National Guardian Life Insurance Company

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

ENDORSEMENT – OUT-OF-NETWORK OPTION

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

In the event the Insured does not have access to an In-Network Provider within the required geographic service area due to any network inadequacy, such Insured is always allowed the option of utilizing the services of an Out-of-Network Provider at the In-Network benefit until such time that an In-Network Provider becomes available.

Description of a network inadequacy: an In-Network Provider is not available to accommodate a member's appointment request within the number of miles or days as specified in the plan's availability and accessibility standards.

You may contact your plan administrator at the following address and telephone number to obtain information regarding the specific standards and to obtain information about any member requirements when the services of an Out-of-Network Provider are used:

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

Toll Free Number: 1-888-729-5433

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.

Kimberly A. Shaul, Secretary

Mark L. Solverud, President

National Guardian Life Insurance Company
It's about people.

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by: National Guardian Life Insurance Company
(called "We," "Our," and "Us")
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

AlwaysCare

Administrator: AlwaysCare Benefits, Inc.
P. O. Box 80139
Baton Rouge, LA 70898-0139

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.

Kimberly A. Shaul, Secretary

Mark Solverud, President

THIS IS A LEGAL CONTRACT- READ YOUR CERTIFICATE CAREFULLY

IMPORTANT CANCELLATION INFORMATION –
PLEASE READ THE PROVISION ENTITLED "INDIVIDUAL TERMINATION DATES"

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

NON-PARTICIPATING

TABLE OF CONTENTS

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.)

Dentist - A doctor of dentistry duly licensed and registered to practice the profession of dentistry and whose license is in good standing with the appropriate licensing or governing body of the State of North Carolina, any other state of the United States, a territory of the United States, a foreign country or other similar jurisdiction.

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

Eligible Dependent - Means a person listed below:

1. Your spouse;
2. Your unmarried dependent child under age 26, 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 who has reached age 26 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 within 31 days of the child's attainment of the limiting age for an already enrolled child, or when You enroll a new disabled child under the plan; and annually thereafter.

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 are in an Eligible Class of the Policyholder, each may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible, dependent coverage may become effective under the other spouse's coverage.

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;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART III. INDIVIDUAL EFFECTIVE DATES

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

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

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

Newborn and Foster Child Coverage: A Dependent child born to an Insured is covered from the moment of birth. A foster child is covered from the date of placement in the foster home. You are encouraged to enroll Your newborn or foster child to facilitate claims payments. If additional premium is charged for adding a foster or newborn child, You must enroll the child within the 31-day enrollment period to continue coverage past the 31-day period.

Adopted Children Coverage: Any child adopted by an Insured is covered from the date of placement, irrespective of whether the adoption becomes final. You are encouraged to enroll adopted child to facilitate claims payments. If additional premium is charged for adding an adopted child, You must enroll the child within the 31-day enrollment period to continue coverage past the 31-day period.

A child for whom You are required to provide coverage by a court or administrative order is not subject to the 31-day period referenced above.

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.

Reinstatement: Coverage stops if Your renewal premium is not paid by the end of the Grace Period. If We later accept a premium without an application for reinstatement, that payment reinstates Your coverage. If We require an application for reinstatement, Your coverage reinstates on the date Your application is approved. Your coverage automatically reinstates on the 45th day after We get Your late payment, unless we send You prior written notice of disapproval of Your application. The reinstated Certificate will cover only Covered Expenses incurred after the date of reinstatement.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 6 month period. Any subsequent revisions will be based upon 12 months of experience. We will give the Policyholder written notice at least 45 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VI. DESCRIPTION OF COVERAGE

A. COVERED DENTAL EXPENSES

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

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

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

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

The benefit is subject to the following:

1. The Covered Procedure must start and be completed while the Insured's coverage is in force, except as provided in the Takeover Benefits provision, 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 twelve (12) 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 three (3) continuous years unless it is a replacement of an existing unserviceable prosthesis.

