STARMOUNT LIFE INSURANCE COMPANY

8485 Goodwood Blvd. Baton Rouge, LA 70806-7878

Administrative Office: Starmount Life Insurance Company 8485 Goodwood Blvd., P.O. Box 98100
Baton Rouge, LA 70898-9100
Toll Free Telephone No: 1-888-729-5433

Policy Modifications

Policy Modifications: Policy/Certificate Number DNGRPCT-2015-NC is amended as follows:

Class A Preventative Services

From: Fluoride to age 16 (1 per 12 months)

To: Fluoride to age 16 (2 per 12 months)

In all other respects, the Policy/Certificate remains the same.

RIDER: This rider, issued August 18, 2020, forms a part of Policy/Certificate No. DNGRPCT-2015-NC issued to Granville County Public Schools. It is effective January 1, 2021. It does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Policy, except as stated herein.

Signed for **The Company**

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

STARMOUNT LIFE INSURANCE COMPANY

(called “We”, “Our”, and “Us”)

8485 Goodwood Blvd. Baton Rouge, LA 70898-9100

GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by:	Starmount Life Insurance Company 8485 Goodwood Blvd. P.O. Box 98100 Baton Rouge, LA 70898-9100
Administrator:	AlwaysCare Benefits, Inc. (a Starmount Life Insurance company) 8485 Goodwood Blvd., P.O. Box 80139 Baton Rouge, LA 70898-0139

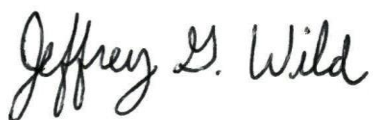
This Certificate explains the dental insurance coverage under the Group Policy (the Policy) issued to the Policyholder. The Policy provides the benefits for the Insured Member (called "You" or "Your") and any Covered Dependents.

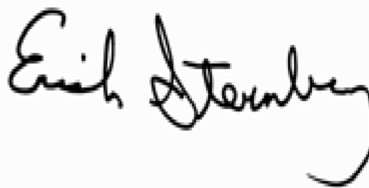
The Policyholder and the Policy Number are shown in the Schedule of Benefits.

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.





Jeffrey G. Wild, Secretary Erich Sternberg, CEO

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.

RIGHT TO RETURN CERTIFICATE FOR 30 DAYS: You may return this Certificate for any reason within 30 days of the date you receive it. Any premium payment is returned. The Certificate is treated as if it never existed.

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.)

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 dependent on You for support and maintenance.
4. 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.

Emergency Care – means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, Emergency Services received from a non preferred provider will be reimbursed at the in-network rate.

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

Initial Term - The twelve month 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 - means covered dental benefits that are received according to the rules of this policy from providers under contract with, or approved in advance by the insurer; and means emergency health care services regardless of the status or affiliation of the provider of such services.

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 3 types of Maximum Reimbursement, depending on the plan issued:

1. **Maximum Allowable Charge (MAC)**: The MAC may be used if a dentist who is a Non-Participating Provider performs a Covered Procedure. The amount of the MAC is equal to the lesser of: (a) the dentist's actual charge; or (b) the "customary charge" for the dental service or supply. We determine the "customary charge" from within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area.
2. **Participating Provider Maximum Allowable Charge (PMAC)**: The PMAC may be used if a dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the dentist has agreed with Us to accept as payment in full for a dental service or supply.
3. **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 - means non-emergency, medically necessary covered dental services that are not received according to the rules of this individual dental policy.

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 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. Children enrolled due to a court order are not considered Late Entrants and therefore are not under any enrollment season restrictions.

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. Placement of foster child or child placed by court or administrative order;
5. Death of a spouse or child;
6. Other changes as permitted by the Policyholder.

If additional monthly premiums will be required to enroll a new spouse or a new dependent child, you must submit an Enrollment Application and Change Form through your group within 31 days of acquiring the new dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home. The 31 day enrollment period will be waived for a child enrolled due to a court order.

If no additional monthly premium will be required when you add a dependent child to your plan, you should complete a Status Change Form so that we may send an identification card to facilitate the child's access to covered services. A newborn child will be covered from the moment of birth. A foster care or adopted child will be covered from the date of placement in the home provided coverage for that child is put in to effect within 31 days.

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 prevent delays of 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 during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to 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.

