 36 months
(l) Maximum of 1 per tooth surface per tooth
(m) Subject to a yearly and lifetime maximum
(n) Maximum of 2 procedures per 12 months
(o) Replacement of existing only if in place for 36 months (for insureds over age 19) and in place for 12 months (for insureds under age 19)
(p) Not in conjunction with TMJ
(q) Benefits based on the benefit for the corresponding non-cosmetic restoration on posterior teeth.
(r) Maximum 1 time per tooth or site
(s) Maximum of 1 per lifetime
(t) Only in conjunction with listed complex oral surgery procedures and subject to review
(u) Limited to 2 oral evaluation procedures, in any combination (D0120, D0140, D0145, D0150, D0170, per 12 month period
(v) Limited to 1 bitewing x-ray procedure (D0270, D0272,

D0273, D0274) up to 4 films per 12 month period
(w) Limited to dependent children under age 16
(x) Limited to patients age 25 and older
(y) 6 months must have passed since initial placement
(z) Maximum of 1 per 7 year period when existing appliance / restoration is not serviceable.
(aa) Maximum of 1 per lifetime, per quadrant or arch
(bb) Maximum of 1 per 5 year period
(cc) Limited to patients age 16 and over
(dd) X-rays and pathology report required
(ee) Limited to 1 x-ray procedure (D0210, D0277, D0330) per 5 year period
(ff) Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion
(gg) not in conjunction when a completed root canal is performed by the same provider)
(hh) limited to once per site per year
(ii) premolar teeth only
(jj) maximum of 3 per quadrant in a 3 year period to address periodontal disease only
(kk) involving a minimum of 2 lower or 3 total impactions or by report. Subject to review and up to a total 1 hour maximum
(ll) maximum of 3 teeth per quadrant and after the appropriate timeframe past D4341 with pocket depths of 5-7 mm. Benefit deducted from surgery benefit in the event surgery is needed within 1 year.
(mm) In lieu of an approvable fixed bridge for a 1 tooth replacement

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount	[Standard Plan Schedule Amount	[Preferred Plan Schedule Amount
D0120	Periodic Oral Evaluation	[(u)]	[(0,12)]	19	27	35
D0140	Limited Oral Evaluation - Problem Focused	[(u)]	[(0,12)]	29	41	53
D0145	Oral Evaluation – Patient under 3-yrs of Age	[(u)]	[(0,12)]	26	37	48
D0150	Comprehensive Oral Evaluation	[(u)]	[(0,12)]	31	44	57
D0170	Re-evaluation - Limited-Problem Focused (not post-op visit) (benefited for accidental injury monitoring only)	[(u)]	[(0,12)]	24	35	45
D0180	Comprehensive periodontal evaluation - new or established patient	[(e)]	[(0,12)]	41	58	75
D0210	Intraoral - Complete Series - FMX (including Bitewings)	[(ee)]	[(0,12)]	53	75	98

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount	[Standard Plan Schedule Amount	[Preferred Plan Schedule Amount
D0220	Intraoral - Periapical First Film		[(0,12)]	11	16	20
D0230	Intraoral - Periapical Each additional Film (6 or more is considered FMX)		[(0,12)]	9	13	17
D0240	Intraoral - Occlusal Film		[(0,12)]	15	22	28
D0250	Extraoral – First Film (by report)		[(0,12)]	22	31	40
D0260	Extraoral – Each Additional Film (by report)		[(0,12)]	19	27	35
D0270	Bitewing - Single Film	[(v)]	[(0,12)]	11	16	20
D0272	Bitewings – Two Films	[(v)]	[(0,12)]	17	24	31
D0273	Bitewings – Three Films	[(v)]	[(0,12)]	21	29	38
D0274	Bitewings - Four Films	[(v)]	[(0,12)]	25	35	46
D0277	Vertical Bitewings - Seven to Eight Films	[(ee)]	[(0,12)]	37	52	68
D0330	Panoramic Film	[(ee)]	[(0,12)]	43	61	79
D0431	Adjunctive Pre-diagnostic test aiding in the detection of muscosal abnormalities	[(d), (ff)]	[(0,12)]	21	30	39
D0472	Accession of Tissue, Gross Exam including report	[(hh)]	[(0,12)]	31	44	57
D0473	Accession of Tissue, Gross and Micro Exam including report	[(hh)]	[(0,12)]	70	99	128
D0474	Accession of Tissue, Gross and Micro Exam (including assessment of . surgical margins) including report	[(hh)]	[(0,12)]	114	161	209
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	[(d), (ff)]	[(0,12)]	66	94	121
D1110	Prophylaxis – Adult (age 14 and above)	[(n)]	[(0,12)]	36	52	67
D1120	Prophylaxis - Child	[(n)]	[(0,12)]	26	37	48
D1203	Topical Application of Fluoride (Prophylaxis not included) - Child	[(w) (d)]	[(0,12)]	14	20	26
D1206	Topical fluoride varnish, therapeutic application of moderate to high caries risk patients	(d)]	[(0,12)]	15	21	27
D1351	Sealant - per tooth	[(b) (w) (g)]	[(0,12)]	21	30	39
D1510	Space Maintainer - Fixed - Unilateral	[(w) (aa)]	[(0,12)]	132	187	242
D1515	Space Maintainer - Fixed - Bilateral	[(w) (aa)]	[(0,12)]	197	279	361
D1520	Space Maintainer - Removable - Unilateral	[(w) (aa)]	[(0,12)]	158	224	290
D1525	Space Maintainer - Removable - Bilateral	[(w) (aa)]	[(0,12)]	234	332	429
D1550	Recementation of Space Maintainer (per Space Maintainer)	[(w) (aa) (y)]	[(0,12)]	28	39	51
D1555	Removal of fixed space maintainer	[(w) (aa)]	[(0,12)]	28	39	51
D2140	Amalgam - One surface, primary or permanent	[(o) (l)]	[(0,12)]	39	56	72
D2150	Amalgam – Two surfaces, primary or permanent	[(o) (l)]	[(0,12)]	48	68	88
D2160	Amalgam - Three surfaces, primary or permanent	[(o) (l)]	[(0,12)]	58	82	106
D2161	Amalgam – Four or more surfaces, primary or permanent	[(o) (l)]	[(0,12)]	68	96	125
D2330	Resin - One surface, Anterior	[(o) (l)]	[(0,12)]	45	64	83
D2331	Resin - Two surfaces, Anterior	[(o) (l)]	[(0,12)]	55	79	102
D2332	Resin - Three surfaces, Anterior	[(o) (l)]	[(0,12)]	67	95	123
D2335	Resin - Four or more surfaces or involving incisal angle (Anterior)	[(o) (l)]	[(0,12)]	81	114	148
D2390	Resin-based composite crown, anterior	[(o) (l) (q)]	[(0,12)]	98	139	180
D2391	Resin-based composite - one surface, posterior	[(o) (l) (q)]	[(0,12)]	50	71	92
D2392	Resin-based composite - two surfaces, posterior	[(o) (l) (q)]	[(0,12)]	66	93	120
D2393	Resin-based composite - three surfaces, posterior	[(o) (l) (q) ]	[(0,12)]	80	114	147
D2394	Resin-Based composite - four or more surfaces, posterior	[(o) (l) (q)]	[(0,12)]	90	128	165
D2510	Inlay - Metallic - One surface	[(z) (cc)]	[(0,12)]	90	128	165
D2520	Inlay - Metallic - Two surfaces	[(z) (cc)]	[(0,12)]	122	172	223
D2530	Inlay - Metallic - Three or more surfaces	[(z) (cc)]	[(0,12)]	152	215	279
D2542	Onlay-Metallic-Two Surfaces	[(z) (cc)]	[(0,12)]	163	231	299
D2543	Onlay-Metallic-Three surfaces	[(z) (cc)]	[(0,12)]	171	242	314