3. **COVERAGE FOR CONGENITAL DEFECTS OR ANOMALIES:** No benefits are payable for congenital defects or anomalies except as follows: When a child, covered from the moment of birth or placement in the adoptive or foster home, requires dental care associated with congenital defects and anomalies, We will cover such defects to the same extent an otherwise covered dental service is provided. This includes individuals born with cleft lip or palate.

4. **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, except for children as explained under "Limitations";

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. orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals provided for treatment of the jaw or temporomandibular joint;
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. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or under an order of the North Carolina Industrial Commission approving settlement agreement under the North Carolina Workers' Compensation Act;
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 anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

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

National Guardian Life Insurance Company
c/o AlwaysCare Benefits, Inc.
P. O. Box 80139
Baton Rouge, LA 70898-0139

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

Proof Of Loss: Written proof of loss must be given to the Administrator within 180 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 will be made immediately upon receipt written 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. with respect to an ineligible person; or
4. 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:** Means a necessary, reasonable and customary item of expense for health care, when the item is covered at least in part by one or more Plans covering the Insured for whom claim is made.

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

3. **Plan:** Is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

    a) Group Insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It does not include school accident-type coverage, blanket, franchise, individual, automobile and homeowner coverage.

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

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.

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:

National Guardian Life Insurance Company
c/o AlwaysCare Benefits, Inc.
P. O. Box 80139
Baton Rouge, LA 70898-0139

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

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

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

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

PART 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 National Guardian 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 thirty-six (36) months of extraction; and (3) treatment would have been covered under the Policyholder's Prior Plan; We will apply the expenses to this plan as long as they are Covered Expenses under both this Certificate and the Prior Plan.

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

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

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

PART XIII. SCHEDULE OF COVERED PROCEDURES

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

Key for Schedule of Covered Procedures

* 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
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 4 films per 12 months
(d) Limited to Dependent Children under age 19
(e) Maximum of 1 procedure per 12 months
(f) Limited to Dependent Children under age 14
(g) Limited to Dependent Children under age 12
(h) Maximum of 1 procedure per 24 months
(i) Limited to Dependent Children under age 19
(j) Applications made to permanent molar teeth only
(k) Maximum of 2 procedures per arch per 24 months
(l) Maximum of 1 per 5 year period per tooth
(m) Maximum of 1 each quadrant per 12 months
(n) Maximum of 1 each quadrant per 24 months
(o) Maximum of 1 each tooth per 24 months
(p) Subject to a yearly and a lifetime maximum
(q) Maximum of 1 each quadrant per 36 months
(r) Replacement of existing only if in place for 12 months (insured under age 19)
(s) Replace existing only if in place for 36 months (insured over age 19)
(t) Benefits will be based on the benefit for the corresponding non-cosmetic restoration.
(u) Maximum 1 time per tooth 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
(dd) Maximum of 1 per 10 year period
(ee) Maximum of 1 per 3 year period
(ff) Maximum of 1 per 4 year period
(gg) Maximum of 1 per 5 year period
(hh) In lieu of a single tooth replacement when a 2 or 3 unit bridge has been approved for coverage
(ii) Maximum of 2 procedures per 12 months
(jj) Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion
(kk) One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at the time of claim.
(ll) Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient's physician and claim narrative must be submitted at the time of the claim.
(mm) Covered only if provided on different date of service than other covered treatment or exam
(nn) Subject to review
(oo) In lieu of Topical Application of Fluoride for a child
(pp) Limited to 2 oral evaluation procedures, in any combination (D0120, D0145, D0150) per 12 month period