SAMPLE CALCULATION OF BENEFITS

	Services are provided by an In-Network Provider	**Services are provided by an Out-of-Network Provider**
Provider submitted charge for a one surface amalgam filling*	$108.00	$108.00
In-network fee	$79.00	N/A
AlwaysCare Benefits payable	$63.20 ($79.00 at 80%)	$86.40 ($108.00 at 80%)
Patient's responsibility to the provider	$15.80 ($79.00 - $63.20 = $15.80)	$21.60 ($108.00 - $86.40 = $21.60)
*This example assumes all deductibles have been met and annual maximums have not been reached.		

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.
If there is not a participating provider within 30 miles of the home of the insured or are unable to obtain an appointment for a wellness examination within 30 days, the insured visit a non-participating provider with claims paid at the In-Network benefit. The insured must provide the claim information to claims department.

A provider directory may be obtained on our website www.alwayscarebenefits.com or by calling our Customer Service department at (888)749-5433.

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; except for children as explained in "Limitations";
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 any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, or myofascial pain;
12. orthognathic surgery;
13. prescribed medications, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
16. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
17. for treatment of malignancies, cysts and neoplasms;
18. for orthodontic treatment;
19. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
20. any procedure We determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
21. service or supply rendered by someone who is related to an Insured by blood 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;
22. 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;
23. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the "Payment of Claims" provision;
24. procedures started but not completed;
25. any duplicate device or appliance;
26. 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;
27. the replacement of 3rd molars;
28. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

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

Starmount Life Insurance Company
c/o AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., 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. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof of loss in the time required, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time proof is otherwise required

Payment of Claims: Payment of services provided by a Preferred Provider are paid directly to the Provider. Payment of services provided by a Non Preferred Provider are paid to either the Provider or You according to Your election.

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.

Within 30 calendar days after receipt of a claim We will provide one or more of the following: (a) payment of the claim; (b) notice of denial of the claim; (c) notice that the proof of loss is inadequate or incomplete; (c) notice that the claim is not submitted on the form required by Us; (d) notice that coordination of benefits information is needed in order to pay the claim; (e) notice that coordination of benefits information is needed in order to pay the claim; (f) notice that the claim is pending based on nonpayment of fees or premiums.

If we request additional information in order to complete the claim process and the information is not received within 90 days the claim will be denied and notice of denial shall be sent to the insured. The denied claim may be reopened within one year by submission of the requested information.

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.

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. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. Total benefits paid must be equal to 100 percent of necessary medical expenses covered by both plans.

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/Secondary Plan**: The order of benefit determination rules state whether this plan is a Primary Plan or Secondary Plan as to another plan covering the person. When this plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When there are more than two plans covering the person, this plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.
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:

Starmount Life Insurance Company
c/o AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Blvd., 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 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 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
- A Preventive/Diagnostic
- B Basic
- C Major
- D Non-Medically Necessary Orthodontia
- E Not Covered
- F Other

Type of Maximum Reimbursement:
- PMAC – Participating Provider Maximum Allowable Charge
- MAC – Maximum Allowable Charge (based on "Customary Charge")
- Indemnity
- SF – Scheduled Fee

¶ Limitations

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 4 radiograph images 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 4 per 12 months with adult prophylaxis
(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 for ages 19 and over.
(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/treatment
(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) Covered only if provided on different date of Service than other covered treatment
(qq) In conjunction with covered orthodontics
(rr) Limited to Dependent Children under age 15
(ss) Not covered in conjunction with a root canal
(tt) Limited to Dependent Children under age 11
(uu) Limited to once per tooth per lifetime
(ww) Limited to Dependent Children under age 22
(xx) Maximum of 1 each quadrant per 36 months
(yy) Maximum of 1 each tooth per 36 months
(zz) Limited to 2 oral evaluation procedure, in any combination (D0120, D0145, D0150) per 12 month period
(aaa) Limited to Dependent Children between the ages 13-18
(bbb) Maximum of 2 per 12 months in lieu of adult prophylaxis