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount	[Standard Plan Schedule Amount	[Preferred Plan Schedule Amount
D2544	Onlay-Metallic-Four or more surfaces	[(z) (cc)]	[(0,12)]	177	251	325
D2610	Inlay – Porcelain/Ceramic - One surface	[(z) (cc) (q)]	[(0,12)]	126	179	231
D2620	Inlay – Porcelain/Ceramic - Two surfaces	[(z) (cc) (q)]	[(0,12)]	148	210	272
D2630	Inlay – Porcelain/Ceramic - Three or more surfaces	[(z) (cc) (q)]	[(0,12)]	158	224	290
D2642	Onlay - Porcelain/Ceramic - Two surfaces	[(z) (cc) (q)]	[(0,12)]	168	238	309
D2643	Onlay - Porcelain/Ceramic - Three surfaces	[(z) (cc) (q)]	[(0,12)]	171	242	314
D2644	Onlay - Porcelain/Ceramic - Four or more surfaces	[(z) (cc) (q)]	[(0,12)]	177	251	325
D2650	Inlay - Resin-Based Composite - One surface	[(z) (cc) (q)]	[(0,12)]	68	96	124
D2651	Inlay - Resin-Based Composite - Two surfaces	[(z) (cc) (q)]	[(0,12)]	117	166	215
D2652	Inlay - Resin-Based Composite - Three or more surfaces	[(z) (cc) (q)]	[(0,12)]	126	179	231
D2662	Onlay - Resin-Based Composite - Two surfaces	[(z) (cc) (q)]	[(0,12)]	132	187	243
D2663	Onlay - Resin-Based Composite - Three surfaces	[(z) (cc) (q)]	[(0,12)]	153	217	281
D2664	Onlay - Resin-Based Composite - Four or more surfaces	[(z) (cc) (q)]	[(0,12)]	158	223	289
D2710	Crown - Resin (Indirect)	[(z) (cc) (q)]	[(0,12)]	65	92	119
D2720	Crown - Resin with High Noble Metal	[(z) (cc) (q)]	[(0,12)]	167	236	305
D2721	Crown - Resin with Predominantly Base Metal	[(z) (cc) (q)]	[(0,12)]	135	192	248
D2722	Crown - Resin with Noble Metal	[(z) (cc) (q)]	[(0,12)]	135	191	248
D2740	Crown - Porcelain/Ceramic Substrate	[(z) (cc) (q)]	[(0,12)]	178	252	326
D2750	Crown - Porcelain Fused to High Noble Metal	[(z) (cc) (q)]	[(0,12)]	167	237	306
D2751	Crown - Porcelain Fused to Predominantly Base Metal	[(z) (cc) (q)]	[(0,12)]	149	211	274
D2752	Crown - Porcelain Fused to Noble Metal	[(z) (cc) (q)]	[(0,12)]	158	223	289
D2780	Crown-3/4 Cast High Noble metal	[(z) (cc) (q)]	[(0,12)]	176	249	322
D2781	Crown - 3/4 Cast High predominantly Base Metal	[(z) (cc)]	[(0,12)]	54	77	99
D2782	Crown - 3/4 Cast Noble Metal	[(z) (cc) (q)]	[(0,12)]	171	242	314
D2783	Crown - 3/4 Cast Porcelain/Ceramic	[(z) (cc) (q)]	[(0,12)]	177	250	324
D2790	Crown - Full Cast High Noble Metal	[(z) (cc)]	[(0,12)]	163	231	299
D2791	Crown - Full Cast Predominantly Base Metal	[(z) (cc)]	[(0,12)]	158	223	289
D2792	Crown - Full Cast Noble Metal	[(z) (cc)]	[(0,12)]	166	235	304
D2910	Recement Inlay	[(y)]	[(0,12)]	15	22	28
D2920	Recement Crown	[(y)]	[(0,12)]	15	21	27
D2930	Prefabricated Stainless Steel Crown - Primary tooth	[(z) (w)]	[(0,12)]	39	55	71
D2931	Prefabricated Stainless Steel Crown - Permanent tooth	[(z) (w)]	[(0,12)]	44	62	80
D2932	Prefabricated Resin Crown	[(z) (w)]	[(0,12)]	46	65	83
D2950	Core Buildup, including any pins	[(z)]	[(0,12)]	39	56	72
D2951	Pin Retention - per tooth, in addition to restoration	[(z)]	[(0,12)]	7	10	13
D2952	Cast Post and Core in addition to Crown	[(z)]	[(0,12)]	59	83	108
D2954	Prefabricated Post and Core in addition to Crown	[(z)]	[(0,12)]	50	70	91
D2980	Crown repair, by report	[(z) (cc)]	[(0,12)]	33	47	91
D3220	Therapeutic Pulpotomy (excluding final restoration)	[(r) (gg)]	[(0,12)]	26	37	48
D3221	Gross Pulpal Debridement, Primary and Permanent	[(r) (gg)]	[(0,12)]	28	39	50
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary tooth (excluding final rest	[(r)]	[(0,12)]	36	51	66
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary tooth (excluding final rest	[(r) ]	[(0,12)]	37	52	68
D3310	Anterior (excluding final restoration)	[(r)]	[(0,12)]	114	162	209
D3320	Bicuspid (excluding final restoration)	[(r)]	[(0,12)]	134	190	247
D3330	Molar (excluding final restoration)	[(r)]	[(0,12)]	171	242	313
D3332	Incomplete Endodontic Therapy (inoperable or fractured tooth)	[(r)]	[(0,12)]	59	83	107
D3333	Internal Root Repair of Perforation Defects	[(r)]	[(0,12)]	45	64	83
D3346	Retreatment of previous Root Canal Therapy – Anterior (at least 6 months after previous root Canal Therapy)	[(r)]	[(0,12)]	131	186	241