Covered Procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Comprehensive or Periodic Oral Exam	A	(0)	(pp)	PMAC	MAC
Oral Evaluation – Patient under 3 yrs of age	A	(0)	(pp)	PMAC	MAC
Problem Focused Exam	B	(0)	(e)	PMAC	MAC
Comprehensive Periodontal Exam	A	(0)	(e)	PMAC	MAC
Emergency Palliative Treatment	B	(0)	(e)	PMAC	MAC
Single Film	A	(0)		PMAC	MAC
Additional Films	A	(0)		PMAC	MAC
Intra-Oral Occlusal Film	A	(0)		PMAC	MAC
Bitewings (single or multiple films)	A	(0)	(c) (e)	PMAC	MAC
Panoramic Film or Full Mouth X-Ray	A	(0)	(h)	PMAC	MAC
Prophylaxis – Adult (age 16 and above)	A	(0)	(ii) (kk)	PMAC	MAC
Prophylaxis – Child	A	(0)	(x) (ii)	PMAC	MAC
Adjunctive Pre-Diagnostic Oral Cancer Screening	A	(0)	(e) (jj)	Up to $45	Up to $45
Topical Application of Fluoride – Child	A	(0)	(e) (x)	PMAC	MAC
Sealant	A	(0)	(b) (x) (j)	PMAC	MAC
Space Maintainer – Fixed Unilateral	A	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Fixed Bilateral	A	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Removable Unilateral	A	(0)	(x) (o)	PMAC	MAC
Space Maintainer – Removable Bilateral	A	(0)	(x) (o)	PMAC	MAC
FILLINGS					
One Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Two Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Three Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
Four + Surface Amalgam	B	(0)	(r) (s)	PMAC	MAC
One Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Two Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Three Surface Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Four + Surface or Incisal Resin – Anterior	B	(0)	(r) (s)	PMAC	MAC
Protective Restoration	B	(0)	(o)	PMAC	MAC
ORAL SURGERY					
Extraction, erupted tooth or exposed root	B	(0)		PMAC	MAC
Extraction, Coronal Remnants	B	(0)		PMAC	MAC
Surgical Extraction	B	(0)		PMAC	MAC
Impacted (soft tissue)	B	(0)		PMAC	MAC
Impacted (partial bony)	B	(0)		PMAC	MAC
Impacted (complete bony)	B	(0)		PMAC	MAC
Surgical Removal of Root	B	(0)		PMAC	MAC
Alveoplasty (with extraction) – per quadrant	B	(0)		PMAC	MAC
Alveoplasty (without extraction) – per quadrant	B	(0)		PMAC	MAC
Incision and Drainage of Abscess – Intraoral	B	(0)		PMAC	MAC
General Anesthesia/Intravenous Sedation	B	(0)	(w)	PMAC	MAC
CROWN AND BRIDGE REPAIR					
Inlay Recementation	C	(0)	(bb)	PMAC	MAC
Crown Recementation	C	(0)	(bb)	PMAC	MAC
Bridge Repair	C	(0)	(bb)	PMAC	MAC
Crown Repair	C	(0)	(bb)	PMAC	MAC
Inlay repair	C	(0)	(bb)	PMAC	MAC
Onlay repair	C	(0)	(bb)	PMAC	MAC
Veneer repair	C	(0)	(bb)	PMAC	MAC
Bridge Recementation	C	(0)	(bb)	PMAC	MAC