	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
Diagnostic and Treatment Services					
D0120 Periodic oral exam	A	(0)	(zz)	PMAC	MAC
D0140 Limited oral evaluation - problem focused	B	(0)	(e)	PMAC	MAC
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver	A	(0)	(zz)	PMAC	MAC
D0150 Comprehensive oral exam	A	(0)	(zz)	PMAC	MAC
D0180 Comprehensive periodontal evaluation - new or established patient	A	(0)	(e)	PMAC	MAC
D0210 Intraoral complete series of radiographic images	A	(0)	(h)	PMAC	MAC
D0220 Intraoral-periapical first radiographic image	A	(0)		PMAC	MAC
D0230 Intraoral-periapical each additional radiographic image	A	(0)		PMAC	MAC
D0240 Intraoral occlusal radiograph image	B	(0)	(ii)	PMAC	MAC
D0270, D0272, D0273, D0274 Bitewings (single or multiple radiographic images)	A	(0)	(c) (e)	PMAC	MAC
D0330 Panoramic radiograph image	B	(0)	(h)	PMAC	MAC
D0431 Adjunctive pre-diagnostic test aiding in the detection of mucosal abnormalities	A	(0)	(e) (jj)	PMAC	up to $45
Preventative Services					
D1110 Prophylaxis – adult	A	(0)	(ii) (kk)	PMAC	MAC
D1120 Prophylaxis – child	A	(0)	(f) (ii) (kk)	PMAC	MAC
D1206 Topical application of fluoride varnish	A	(0)	(x) (e) (oo)	PMAC	MAC
D1208 Topical application of fluoride	A	(0)	(x) (ii)	PMAC	MAC
D1351 Sealant – per tooth	A	(0)	(b) (x) (j)	PMAC	MAC
D1352 Preventative resin restoration in a moderate to high caries risk patient-permanent tooth	A	(0)	(b) (j) (x) (nn)	PMAC	MAC
D1510 Space maintainer – fixed – unilateral	A	(0)	(x) (o)	PMAC	MAC
D1515 Space maintainer – fixed – bilateral	A	(0)	(x) (o)	PMAC	MAC
D1520 Space maintainer – removable –unilateral	A	(0)	(x) (o)	PMAC	MAC
D1525 Space maintainer – removable – bilateral	A	(0)	(x) (o)	PMAC	MAC
Emergency Services					
D9110 Palliative (emergency) treatment of dental pain-minor procedure	B	(0)	(e)	PMAC	MAC

Minor Restorative Services					
D2140 Amalgam – one surface, primary or permanent	B	(0)	(r) (s)	PMAC	MAC
D2150 Amalgam – two surfaces, primary or permanent	B	(0)	(r) (s)	PMAC	MAC
D2160 Amalgam – three surfaces, primary or permanent	B	(0)	(r) (s)	PMAC	MAC
D2161 Amalgam – four or more surfaces, primary or permanent	B	(0)	(r) (s)	PMAC	MAC
D2330 Resin-based composite – one surface, anterior	B	(0)	(r) (s)	PMAC	MAC
D2331 Resin-based composite – two surfaces, anterior	B	(0)	(r) (s)	PMAC	MAC
D2332 Resin-based composite – three surfaces, anterior	B	(0)	(r) (s)	PMAC	MAC
D2335 Resin-based composite – four or more surfaces or involving incisal angle, anterior	B	(0)	(r) (s)	PMAC	MAC
D2330 Resin-based composite – one surface, posterior	B	(0)	(r) (s)	PMAC	MAC
D2331 Resin-based composite – two surfaces, posterior	B	(0)	(r) (s)	PMAC	MAC
D2332 Resin-based composite – three surfaces, posterior	B	(0)	(r) (s)	PMAC	MAC
D2335 Resin-based composite – four or more surfaces or involving incisal angle, posterior	B	(0)	(r) (s)	PMAC	MAC
D2910 Recement inlay, onlay, or partial coverage restoration	B	(0)	(bb)	PMAC	MAC
D2920 Recement crown	B	(0)	(bb)	PMAC	MAC
D2930 Prefabricated stainless steel crown – primary tooth	C	(12	(l)	PMAC	MAC
D2940 Protective restoration	B	(0)	(o)	PMAC	MAC
Endodontic Services					
D3220 Therapeutic pulpotomy (excluding final restoration)	B	(0)	(f) (u)	PMAC	MAC
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	B	(0)	(u)	PMAC	MAC
D3430 Retrograde filling – per root	B	(0)	(u)	PMAC	MAC
D3310 Endodontic therapy, anterior tooth	B	(0)	(u)	PMAC	MAC
D3320 Endodontic therapy, bicuspid tooth	B	(0)	(u)	PMAC	MAC
D3330 Endodontic therapy, molar	B	(0)	(u)	PMAC	MAC
D3346 Retreatment of previous root canal therapy – anterior	B	(0)	(u) (bb)	PMAC	MAC