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount	[Standard Plan Schedule Amount	[Preferred Plan Schedule Amount
D3347	Retreatment of previous Root Canal Therapy – Bicuspid (at least 6 months after previous root Canal Therapy)	[(r)]	[(0,12)]	151	214	278
D3348	Retreatment of previous Root Canal Therapy – Molar (at least 6 months after previous root Canal Therapy)	[(r)]	[(0,12)]	188	266	344
D3351	Apexification/Recalcification - Initial Visit (apical closure/calcific repair of perforations, root resorption, etc.)	[r]	[(0,12)]	50	70	91
D3352	Apexification/Recalcification - interim medication replacement	[r]	[(0,12)]	29	41	53
D3353	Apexification/Recalcification - Final Visit (includes completed root canal therapy)	[r]	[(0,12)]	81	115	149
D3410	Apicoectomy/Periradicular Surgery - Anterior	[r]	[(0,12)]	133	189	245
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	[r]	[(0,12)]	144	204	264
D3425	Apicoectomy/Periradicular Surgery - Molar (first root)	[r]	[(0,12)]	158	223	289
D3426	Apicoectomy/Periradicular Surgery (each additional root)	[r]	[(0,12)]	50	70	91
D3430	Retrograde Filling - per root	[r]	[(0,12)]	36	51	66
D3450	Root Amputation - per root	[r]	[(0,12)]	81	115	149
D3920	Hemisection (including any root removal), not including Root Canal Therapy	[(s)]	[(0,12)]	59	83	108
D4210	Gingivectomy or Gingivoplasty - per quadrant	[(k)]	[(0,12)]	89	125	162
D4211	Gingivectomy or Gingivoplasty, per tooth	[(k)]	[(0,12)]	35	49	64
D4240	Gingival Flap Procedure, including Root Planing - per quadrant	[(k)]	[(0,12)]	113	159	206
D4241	Gingival Flap Procedure, including Root Planing - one to three teeth per quadrant	[(k)]	[(0,12)]	83	117	151
D4249	Clinical Crown Lengthening - Hard Tissue	[(r)]	[(0,12)]	135	191	248
D4260	Osseous Surgery (including Flap Entry and Closure) - per quadrant	[(k)]	[(0,12)]	170	241	312
D4261	Osseous Surgery (including Flap Entry and Closure) - one to three teeth, per quadrant	[(k)]	[(0,12)]	149	211	273
D4263	Bone Replacement Graft - first site in quadrant	[(r)]	[(0,12)]	72	102	132
D4264	Bone Replacement Graft - each additional site in quadrant	[(r)]	[(0,12)]	45	64	83
D4265	Biologic materials to aid in soft and osseous tissue regeneration	[(r)]	[(0,12)]	66	93	120
D4270	Pedicle Soft Tissue Graft Procedure	[(k)]	[(0,12)]	137	194	251
D4271	Free Soft Tissue Graft Procedure (including Donor Site Surgery)	[(k)]	[(0,12)]	149	210	272
D4273	Subepithelial Connective Tissue Graft Procedure (including Donor Site Surgery)	[(k)]	[(0,12)]	171	242	314
D4274	Distal or Proximal Wedge Procedure (when not performed in conjunction with Surgical procedures in the same area)	[(k)]	[(0,12)]	81	115	149
D4275	Soft tissue allograft	[(k)]	[(0,12)]	140	198	256
D4276	Combined connective tissue and double pedicle graft	[(k)]	[(0,12)]	176	249	322
D4341	Periodontal Scaling and Root Planing, per quadrant	[(k)]	[(0,12)]	38	54	70
D4342	Periodontal Scaling and Root Planing - one to three teeth, per quadrant	[(k)]	[(0,12)]	25	36	46
D4381	Localized delivery of chemo agents	[(k) (ll)]	[(0,12)]	9	12	16
D4910	Periodontal Maintenance Procedures (following active therapy and in lieu of a D1110)	[(n)]	[(0,12)]	22	31	40
D5110	Complete Denture - Maxillary	[(z)]	[(0,12)]	189	268	347
D5120	Complete Denture - Mandibular	[(z)]	[(0,12)]	189	268	347
D5130	Immediate Denture - Maxillary	[(z)]	[(0,12)]	210	297	384
D5140	Immediate Denture - Mandibular	[(z)]	[(0,12)]	210	297	384
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	[(z)]	[(0,12)]	150	213	276
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps,rests and teeth)	[(z)]	[(0,12)]	166	235	304
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin	[(z)]	[(0,12)]	214	303	393