DENTURE REPAIR					
Repair Denture Base	C	(0)	(e) (bb)	PMAC	MAC
Repair Teeth – per tooth	C	(0)	(e) (bb)	PMAC	MAC
Repair Partial Base	C	(0)	(e) (bb)	PMAC	MAC
Repair Partial Framework	C	(0)	(e) (bb)	PMAC	MAC
Repair Broken Clasp	C	(0)	(e) (bb)	PMAC	MAC
Add Tooth to Existing Partial Denture	C	(0)	(e) (bb)	PMAC	MAC
Add Clasp to Existing Partial Denture	C	(0)	(e) (bb)	PMAC	MAC
Replace Teeth – per tooth	C	(0)	(e) (bb)	PMAC	MAC
Reline Upper Denture	C	(0)	(h) (bb)	PMAC	MAC
Reline Lower Partial Denture	C	(0)	(h) (bb)	PMAC	MAC
Reline Upper Denture (Lab)	C	(0)	(h) (bb)	PMAC	MAC
Reline Lower Denture (Lab)	C	(0)	(h) (bb)	PMAC	MAC
Reline Upper Partial Denture (Lab)	C	(0)	(h) (bb)	PMAC	MAC
Reline Lower Partial Denture (Lab)	C	(0)	(h) (bb)	PMAC	MAC
Rebase Complete Denture – Upper	C	(0)	(h) (bb)	PMAC	MAC
Rebase Complete Denture – Lower	C	(0)	(h) (bb)	PMAC	MAC
Rebase Partial Denture – Lower	C	(0)	(h) (bb)	PMAC	MAC
Tissue Conditioning – Upper	C	(0)	(k) (bb)	PMAC	MAC
Tissue Conditioning – Lower	C	(0)	(k) (bb)	PMAC	MAC
Denture Adjustment Maxillary – Upper	C	(0)	(a) (bb)	PMAC	MAC
Denture Adjustment Mandibular – Lower	C	(0)	(a) (bb)	PMAC	MAC
Partial Adjustment Maxillary – Upper	C	(0)	(a) (bb)	PMAC	MAC
Partial Adjustment Mandibular – Lower	C	(0)	(a) (bb)	PMAC	MAC
PERIODONTICS (Non-surgical)					
Scaling and Root Planing–per quadrant	B	(0)	(n)	PMAC	MAC
Periodontal Debridement (full mouth)	B	(0)	(v)	PMAC	MAC
Periodontal Maintenance Procedure	B	(0)	(ii) (kk)	PMAC	MAC
ENDODONTICS					
Vital Pulpotomy – primary teeth only	B	(0)	(f)	PMAC	MAC
Root Canal – Anterior	B	(0)		PMAC	MAC
Root Canal – Bicuspid	B	(0)		PMAC	MAC
Root Canal – Molar	B	(0)		PMAC	MAC
Apicoectomy – Anterior	B	(0)	(u)	PMAC	MAC
Apicoectomy – Bicuspid	B	(0)	(u)	PMAC	MAC
Apicoectomy – Molar	B	(0)	(u)	PMAC	MAC
Retrograde Filling	B	(0)	(u)	PMAC	MAC
Root Amputation	B	(0)	(u)	PMAC	MAC
MISCELLANEOUS					
Occlusal Guard	E				
PERIODONTICS (Surgical)					
Gingivectomy or Gingivoplasty – per quadrant	B	(0)	(n)	PMAC	MAC
Gingivectomy or gingivoplasty – per tooth	B	(0)	(o)	PMAC	MAC
Gingival Flap Procedure – per quadrant	B	(0)	(n)	PMAC	MAC
Osseous Surgery – per quadrant	B	(0)	(n)	PMAC	MAC
Pedicle Soft Tissue Grafts	B	(0)	(n)	PMAC	MAC
Free Soft Tissue Graft, first tooth	B	(0)	(n)	PMAC	MAC
Free Soft Tissue Graft, additional tooth	B	(0)	(n)	PMAC	MAC
Subepithelial Connective Tissue Graft	B	(0)	(n)	PMAC	MAC
CROWN					
Crown Resin – resin with high noble metal	C	(0)	(l) (t)	PMAC	MAC
Crown Resin – resin with noble metal	C	(0)	(l) (t)	PMAC	MAC

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

OTHER					
Endosteal Implants	C	(0)	(hh) (u)	PMAC	MAC
Cosmetic	E				
TMJ	E				
ORTHODONTIA **					
Initial Orthodontic Examination	D	(0)	(d)	PMAC	MAC
Initial Placement of Braces or Appliances	D	(0)	(d)	PMAC	MAC
Continuing Treatment for Braces or Appliances including retention	D	(0)	(d)	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-insurance on a monthly basis as claims are submitted. The subsequent monthly payments will be made only if Your dependent remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the Overall Maximum Benefit payable has been paid, no further benefits will be paid.
4. The lifetime maximum is equal to the member's lifetime maximum and is inclusive with the prior carrier, if applicable.