D3347 Retreatment of previous root canal therapy – bicuspid	B	(0)	(u) (bb)	PMAC	MAC
D3348 Retreatment of previous root canal therapy – molar	B	(0)	(u) (bb)	PMAC	MAC
D3410 Apicoectomy – anterior	B	(0)	(u)	PMAC	MAC
D3421 Apicoectomy - bicuspid (first root)	B	(0)	(u)	PMAC	MAC
D3425 Apicoectomy - molar (first root)	B	(0)	(u)	PMAC	MAC
D3426 Apicoectomy (each additional root)	B	(0)	(u)	PMAC	MAC
D3450 Root amputation per root	B	(0)	(u)	PMAC	MAC
Non-Surgical Periodontal Services					
D4341 Periodontal scaling and root planing, four or more teeth per quadrant	B	(0)	(n)	PMAC	MAC
D4342 Periodontal scaling and root planing - one to three teeth per quadrant	B	(0)	(n)	PMAC	MAC
D4910 Periodontal maintenance	B	(0)	(ii) (kk)	PMAC	MAC
Surgical Periodontal Services					
D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	B	(0)	(n)	PMAC	MAC
D4211 Gingivectomy or gingivoplasty –one to three contiguous teeth or tooth bounded spaces per quadrant	B	(0)	(h)	PMAC	MAC
D4240 Gingival flap procedure, including root planning – four or more teeth per quadrant	B	(0)	(n)	PMAC	MAC
D4241 Gingival flap procedure, including root planning - one to three teeth per quadrant	B	(0)	(n)	PMAC	MAC
D4260 Osseous surgery – (including flap entry and closure) – four or more teeth per quadrant	B	(0)	(n)	PMAC	MAC
D4261 Osseous surgery (including flap entry and closure) - one to three teeth per quadrant	B	(0)	(n)	PMAC	MAC
D4270 Pedicle soft tissue grafts	B	(0)	(n)	PMAC	MAC
D4273 Subepithelial connective tissue graft procedure, per tooth	B	(0)	(n)	PMAC	MAC
D4277 Free soft tissue graft 1st Tooth	B	(0)	(n)	PMAC	MAC
D4278 Free soft tissue graft-additional teeth	B	(0)	(n)	PMAC	MAC
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis	B	(0)	(mm) (v)	PMAC	MAC

Prosthodontic Repair Services					
D2980 Crown repair necessitated by restorative material failure	B	(0)	(bb) (nn)	PMAC	MAC
D2981 Inlay repair necessitated by restorative material failure	B	(0)	(bb) (nn)	PMAC	MAC
D2982 Onlay repair necessitated by restorative material failure	B	(0)	(bb) (nn)	PMAC	MAC
D2983 Veneer repair necessitated by restorative material failure	B	(0)	(bb) (nn)	PMAC	MAC
D5410 Adjust complete denture – maxillary	B	(0)	(a)	PMAC	MAC
D5411 Adjust complete denture – mandibular	B	(0)	(a)	PMAC	MAC
D5421 Adjust partial denture – maxillary	B	(0)	(a)	PMAC	MAC
D5422 Adjust partial denture – mandibular	B	(0)	(a)	PMAC	MAC
D5510 Repair broken complete denture base	B	(0)	(e) (bb)	PMAC	MAC
D5520 Replace missing or broken teeth - complete denture (each tooth)	B	(0)	(e) (bb)	PMAC	MAC
D5610 Repair resin denture base	B	(0)	(e) (bb)	PMAC	MAC
D5620 Repair cast framework	B	(0)	(e) (bb)	PMAC	MAC
D5630 Repair or replace broken clasp	B	(0)	(e) (bb)	PMAC	MAC
D5640 Replace broken teeth - per tooth	B	(0)	(e) (bb)	PMAC	MAC
D5650 Add tooth to existing partial denture	B	(0)	(e) (bb)	PMAC	MAC
D5660 Add clasp to existing partial denture	B	(0)	(e) (bb)	PMAC	MAC
D5710 Rebase complete maxillary denture	B	(0)	(h) (bb)	PMAC	MAC
D5711 Rebase complete mandibular denture	B	(0)	(h) (bb)	PMAC	MAC
D5720 Rebase maxillary partial denture	B	(0)	(h) (bb)	PMAC	MAC
D5721 Rebase mandibular partial denture	B	(0)	(h) (bb)	PMAC	MAC
D5730 Reline complete maxillary denture (chairside)	B	(0)	(h) (bb)	PMAC	MAC
D5731 Reline Complete Mandibular Denture (chair side)	B	(0)	(h) (bb)	PMAC	MAC
D5740 Reline maxillary partial denture (chair side)	B	(0)	(h) (bb)	PMAC	MAC
D5741 Reline mandibular partial denture (chair side)	B	(0)	(h) (bb)	PMAC	MAC
D5750 Reline complete maxillary denture (laboratory)	B	(0)	(h) (bb)	PMAC	MAC
D5751 Reline complete mandibular denture (laboratory)	B	(0)	(h) (bb)	PMAC	MAC
D5760 Reline maxillary partial denture (laboratory)	B	(0)	(h) (bb)	PMAC	MAC
D5761	B	(0)	(h) (bb)	PMAC	MAC