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount	[Standard Plan Schedule Amount	[Preferred Plan Schedule Amount
	Denture Bases (inclu					
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (incl	[(z)]	[(0,12)]	214	303	393
D5281	Removable Unilateral Partial Denture - One piece cast Metal (including clasps and teeth)	[(z)]	[(0,12)]	122	172	223
D5410	Adjust Complete Denture - Maxillary	[(d) (y)]	[(0,12)]	12	17	21
D5411	Adjust Complete Denture - Mandibular	[(d) (y)]	[(0,12)]	12	17	21
D5421	Adjust Partial Denture - Maxillary	[(d) (y)]	[(0,12)]	12	17	22
D5422	Adjust Partial Denture - Mandibular	[(d) (y)]	[(0,12)]	12	17	21
D5510	Repair broken Complete Denture Base	[(d) (y)]	[(0,12)]	27	38	49
D5520	Replace missing or broken teeth - Complete Denture (each tooth)	[(d) (y)]	[(0,12)]	23	32	41
D5610	Repair Resin Denture Base	[(d) (y)]	[(0,12)]	26	37	48
D5620	Repair Cast Framework	[(d) (y)]	[(0,12)]	32	45	58
D5630	Repair or Replace Broken Clasp	[(d) (y)]	[(0,12)]	32	45	58
D5640	Replace broken teeth - per tooth	[(d) (y)]	[(0,12)]	23	33	43
D5650	Add tooth to existing Partial Denture	[(d) (y)]	[(0,12)]	28	40	51
D5660	Add Clasp to existing Partial Denture	[(d) (y)]	[(0,12)]	32	46	59
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	[(z)]	[(0,12)]	86	121	157
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	[(z)]	[(0,12)]	90	128	165
D5710	Rebase Complete Maxillary Denture	[(f) (y)]	[(0,12)]	72	102	132
D5711	Rebase Complete Mandibular Denture	[(f) (y)]	[(0,12)]	72	102	132
D5720	Rebase Maxillary Partial Denture	[(f) (y)]	[(0,12)]	72	102	132
D5721	Rebase Mandibular Partial Denture	[(f) (y)]	[(0,12)]	72	102	132
D5730	Reline Complete Maxillary Denture (chair side)	[(f) (y)]	[(0,12)]	48	68	87
D5731	Reline Complete Mandibular Denture (chair side)	[(f) (y)]	[(0,12)]	46	65	84
D5740	Reline Maxillary Partial Denture (chair side)	[(f) (y)]	[(0,12)]	45	64	83
D5741	Reline mandibular Partial Denture (chair side)	[(f) (y)]	[(0,12)]	45	64	83
D5750	Reline Complete Maxillary Denture (laboratory)	[(f) (y)]	[(0,12)]	63	89	116
D5751	Reline Complete Mandibular Denture (laboratory)	[(f) (y)]	[(0,12)]	63	89	116
D5760	Reline Maxillary Partial Denture (laboratory)	[(f) (y)]	[(0,12)]	63	89	116
D5761	Reline Mandibular Partial Denture (laboratory)	[(f) (y)]	[(0,12)]	63	89	116
D5810	Interim complete denture (maxillary)	[(s)]	[(0,12)]	99	140	182
D5811	Interim complete denture (mandibular)	[(s)]	[(0,12)]	101	144	186
D5820	Interim partial denture (maxillary)	[(s)]	[(0,12)]	82	116	150
D5821	Interim partial denture (mandibular)	[(s)]	[(0,12)]	87	124	160
D5850	Tissue Conditioning, Maxillary	[(f) (y)]	[(0,12)]	23	32	41
D5851	Tissue Conditioning, Mandibular	[(f) (y)]	[(0,12)]	23	32	41
D6058	Abutment supported porcelain/ceramic crown	[(z) (cc) (mm) (q)]	[(0,12)]	223	315	408
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	219	311	402
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	[(z) (cc) (mm) (q)]	[(0,12)]	198	281	363
D6061	Abutment supported porcelain fused to metal crown (noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	207	293	380
D6062	Abutment supported cast metal crown (high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	216	306	396
D6063	Abutment supported cast metal crown (predominantly base metall)	[(z) (cc) (mm)]	[(0,12)]	189	267	346
D6064	Abutment supported cast metal crown (noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	243	344	446
D6065	Implant supported porcelain/ceramic crown	[(z) (cc)]	[(0,12)]	234	332	429

