Thank you for choosing AlwaysDental℠!

Here are some tips for using your plan…

1. You may choose any licensed general dentist or dental specialist. Most dentists will file a claim with us on your behalf, and ask you to pay any remaining amounts.

2. Although we receive over 90% of claims direct from dental offices, some providers do not accept insurance and may ask you to pay them upfront. If this happens, please submit the claim to us yourself. Claim forms are available at our web site (www.starmountlife.com) or can be faxed to you (call us at 888-729-5433).

3. We also have a panel of participating providers who have agreed to provide discounts to our members. Visit www.alwaysdental.com to view a listing of these providers in your area.

4. The first time you use the plan, please let the dental office know your coverage has moved to Starmount and AlwaysDental℠ and that they don't have to be part of any network to be paid by us. All they will need to do is submit a standard claim form, and we will reimburse them based on your plans allowances.

5. If you are having major work done, ask your doctor to submit a pre-treatment estimate request to us, so that you know how much you will have to pay out of pocket.

6. If your dentist wants information about becoming a participating dentist please call our Provider Relations Department 1-888-729-5433, x159.

We hope you enjoy the plan. Feel free to call with any questions.
1-888-729-5433

STARMOUNT LIFE INSURANCE COMPANY

(called "We", "Our", and "Us")

GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by: Starmount Life Insurance Company
P.O. Drawer 98100
Baton Rouge, LA 70898-9100

Administrator: Starmount Life Insurance Company
P.O. Drawer 98100
Baton Rouge, LA 70898-9100

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

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

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

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

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

Hans Sternberg, President

TABLE OF CONTENTS

PART I.	DEFINITIONS	Page 4
PART II.	INDIVIDUAL EFFECTIVE DATES	Page 5
	A. Active Employee	Page 5
	B. Eligible Dependents	Page 5
PART III.	INDIVIDUAL TERMINATION DATES	Page 6
	A. All Insureds	Page 6
	B. Insured Dependents	Page 6
PART IV.	INDIVIDUAL PREMIUMS	Page 7
PART V.	DESCRIPTION OF COVERAGE	Page 7
PART VI.	LIMITATIONS	Page 8
PART VII.	EXCLUSIONS	Page 8
PART VIII.	CLAIM PROVISIONS	Page 9
PART IX.	GENERAL PROVISIONS	Page 12
PART X.	REPLACEMENT OF EXISTING COVERAGE	Page 12
PART XI.	SCHEDULE OF COVERED PROCEDURES	Page 13
PART XII.	SCHEDULE OF BENEFITS	Page 18

PART I. DEFINITIONS

Active Employee - An Actively At Work Employee of the Employer named as the Policyholder.

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

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

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

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

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

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

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

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

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

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

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

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

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

Eligible Dependents - Your spouse and unmarried children (living with You in a regular parent-child relationship) and who are less than twenty-one (21) years of age, including step-children, legally adopted children, grandchildren, and foster children. However, a spouse is not eligible for coverage if: (1) he is eligible for insurance under the Policy on his own account, unless he waives his Employee status; or (2) he is on active duty with the Armed Forces of any country. Unmarried children who are twenty-one (21) but less than twenty-four (24) years of age will also be considered Eligible Dependents if they are enrolled on a full-time basis in an accredited school or college, attend vocational, technical, vocational-technical or trade schools or institutes and are dependent upon the Employee for their maintenance and support. If a husband and wife are both eligible under the Policy as an Employee, only one is eligible for insurance for any Eligible Dependent child(ren). In addition, unmarried children who are placed in the home of an Active Employee pursuant to Part III of Chapter 1 of Code Title VII of Code Book I of Title 9 of the Louisiana Revised Statutes of 1950, following execution of an act of voluntary surrender in favor of the Active Employee or the Active Employee's legal representative shall be considered a dependent child of the Active Employee.

Employee - The individual employed by the Policyholder.

Employer - The entity for whose Employees dental care benefits are being provided.

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

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

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

Insured - The Insured Employee and each Insured Dependent.

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

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

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

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

Policyholder - The entity that contracts with Us on behalf of its Employees or members.