Reline mandibular partial denture (laboratory)					
D5850 Tissue conditioning, maxillary	B	(0)	(k) (bb)	PMAC	MAC
D5851 Tissue conditioning, mandibular	B	(0)	(k) (bb)	PMAC	MAC
D6930 Recement fixed partial denture	B	(0)	(bb)	PMAC	MAC
D6980 Fixed partial denture repair necessitated by restorative material failure	B	(0)	(bb)	PMAC	MAC
Oral Surgery					
D7111 Extraction, coronal remnants – deciduous tooth	B	(0)		PMAC	MAC
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	B	(0)		PMAC	MAC
D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	C	(12)	(nn)	PMAC	MAC
D7220 Removal of impacted tooth- soft tissue	C	(12)	(nn)	PMAC	MAC
D7230 Removal of Impacted tooth- partially bony	C	(12)	(nn)	PMAC	MAC
D7240 Removal of impacted tooth- completely bony	C	(12)	(nn)	PMAC	MAC
D7250 Surgical removal of residual tooth roots (cutting procedure)	C	(12)		PMAC	MAC
D7310 Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	C	(12)	(u)	PMAC	MAC
D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	C	(12)		PMAC	MAC
D7320 Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	C	(12)		PMAC	MAC
D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	C	(12)		PMAC	MAC
D7510 Incision and drainage of abscess –intraoral soft tissue	C	(12)		PMAC	MAC
Anesthesia Services					
D9220 General anesthesia - first 30 minutes	C	(12)	(w)	PMAC	MAC
D9221 General anesthesia - each additional 15 minutes	C	(12)	(w)	PMAC	MAC

Major Restorative Services					
D2510 Inlay metallic – one surface	C	(12)	(l)	PMAC	MAC
D2520 Inlay metallic – two surfaces	C	(12)	(l)	PMAC	MAC
D2530 Inlay metallic – three or more surfaces	C	(12)	(l)	PMAC	MAC
D2542 Onlay metallic – two surfaces	C	(12)	(l)	PMAC	MAC
D2543 Onlay metallic – three surfaces	C	(12)	(l)	PMAC	MAC
D2544 Onlay metallic – four or more surfaces	C	(12)	(l)	PMAC	MAC
D2720 Crown Resin – resin with high noble metal	C	(12)	(l) (t)	PMAC	MAC
D2722 Crown Resin – resin with noble metal	C	(12)	(l) (t)	PMAC	MAC
D2721 Crown Resin – resin with predominately base metal	C	(12)	(l) (t)	PMAC	MAC
D2780 Crown – ¾ cast high noble metal	C	(12)	(l) (t)	PMAC	MAC
D2781 Crown-3/4 Cast Predominantly Base Metal	C	(12)	(l) (t)	PMAC	MAC
D2782 Crown ¾ Cast Noble Metal	C	(12)	(l) (t)	PMAC	MAC
D2783 Crown ¾ Porcelain/Ceramic	C	(12)	(l) (t)	PMAC	MAC
D2790 Crown – full cast high noble metal	C	(12)	(l) (t)	PMAC	MAC
D2791 Crown – full cast predominantly base metal	C	(12)	(l)	PMAC	MAC
D2792 Crown – Full cast noble metal	C	(12)	(l) (t)	PMAC	MAC
D2950 Core Buildup, including any pins	C	(12)	(l)	PMAC	MAC
D2952 Post and Core – In Addition to Crown	C	(12)	(l)	PMAC	MAC
D2954 Prefabricated Post and Core – In Addition to Crown	C	(12)	(l)	PMAC	MAC
D2960, D2961, D2962 Veneers – excluding cosmetic; restorative only	C	(12)	(l)	PMAC	MAC
Prosthodontic Services					
D5110 Complete Denture – maxillary	C	(12)	(l)	PMAC	MAC
D5120 Complete Denture – mandibular	C	(12)	(l)	PMAC	MAC
D5130 Immediate Denture – maxillary	C	(12)	(l)	PMAC	MAC
D5140 Immediate Denture – mandibular	C	(12)	(l)	PMAC	MAC
D5211 Maxillary Partial Denture - Resin Base	C	(12)	(l)	PMAC	MAC
D5212 Mandibular Partial Denture - Resin Base	C	(12)	(l)	PMAC	MAC
D5213 Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases	C	(12)	(l)	PMAC	MAC