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount	[Standard Plan Schedule Amount	[Preferred Plan Schedule Amount
		(mm) (q)]				
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	234	332	429
D6067	Implant supported metal crown (titanium, titanium all, high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	233	330	427
D6068	Abutment supported retainer of porcelain/ceramic FPD	[(z) (cc) (mm) (q)]	[(0,12)]	202	286	370
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	216	306	396
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)	[(z) (cc) (mm) (q)]	[(0,12)]	214	303	393
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	216	306	396
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	186	264	342
D6073	Abutment supported retainer for cast metal FPD (predominately base metal)	[(z) (cc) (mm)]	[(0,12)]	198	281	363
D6074	Abutment supported retainer for cast metal FPD (noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	202	286	370
D6075	Implant supported retainer for ceramic FPD	[(z) (cc) (mm) (q)]	[(0,12)]	216	306	396
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	225	319	413
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)	[(z) (cc) (mm) (q)]	[(0,12)]	176	249	322
D6092	Recement of implant/abutment supported crown	[(d)]	[(0,12)]	16	23	30
D6093	Recement of implant/abutment supported fixed partial denture	[(d)]	[(0,12)]	23	32	41
D6210	Pontic - Cast High Noble Metal	[(z) (cc) (q)]	[(0,12)]	158	223	289
D6211	Pontic - Cast Predominantly Base Metal	[(z) (cc)]	[(0,12)]	146	207	267
D6212	Pontic - Cast Noble Metal	[(z) (cc) (q)]	[(0,12)]	161	228	295
D6240	Pontic - Porcelain fused to High Noble Metal	[(z) (cc) (q)]	[(0,12)]	163	232	300
D6241	Pontic - Porcelain fused to Predominantly Base Metal	[(z) (cc) (q)]	[(0,12)]	146	207	268
D6242	Pontic - Porcelain fused to Noble Metal	[(z) (cc) (q)]	[(0,12)]	156	222	287
D6245	Pontic - Porcelain/Ceramic	[(z) (cc) (q)]	[(0,12)]	176	250	323
D6250	Pontic - Resin with High Noble Metal	[(z) (cc) (q)]	[(0,12)]	162	230	297
D6251	Pontic - Resin with Predominantly Base Metal	[(z) (cc) (q)]	[(0,12)]	144	204	264
D6252	Pontic - Resin with Noble Metal	[(z) (cc) (q)]	[(0,12)]	153	217	281
D6545	Retainer - Cast Metal for Resin Fixed Prosthesis	[(z) (cc) (q)]	[(0,12)]	72	102	132
D6548	Retainer - Porcelain/Ceramic (resin bonded fixed prosthesis)	[(z) (cc) (q)]	[(0,12)]	86	121	157
D6600	Inlay – porcelain/ceramic, two surfaces	[(z) (cc) (q)]	[(0,12)]	135	191	248
D6601	Inlay – Porcelain/ceramic, three or more surfaces	[(z) (cc) (q)]	[(0,12)]	171	242	314
D6602	Inlay - cast high noble metal, two surfaces	[(z) (cc) (q)]	[(0,12)]	126	179	231
D6603	Inlay - cast high noble metal, three or more surfaces	[(z) (cc) (q)]	[(0,12)]	144	204	264
D6604	Inlay - cast predominantly base metal, two surfaces	[(z) (cc)]	[(0,12)]	117	166	215
D6605	Inlay - cast predominantly base metal, three or more surfaces	[(z) (cc)]	[(0,12)]	162	230	297
D6606	Inlay - cast noble metal, two surfaces	[(z) (cc) (q)]	[(0,12)]	125	177	229
D6607	Inlay - cast noble metal, three or more surfaces	[(z) (cc) (q)]	[(0,12)]	161	228	295
D6608	Onlay - porcelain/ceramic, two surfaces	[(z) (cc) (q)]	[(0,12)]	161	229	296
D6609	Onlay - porcelain/ceramic, three or more surfaces	[(z) (cc) (q)]	[(0,12)]	171	242	314
D6610	Onlay - cast high noble metal, two surfaces	[(z) (cc) (q)]	[(0,12)]	144	204	264
D6611	Onlay - cast high noble metal, three or more surfaces	[(z) (cc) (q)]	[(0,12)]	171	242	214
D6612	Onlay - cast predominantly base metal, two surfaces	[(z) (cc)]	[(0,12)]	135	191	247

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount]	[Standard Plan Schedule Amount]	[Preferred Plan Schedule Amount]
D6613	Onlay - cast predominantly base metal, three or more surfaces	[(z) (cc)]	[(0,12)]	170	241	312
D6614	Onlay - cast noble metal, two surfaces	[(z) (cc) (q)]	[(0,12)]	138	196	254
D6615	Onlay - cast noble metal, three or more surfaces	[(z) (cc) (q)]	[(0,12)]	173	245	317
D6720	Crown - Resin with High Noble Metal	[(z) (cc) (q)]	[(0,12)]	162	230	297
D6721	Crown - Resin with Predominantly Base Metal	[(z) (cc)]	[(0,12)]	148	209	271
D6722	Crown - Resin with Noble Metal	[(z) (cc) (q)]	[(0,12)]	149	212	274
D6740	Crown - Porcelain/Ceramic	[(z) (cc) (q)]	[(0,12)]	178	252	326
D6750	Crown - Porcelain fused to High Noble Metal	[(z) (cc) (q)]	[(0,12)]	166	235	304
D6751	Crown - Porcelain fused to Predominantly Base Metal	[(z) (cc)]	[(0,12)]	149	210	272
D6752	Crown - Porcelain fused to Noble Metal	[(z) (cc) (q)]	[(0,12)]	158	223	289
D6780	Crown - 3/4 Cast High Noble Metal	[(z) (cc) (q)]	[(0,12)]	162	230	297
D6781	Crown - 3/4 Cast Predominately Based Metal	[(z) (cc)]	[(0,12)]	153	217	281
D6782	Crown - 3/4 Cast Noble Metal	[(z) (cc) (q)]	[(0,12)]	164	232	300
D6783	Crown - 3/4 Porcelain/Ceramic	[(z) (cc) (q)]	[(0,12)]	180	255	330
D6790	Crown - Full Cast High Noble Metal	[(z) (cc) (q)]	[(0,12)]	161	228	295
D6791	Crown - Full Cast Predominantly Base Metal	[(z) (cc)]	[(0,12)]	149	210	272
D6792	Crown - Full Cast Noble Metal	[(z) (cc) (q)]	[(0,12)]	162	230	297
D6930	Recement Fixed Partial Denture	[(d) (y)]	[(0,12)]	22	31	40
D6940	Stress breaker	[(z) (cc)]	[(0,12)]	45	64	83
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	[(z) (cc)]	[(0,12)]	57	81	105
D6972	Prefabricated post and core + retainer	[(z) (cc)]	[(0,12)]	48	68	87
D6980	Fixed partial denture repair, by report	[(j) (y)]	[(0,12)]	36	51	66
D7111	Coronal remnants - deciduous tooth	[r]	[(0,12)]	34	48	63
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	[r]	[(0,12)]	44	62	81
D7210	Surgical Removal of Erupted tooth requiring elevation of Mucoperiosteal Flap	[r]	[(0,12)]	41	57	74
D7220	Removal of Impacted tooth - Soft Tissue	[r]	[(0,12)]	49	70	90
D7230	Removal of Impacted tooth - Partially Bony	[r]	[(0,12)]	63	89	116
D7240	Removal of Impacted tooth - Completely Bony	[r]	[(0,12)]	72	102	132
D7241	Removal of Impacted tooth - Completely Bony, with unusual surgical complications	[r]	[(0,12)]	86	121	157
D7250	Surgical Removal of Residual tooth roots (cutting procedure)	[r]	[(0,12)]	45	63	82
D7260	Oroantral Fistula Closure	[r]	[(0,12)]	161	228	295
D7261	Primary closure of a sinus perforation	[r]	[(0,12)]	108	153	198
D7270	Tooth Reimplantation and/or stabilization of Accidentally Evulsed or Displaced	[(s)]	[(0,12)]	70	99	129
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	[r]	[(0,12)]	99	140	182
D7280	Surgical access of an unerupted tooth	[r]	[(0,12)]	81	115	149
D7281	Surgical Exposure of Impacted or Unerupted tooth to Aid Eruption	[(s)]	[(0,12)]	81	115	149
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	[r]	[(0,12)]	41	57	74
D7285	Biopsy of Oral Tissue - Hard (bone, tooth)	[(dd)]	[(0,12)]	79	112	145
D7286	Biopsy of Oral Tissue - Soft (all others)	[(dd)]	[(0,12)]	54	77	100
D7287	Cytology sample collection		[(0,12)]	23	32	41
D7310	Alveoloplasty in conjunction with Extractions - per quadrant	[(aa)]	[(0,12)]	39	55	71
D7320	Alveoloplasty not in conjunction with Extractions - per quadrant	[(aa)]	[(0,12)]	54	77	100
D7340	Vestibuloplasty - Ridge Extension (secondary Epithelialization)	[(s)]	[(0,12)]	153	217	281
D7410	Radical Excision - Lesion Diameter up to 1.25 Cm	[(dd)]	[(0,12)]	68	96	124
D7411	Excision of benign lesion greater than 1.25 cm	[(dd)]	[(0,12)]	108	153	198