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

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

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

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

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

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

PART II. INDIVIDUAL EFFECTIVE DATES

A. Active Employee

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

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

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

a. When no Employee contributions are required, the Employee's effective date will be the later of:
   (i) the Policyholder's Effective Date; or
   (ii) the day coinciding with the date that the Employee meets all of the Eligibility Requirements.

b. When Employee contributions are required, the Employee's effective date will be the later of:
   (i) the Policyholder's Effective Date; or
   (ii) the day coinciding with:
   - ♦ the date the Employee meets all of the Eligibility Requirements, if written application is made on or prior to the date that the Employee meets all of the Eligibility Requirements;
   - ♦ the date of the written application, if made within 31 days following the date that the Employee meets all of the Eligibility Requirements;
   - ♦ the effective date prescribed for the next following period of open enrollment as has been agreed to by the Employer and Us, if written application is made more than 31 days after the date that the Employee meets all of the Eligibility Requirements; or
   - ♦ the date of written application, if made within 31 days following the date that the Employee has a change in life status as determined by the Policyholder's flexible benefit plan.

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

B. Eligible Dependents

An Eligible Dependent will be covered on the later of:

a. the date the Dependent meets all of the requirements of an Eligible Dependent, if written application is made on or prior to

the date that the Dependent is an Eligible Dependent;

b. the date of the written application, if made within 31 days following the date that the Dependent meets all of the requirements of an Eligible Dependent;

c. the effective date prescribed for the next following period of open enrollment as has been agreed to by the Policyholder and Us, if written application is made more than 31 days after the date that the Dependent meets all of the requirements of an Eligible Dependent; or

d. the date of written application, if made within 31 days following the date that the Employee has a change in life status as determined by the Employer's flexible benefit plan.

Newborn Coverage: Any child born to an Insured is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with the additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

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

PART III. INDIVIDUAL TERMINATION DATES

A. All Insureds

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

a. the date that the Policy terminates;

b. the date that the Policyholder's coverage terminates under the Policy;

c. the date that You are no longer a full-time Employee;

d. the date that You die;

e. on any premium due date, if the full payment for Your insurance is not made within 31 days following the premium due date.

Insurance Coverage for Persons called to Service in the Uniformed Services.
An Employee shall have the right to maintain the insurance coverage under this policy if such person in called to service in the Uniformed Services. Upon timely receipt of the Employee's contributions required by the policy, the Policyholder shall provide the Insurer with those contributions plus an amount equal to what the Policyholder would have contributed during the period of service in the uniformed services. The Employee shall notify the Policyholder of his election to continue insurance coverage at the time he enters service in the Uniformed Services.

Dependents of an Employee who are covered by the policy who are subsequently called to service in the Uniformed Services shall continue to be considered Dependents under the provisions of the policy without any lapse of coverage, provided that all required contributions are paid in accordance with the policy.

An Employee who leaves employment to perform service in the Uniformed Services and who reapplies for coverage, after release, shall be reinstated, including all of his Dependents previously covered, without any clause or restriction because of a preexisting condition. In addition, any Dependent covered under the policy who is called to service in the Uniformed Services and whose coverage under the policy is not maintained during such service, after release and upon application of the Policyholder, shall be reinstated without any clause or restriction because of a preexisting condition.

B. Insured Dependents

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

a. the date that Your insurance terminates;

b. the last day of the month for which premium has not been paid for the Insured Dependent;

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

Every unmarried child under the age of 24 who is enrolled as a full-time student at an accredited college or university, or a vocational, technical, vocational-technical, or trade school or institute, or secondary school and who is dependent for their support on the Active Employee shall continue to be considered a dependent if the unmarried child develops a mental or nervous condition, problem, or disorder which renders the unmarried child, in the opinion of a qualified psychiatrist, subject, if deemed necessary, to a second opinion, unable to attend school as a full-time student and from holding self-sustaining employment until the student reaches the age of 24.