D5214 Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases	C	(12)	(l)	PMAC	MAC
D5281 Removable Unilateral Partial Denture - One piece cast Metal	C	(12)	(l)	PMAC	MAC
D6010 Surgical placement of implant body; endosteal implant	C	(12)	(hh) (v)	PMAC	MAC
D6013 Surgical placement of mini implant	C	(12)	(hh) (v)	PMAC	MAC
D6056 Prefabricated Abutment	C	(12)	(v)	PMAC	MAC
D6057 Custom Abutment	C	(12)	(v)	PMAC	MAC
D6058 Abutment supported porcelain/ceramic crown	C	(12)	(t) (gg)	PMAC	MAC
D6059 Abutment supported porcelain fused to metal crown	C	(12)	(t) (gg)	PMAC	MAC
D6060 Abutment supported porcelain fused to metal crown, predominantly base metal	C	(12)	(t) (gg)	PMAC	MAC
D6061 Abutment supported porcelain fused to metal crown, noble metal	C	(12)	(t) (gg)	PMAC	MAC
D6062 Abutment supported cast metal crown, high noble metal	C	(12)	(t) (gg)	PMAC	MAC
D6063 Abutment supported cast metal crown, predominantly base metal	C	(12)	(t) (gg)	PMAC	MAC
D6064 Abutment supported cast metal crown, noble metal	C	(12)	(t) (gg)	PMAC	MAC
D6065 Implant supported ceramic crown	C	(12)	(t) (gg)	PMAC	MAC
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	C	(12)	(t) (gg)	PMAC	MAC
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)	C	(12)	(t) (gg)	PMAC	MAC
D6080 Implant Maintenance Procedures	C	(12)	(a)	PMAC	MAC
D6092 Recement of implant/abutment supported crown	C	(12)	(e) (bb)	PMAC	MAC
D6210 Pontic Cast High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
D6211 Pontic Cast Predominantly Base Metal	C	(12)	(l)	PMAC	MAC
D6212 Pontic Cast Noble Metal	C	(12)	(l) (t)	PMAC	MAC
D6214 Pontic – Titanium	C	(12)	(l) (t)	PMAC	MAC
D6250 Pontic Resin with High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
D6251 Pontic Resin with Predominantly Base Metal	C	(12)	(l) (t)	PMAC	MAC
D6252 Pontic Resin with Noble Metal	C	(12)	(l) (t)	PMAC	MAC