Procedure	Description	Limitations	Waiting Periods	[Value Plan Schedule Amount	[Standard Plan Schedule Amount	[Preferred Plan Schedule Amount
D7412	Excision of benign lesion, complicated	[(dd)]	[(0,12)]	171	242	314
D7413	Excision of malignant lesion up to 1.25 cm	[(dd)]	[(0,12)]	94	133	172
D7414	Excision of malignant lesion greater than 1.25 cm	[(dd)]	[(0,12)]	163	231	299
D7440	Excision of Malignant Tumor-Lesion Diameter up to 1.25 Cm	[(dd)]	[(0,12)]	179	254	328
D7441	Excision of Malignant Tumor - Lesion Diameter greater than 1.25 Cm	[(dd)]	[(0,12)]	180	255	330
D7450	Removal of Odontogenic Cyst or Tumor - Lesion Diameter up to 1.25 Cm	[(dd)]	[(0,12)]	81	115	149
D7451	Removal of Odontogenic Cyst or Tumor - Lesion Diameter greater than 1.25 Cm	[(dd)]	[(0,12)]	135	191	248
D7460	Removal of Nonodontogenic Cyst or Tumor - Lesion Diameter up to 1.25 Cm	[(dd)]	[(0,12)]	80	113	146
D7461	Removal of Nonodontogenic Cyst or Tumor - Lesion Diameter greater than 1.25 Cm	[(dd)]	[(0,12)]	119	169	218
D7465	Destruction of lesion(s) by physical or chemical method, by report		[(0,12)]	45	64	83
D7471	Removal of Exostosis - per site (up to maximum of 3 sites )	[(s)]	[(0,12)]	90	128	165
D7472	Removal of torus palatinus (up to 1 site)	[(s)]	[(0,12)]	117	165	214
D7473	Removal of torus mandibularis (up to 2 sites)	[(s)]	[(0,12)]	100	142	183
D7485	Surgical reduction of osseous tuberosity	[(s)]	[(0,12)]	82	117	151
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue		[(0,12)]	33	47	61
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	[(dd)]	[(0,12)]	113	159	206
D7530	Removal of Foreign Body, Skin, or Subcutaneous Alveolar Tissue	[(s)]	[(0,12)]	45	64	83
D7540	Removal of reaction-producing foreign bodies – musculoskeletal system	[(s)]	[(0,12)]	68	96	124
D7550	Partial Ostectomy/Sequestrectomy	[(s)]	[(0,12)]	48	68	87
D7560	Maxillary Sinusotomy	[(s)]	[(0,12)]	216	306	396
D7910	Suture of Recent Small Wounds to 5 Cm (not associated with periodontal or oral surgery procedure)		[(0,12)]	27	38	50
D7960	Frenulectomy (Frenectomy or Frenotomy) - separate procedure	[(aa)]	[(0,12)]	65	92	119
D7970	Excision of Hyperplastic Tissue - per arch		[(0,12)]	59	83	107
D7972	Surgical reduction of fibrous	[(s)]	[(0,12)]	54	77	99
D7980	Sialolithotomy		[(0,12)]	86	122	158
D7983	Closure of salivary fistula		[(0,12)]	217	308	399
D8210	Removable appliance therapy (for harmful habit control only)	[(s)]	[(0,12)]	84	119	154
D8220	Fixed appliance therapy (for harmful habit control only)	[(s)]	[(0,12)]	84	119	154
D9110	Palliative (emergency) treatment of dental pain - minor procedure	[(d)]	[(0,12)]	16	23	29
D9120	Fixed partial denture sectioning	[(s)]	[(0,12)]	18	26	33
D9220	General Anesthesia - first 30 minutes	[(t) (kk)]	[(0,12)]	61	86	111
D9221	General Anesthesia - each additional 15 minutes	[(t) (kk)]	[(0,12)]	23	33	42
D9241	IV Sedation/Analgesia - first 30 mins	[(t) (kk)]	[(0,12)]	57	80	104
D9242	IV Sedation/Analgesia - each additional 15 minutes	[(t) (kk)]	[(0,12)]	19	27	35
D9440	Office Visit - after regularly scheduled hours	[(d) (dd)]	[(0,12)]	21	30	39
D9911	-Application of desensitizing resin for cervical and/or root surface, per tooth	[(x) (d) ]	[(0,12)]	8	11	15
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	[(dd) (d) (p)]	[(0,12)]	13]	18]	23]

Current Dental Terminology © American Dental Association

**PART [XIV]. SCHEDULE OF BENEFITS**

**Policyholder:** [Group Name]

**Policyholder'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]

**Eligibility Period:** [First of the month following 60 Days from the first day of Active Work]

**Mode of Premium Payment:** [MONTHLY]

**Method of Premium Payment:** [Remitted by Policyholder]

**Premium Due Date:** 1<sup>st</sup> of every month

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

**Deductible:** In-Network [\$50 Individual Deductible.  
Maximum per Family Deductible: 3, unlimited]  
[Applies to Classes: B, C]  
Out-of-Network [\$50 Individual Deductible.  
Maximum per Family Deductible: 3, unlimited]  
[Applies to Classes: B, C]