PART XIV. SCHEDULE OF BENEFITS

Policyholder: Jones County Government

Policyholder's Address: 418 Highway 58 N
Trenton, NC 28585

Effective Date: July 1, 2015

Initial Term: 24 Months

Eligible Classes: ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK

Eligibility Period: First of the month following 30 Days from the first day of Active Work

Mode of Premium Payment: MONTHLY

Method of Premium Payment: Remitted by Policyholder

Premium Due Date: 1st of every month

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

Annual Deductible: In-Network $50 Individual Deductible.
Maximum per Family Deductible: 3
Applies to Classes: B, C

Out-of-Network $50 Individual Deductible.
Maximum per Family Deductible: 3
(Overall Out-of-Network Maximum Family Deductible Dollar Amount may not exceed 2 times the In-Network Maximum Family Deductible Dollar Amount)
Applies to Classes: B, C

Co-Pay: See Schedule of Covered Procedures

Certificate Year Maximum Annual Benefit: Per Insured

In-Network

Year 1	Year 2	Year 3 & Forward
$1,000	$1,000	$1,000

Out-of-Network

Year 1	Year 2	Year 3 & Forward
$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 Maximum Benefit	Maximum Benefit Annual/Lifetime
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%	No	None/$1,000

Certificate Year 2:

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

Certificate Year 3 and later:

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum Benefit	Maximum Benefit Annual/Lifetime
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%	No	None/$1,000

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

Plan Type: □ Indemnity: No participating provider network

√ Participating Provider Program:

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

□ Scheduled Fee Plan

National Guardian® Life Insurance Company
It's about people.

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

Carryover Benefits Rider

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

Effective Date: This rider is effective on July 1, 2015.

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

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

If an Insured submits Qualifying Claims for Covered Expenses during a Benefit Year and, in that Benefit Year, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Threshold Limit, the Insured will be credited a Carryover Benefit for that Benefit Year. In addition, the Insured must have at least one cleaning and one routine exam per year.

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

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

The Threshold Limit, Carryover Benefit, and Carryover Account Limits for this Policy/Certificate are:

- Threshold Limit: $500
- Carryover Benefit: $250
- Carryover Account Limit: $1,000

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

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

Other Specifications:
Policy Year Plans: If the effective date of an Insured's dental coverage is within the three months prior to the start of this plan's next Policy Year, this benefit rider will not apply to the Insured until the next Policy Year. And:

- Only claims incurred on or after the start of the next Policy Year will count toward the Threshold Limit;
- Requirement of 1 cleaning and 1 exam incurred after January 1; and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Policy Year that starts one year from the date the rider first applies.

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

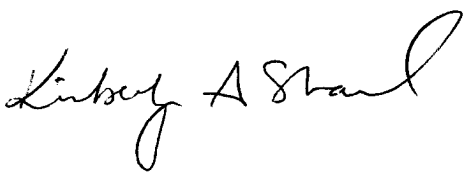
- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit*;* and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

Definitions:

- "Benefit Year" means Calendar Year or Policy Year, according to the type of plan applicable under the Policy/Certificate to which this rider is attached**.**
- "Carryover Account" means the amount of an Insured's accrued Carryover Benefits.
- "Carryover Account Limit" means the maximum amount of cumulative Carryover Benefits that an Insured can store in his or her Carryover Account.
- "Carryover Benefit*"* means the dollar amount, which will be added to an Insured's Carryover Account when he or she receives benefits in a Benefit Year that do not exceed the Threshold Limit.
- Qualifying Claim means a claim under Procedure Classes A, B, C, and D, (Orthodontia) and must include 1 exam and 1 cleaning.
- "Threshold Limit" means the maximum amount of benefits that an Insured can receive during a Benefit Year and still be entitled to receive the Carryover Benefit. This includes all claims processed under all Procedure Classes.

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

Signed for National Guardian Life Insurance Company, at its Home Office, 2 East Gilman Street, Madison, WI 53701-1191.



Kimberly A. Shaul, Secretary

Mark Solverud, President