D6545 Retainer – cast metal for resin bonded fixed prosthesis	C	(12)	(l)	PMAC	MAC
D6710 Crown - indirect resin based composite	C	(12)	(l) (t)	PMAC	MAC
D6720 Crown - resin with high noble metal	C	(12)	(l) (t)	PMAC	MAC
D6721 Crown - resin with predominantly base metal	C	(12)	(l) (t)	PMAC	MAC
D6722 Crown - resin with noble metal	C	(12)	(l) (t)	PMAC	MAC
D6780 Crown ¾ Cast High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
D6781 Crown ¾ cast predominantly base metal	C	(12)	(l) (t)	PMAC	MAC
D6782 Crown ¾ cast noble metal	C	(12)	(l) (t)	PMAC	MAC
D6783 Crown ¾ porcelain/ceramic	C	(12)	(l) (t)	PMAC	MAC
D6790 Crown Full Cast High Noble Metal	C	(12)	(l) (t)	PMAC	MAC
D6791 Crown Full Cast Predominantly Base Metal	C	(12)	(l) (t)	PMAC	MAC
D6792 Crown Full Cast Noble Metal	C	(12)	(l) (t)	PMAC	MAC
Orthodontia*					
Initial Orthodontic Examination	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8020 Limited orthodontic treatment of the transitional dentition	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8030 Limited orthodontic treatment of the adolescent dentition	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8050 Interceptive orthodontic treatment of the primary dentition	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8060 Interceptive orthodontic treatment of the transitional dentition	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8070 Comprehensive orthodontic treatment of the transitional dentition	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8080 Comprehensive orthodontic treatment of the adolescent dentition	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8670 Continuing Treatment for Braces or Appliances including retention	D	(12)	(d) (nn) (qq)	PMAC	MAC
D8680 Orthodontic retention	D	(12)	(d) (nn) (qq)	PMAC	MAC
Interceptive Orthodontic Treatment	D	(12)	(d)	PMAC	MAC

Current Dental Terminology © American Dental Association

* **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 XIV. SCHEDULE OF BENEFITS

Policyholder:	Granville County Public Schools – High Plan
Policyholder's Address:	101 Delacroix Street Oxford, NC 27565
Effective Date:	This Certificate is issued January 1, 2021, and replaces the original Group Certificate effective date January 1, 2016.
Initial Term:	24 Months
Eligible Classes:	ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK
Eligibility Period:	First of the month following Date of Hire.
Mode of Premium Payment:	MONTHLY
Method of Premium Payment:	Remitted by Policyholder
Premium Due Date:	1st of every month
Certificate Year:	Your Certificate Year is on a Calendar Year Plan.
Annual Deductible:	In-Network $50 Individual Deductible. Maximum per Family Deductible: 3 Applies to Classes: B and C Out-of-Network $50 Individual Deductible. Maximum per Family Deductible: 3 Applies to Classes: B and C
Co-Pay:	See Schedule of Covered Procedures
Certificate Year Maximum Annual Benefit:	Per Insured

In-Network

Year 1	Year 2	Year 3 & Forward
$1,250	$1,250	$1,250

Out-of- Network

Year 1	Year 2	Year 3 & Forward
$1,250	$1,250	$1,250

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%	No	None/$1,250

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%	No	None/$1,250

Certificate Year 3 and later:

	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	100%	100%	Yes	None/None
Class B	80%	80%	Yes	None/None
Class C	50%	50%	Yes	None/None
Class D	50%	50%	No	None/$1,250

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

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine policy and insured payment obligations.

Starmount Life Insurance Company

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

Carryover Benefits Rider

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

Effective Date: This rider is effective on January 1, 2016.

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: $600
- Carryover Benefit: $300
- Carryover Account Limit: $1,200

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

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

Other Specifications:

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

- Only claims incurred on or after January 1 will count toward the Threshold Limit;
- Requirement of 1 cleaning and 1 exam incurred after January 1; and

Carryover Benefits will not be applied to an Insured's Carryover Account until the Calendar Year that starts one year from the date the rider first applies.

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

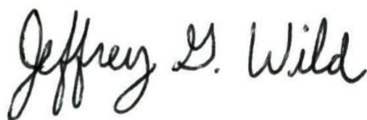
- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit; and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Benefit Year that starts one year from the date the rider first applies.

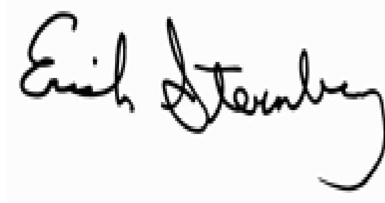
Definitions:

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

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

Signed for Starmount Life Insurance Company, at its Home Office, 8485 Goodwood Blvd., Baton Rouge, LA 70806-7878.





Jeffrey G. Wild, Secretary **Erich Sternberg, CEO**