**Co-Pay:** [See Schedule of Covered Procedures]

**Certificate Year Maximum Annual Benefit:** [Per Insured]  
In-Network  

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 &amp; Forward</u>
[\$1,000]	[\$1,000]	[\$1,000]

Out-of- Network  

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 &amp; Forward</u>
[\$1,000]	[\$1,000]	[\$1,000]

**Waiting Periods** [See Schedule of Covered Procedures]

**TABLE OF INSURANCE PERCENTAGES:**

**Certificate Year 1:**

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

**Certificate Year 2:**

	Insurance Percentage In-Network	Insurance Percentage Out-of Network	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	[100%]	[100%]	[Yes]	[None/None]
Class B	[80%]	[80%]	[Yes]	[None/None]
Class C	[50%]	[50%]	[Yes]	[None/None]
Class D	[50%]	[50%]	[Yes]	[\$500/\$1,000]
Class E	[0%]	[0%]	[Yes]	[\$500/\$1,000]
Class F	[0%]	[0%]	[Yes]	[\$500/\$1,000]

**Certificate Year 3 and later:**

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

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

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

SERFF Tracking Number: STAR-127077537 State: Arkansas  
 Filing Company: Starmount Life Insurance Company State Tracking Number: 49108  
 Company Tracking Number:  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Group dental policy  
 Project Name/Number: /DN-2010-AR

## Supporting Document Schedules

	Item Status:	Status Date:
<p><b>Satisfied - Item:</b> Flesch Certification</p> <p><b>Comments:</b></p> <p><b>Attachments:</b>            Flesch Readability.pdf            DNGRP-CIN AR.pdf            Certification of Rule 19 .pdf            04GA-AR.pdf</p>	Approved-Closed	06/30/2011
<p><b>Satisfied - Item:</b> Application</p> <p><b>Comments:</b>            GRP Application:GRPAPP 03/11 and Group Enrollment Form: Enroll 03/11 approved on 6/1/11 under SERFF # STAR-127160664</p>	Approved-Closed	06/30/2011
<p><b>Satisfied - Item:</b> Statement of Variability</p> <p><b>Comments:</b></p> <p><b>Attachment:</b>            Statement of Variability-Starmount 2010.pdf</p>	Approved-Closed	06/30/2011

**STARMOUNT LIFE INSURANCE COMPANY**

**FLESCH READABILITY ANALYSIS**

<b>FORM</b>	<b>WORDS</b>	<b>PARAGRAPHS</b>	<b>SENTENCES</b>	<b>SCORE</b>
DN-2010-AR	2417	121	83	44.3
DN-2010GRPCT-AR	7236	321	293	41.7
DN-2010GRPCT-SCP	2687	1070	51	46.5
DN-2010GRPCT-SCP-SF	4665	2157	29	44.3
DNGRPEND-AR 2010	261	20	8	45.0
DN-2010GRPCT-SOB	375	65	6	56.0

This is to certify that this form meets the minimum score on the Flesch reading ease test in the NAIC Life and Health Insurance Policy Language Simplification Model Act. The Flesch score has been measured by the method described in the act and reflects all text excluding only language or terminology in the following categories entitled to be excepted under the act: the name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specifications pages, schedules or table; language required by law or regulation; medical terminology; and words which are defined in the policy.

Digitally signed by Jeffrey G. Wild  
DN: cn=Jeffrey G. Wild, o=Starmount Life, ou=Financial,  
email=JeffW@Starmountlife.com, c=US  
Date: 2011.03.04 15:09:11 -06'00'

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Jeffrey G. Wild  
Chief Financial Officer  
Starmount Life Insurance Company

DATE: 03/4/2011



**STARMOUNT LIFE INSURANCE COMPANY**

8485 Goodwood Blvd., Baton Rouge, LA 70806-7878

**CONSUMER INFORMATION NOTICE**

Policyholder Service Office of Company

Address:

Telephone Number:

Agent (to be completed at time of application)

Name of Agent \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

If we at Starmount Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201  
(501) 371-2640 or (800) 852-5494

# ***Starmount Life Insurance Company***

P.O. Box 98100  
Baton Rouge, LA 70898

## Certification

This is to certify that I have reviewed Regulation 19 and this submission meets the provisions of this rule as well as all applicable requirements of the Arkansas Department of Insurance.

**Jeffrey G. Wild**

Digitally signed by Jeffrey G. Wild  
DN: cn=Jeffrey G. Wild, c=US, o=Starmount  
Life, ou=Financial,  
email=JeffW@Starmountlife.com  
Date: 2011.02.23 15:52:38 -06'00'

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Jeffrey G. Wild  
Chief Financial Officer  
Starmount Life Insurance Company

DATE: February 23, 2011

**LIMITATIONS AND EXCLUSIONS UNDER THE  
ARKANSAS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION ACT**

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

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

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

(Continued on reverse side)

## **COVERAGES**

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

## **EXCLUSIONS FROM COVERAGE**

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

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

## **GROUP DENTAL PRODUCT - DEFINITION OF VARIABLE TEXT**

### **GROUP POLICY FORM – DN-2010:**

Page 1:

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

#### **PART I: PROVISIONS SPECIFIC TO EMPLOYER GROUPS**

1. The Maximum Continuation Periods may be shown as either [six (6) Months] [twelve (12) Months] OR [N/A].
2. This entire provision may be deleted if the Group Policy is issued to a non-employer group.

#### **PART II: WHEN INSURANCE UNDER THIS POLICY ENDS**

1. Based on a specific Policyholder's rule, we may revise the percentage of participation requirements under both item a and b, to be either [75%] or [100%].
2. Statement 2, regarding termination of all Dependent insurance may be deleted in its entirety. In this instance, the number [1] in front of the preceding paragraph will be deleted.
3. Provides for renewability on either a [month-to-month] basis or [twelve (12) month] basis, as agreed to between the company and the policyholder.

### **CERTIFICATE FORM – DN-2010CT:**

Page 1:

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

#### **TABLE OF CONTENTS:**

1. Part IX: Coordination of Benefits may be deleted entirely if the provision is not included in the Certificate.
2. Part XII: Takeover Benefits may be deleted entirely if the provision is not included in the Certificate.
3. Sequence of Roman Numerals will change if either of the above provisions is deleted.

#### **PART I. DEFINITIONS:**

1. Eligible Dependent:
  - a. The words [or lawful Domestic Partner] may be deleted entirely if the Policyholder does not extend coverage to domestic partners.
  - b. Under 2. the age shown for unmarried dependent children may range from 18 thru 30.
  - c. Under 3. the first age shown will match the age shown in 2. The second age shown may range from 21 thru 30.
  - d. Paragraph 3 may be deleted in its entirety, to allow us to remove conditions for full-time student status. In this instance, we would cover all dependents within the age limits shown in 2, regardless of student status.
  - e. Paragraph 4 will be re-numbered as 3, if paragraph 3 is deleted in its entirety.
2. Definition of Late Entrant may be deleted entirely if the policyholder does not impose late entrant penalties.
3. Definition of Re-enrollee may be deleted entirely if the policyholder does not impose late entrant penalties.

## PART II. ELIGIBILITY AND ENROLLMENT:

1. “Eligibility” Provision: In the “Dual Eligibility Status” section, the words [or Domestic Partner(‘s)] may be deleted entirely if the Policyholder does not extend coverage to domestic partners.
2. “Enrollment” provision:
  - a. Initial Enrollment: The number of days for initial enrollment may be either [thirty (30)] [thirty-one (31)] or [sixty (60)] days.
  - b. The entire “Initial Enrollment” paragraph may be deleted if there is no specific initial enrollment period.
  - c. The last sentence in the “Initial Enrollment” paragraph may be deleted if the policyholder does not impose penalties for Late Entrants.
  - d. The entire “Open Enrollment” paragraph may be deleted if there is no specific Open Enrollment period.
  - e. The entire “Late Entrants” paragraph may be deleted if the policyholder does not impose special restrictions for Late Entrants.
  - f. In the “Change in Family Status” section, the number of days for initial enrollment will be either [thirty (30)] [thirty-one (31)] or [sixty (60)] days. .
  - g. In the “Change in Family Status” section, item #1, “or Domestic Partnership” may be deleted if the Policyholder does not extend coverage to domestic partners.

## PART III. INDIVIDUAL EFFECTIVE DATES:

1. [Domestic Partnership] may be deleted from the 2<sup>nd</sup> paragraph entirely if the Policyholder does not extend coverage to domestic partners.
2. Under the “Newborn Coverage” provision both [spouse] and [or Domestic Partner] may be deleted entirely if the Policyholder wants to extend coverage to newborns of any insured (i.e., a dependent child).
3. Under the “Newborn Coverage” provision [or Domestic Partner] may be deleted entirely if the Policyholder does not extend coverage to domestic partners.

## PART IV. INDIVIDUAL TERMINATION DATES:

1. The last sentence, [This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.] may be deleted entirely if Policyholder does not restrict when a change may be made.

## PART V. INDIVIDUAL PREMIUMS:

1. In the Right to Change Premiums provision, the [twelve (12)] month period may be changed to [twenty-four (24)].

## PART VI. DESCRIPTION OF COVERAGE:

1. Under E. PRE-ESTIMATE, the dollar amount in brackets may range from \$100 - \$1,000, in \$100 increments

## PART VII. LIMITATIONS AND EXCLUSIONS:

1. Under A. LIMITATIONS:
  - a. the entire paragraph titled [Limitation for Late entrants and Re-enrollees] paragraph may be deleted if policyholder does not impose special restrictions for Late Entrants.
  - b. Within the Limitation For Late Entrants and Re-enrollees paragraph, each sentence in brackets may be deleted entirely.
  - c. In the second sentence of this provision, the number of months listed may appear as six (6), twelve (12), eighteen (18) or twenty-four (24), as shown within the brackets.
  - d. The entire paragraph titled [Missing Teeth Limitation] may be deleted entirely.
  - e. Under item b(iii), the number of years may be either one (1), three (3), or five (5), as shown within the brackets.
  - f. The entire paragraph titled [Other limitations] may be deleted entirely.
  - g. Each sentence within the [Other limitation] paragraph may be deleted.
  - h. The remaining provisions under Section A, Limitations, will be re-numbered if the above paragraph is deleted.

## PART VIII. CLAIM PROVISIONS:

1. Under the “Notice of Claim” the address may be changed to the specific Administrator’s information.

PART IX. COORDINATION OF BENEFITS (COB):

1. All of Part IX: Coordination of Benefits, may be deleted in its entirety if the plan does not coordinate with other plans.
2. The Roman Numerals of all remaining titles are bracketed so they may be re-numbered if the above provision is deleted.

PART X. GRIEVANCE PROCEDURE:

1. The address may be changed to the specific Administrator's information.

PART XII. TAKEOVER BENEFITS:

1. All of Part XII: Takeover Benefits, may be deleted in its entirety, if the policy being issued is not a "takeover benefit."

PART XIII. SCHEDULE OF COVERED PROCEDURES:

Two separate Schedules are attached to the filing, as follows:

DNGRPCT SCP 2010 is used for plans where reimbursement is based on actual charges incurred or when there is a benefit difference for in-network vs. out-of-network providers.

DNGRPCT SCP-SF 2010 is used for plans where benefits are based on a Scheduled Fee.

1. All items are bracketed so that Covered Procedures may be deleted or new procedures added. Procedure Classes, Waiting Periods, and Limitations may be revised.
2. Waiting Periods may range from zero (0) thru twenty-four (24) months.
3. DNGRPCT SCP-SF 2010 : The Schedule Amount for each procedure may change. The amount will be within a range from 0 through \$1,000.
4. DNGRPCT SCP 2010: the entire [Orthodontia Services] provision may be deleted if the plan does not provide orthodontia benefits.

PART XIV. SCHEDULE OF BENEFITS

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