PART IV. INDIVIDUAL PREMIUMS

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

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

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

PART V. DESCRIPTION OF COVERAGE

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

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

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

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

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

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

We consider a dental treatment to be started as follows:

a. for a full or partial denture, the date the first impression is taken;
b. for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
c. for root canal therapy, on the date the pulp chamber is first opened;
d. for periodontal surgery, the date the surgery is performed; and
e. for all other treatment, the date treatment is rendered.

We consider a dental treatment to be completed as follows:

a. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
b. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
c. for root canal therapy, the date a canal is permanently filled.

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

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

3. Choice of Providers: An Insured may choose a dentist of his choice. An Insured may choose the services of a dentist who is either a Contracting Provider or a Non Contracting Provider. Benefits under this Certificate are determined and payable in either case. The Insured will generally incur less out-of-pocket cost is a Contracting Provider is chosen.

4. Pre-Estimate: If the charge for any treatment is expected to exceed $300, We recommend that a dental treatment plan be submitted to Us for review before treatment begins. An estimate of the benefits payable will be sent to You and Your dentist.
In addition to a dental treatment plan, before orthodontic treatment begins, We may request any of the following information to help determine benefits payable for orthodontic services:

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

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

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

condition according to generally accepted standards of care. This payment may be applied toward a more expensive course of treatment.

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

PART VI. LIMITATIONS

Coverage for a Late Entrant or a Re-enrollee will be limited to those procedures listed under **Procedure Class A** in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-enrollee's Eligible Dependents, if enrolled.

Missing Teeth Limitation: We will not pay benefits for replacement of teeth missing on an Insured's effective date of insurance under this Certificate for the purpose of the initial placement of a full denture, partial denture or fixed bridge. However, expenses for the replacement of teeth missing on the effective date will be considered for payment as follows:

a. The initial placement of full or partial dentures will be considered a covered procedure if the placement includes the initial replacement of a functioning natural tooth extracted while the Insured is covered under the policy.

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

Other Limitations: Multiple restorations on one surface are payable as one surface. Coverage is limited to either one prophylaxis or one periodontal maintenance per six month period. Coverage is limited to one full mouth radiograph or panoramic film per the limitation period listed in the Schedule of Covered Procedures.

PART VII. EXCLUSIONS

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

1. service or supply not shown on the Schedule of Covered Procedures;
2. any procedure begun after an Insured's insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty days after Your or Your Dependent(s) insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations;
6. the replacement of lost or discarded or stolen appliances;
7. replacement of bridges unless the bridge is more than 5 years old and cannot be made serviceable;
8. replacement of full or partial dentures unless the prosthetic appliance is more than 5 years old and cannot be made serviceable;
9. replacement of crowns, inlays or onlays unless the prior restoration is more than 5 years old and cannot be made serviceable;
10. appliances, services or procedures relating to: (I) the change or maintenance of vertical dimension; (ii) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (iii) splinting; (iv) correction of attrition, abrasion, erosion or abfraction; (v) bite registration or (vi) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
12. orthognathic surgery;
13. prescribed drugs, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment unless otherwise listed as a Covered Procedure;
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 (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured's household;
23. expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage);

24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under Payment of Claims in Part VIII. Claim Provisions;
25. procedures begun but not completed;
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures, plus the services of anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

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

Starmount Life Insurance Company
Dental Claims
P.O. Box 98100
Baton Rouge, LA 70898-9100

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

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

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

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

Time Payment of Claims: Benefits payable under this policy will be paid either immediately or within thirty (30) days upon receipt of written proof of loss.

Third Party Recovery: To the extent that benefits are provided or paid under the Policy You agree that if You fully recover Your damages from a third party, then You will reimburse Us the portion of the damages recovered for the expenses incurred that were provided or paid by Us. We agree to pay our portion of Your attorneys' fee or other costs associated with a claim or lawsuit to the extent that We recover any portion of the benefits paid under the Policy pursuant to Our right of recovery.

Subrogation: To the extent that benefits are provided or paid under the Policy, We shall be subrogated to all rights of recovery which You may acquire against any other party for the recovery of the amount paid under the Policy, however Our right of subrogation is secondary to Your right to be fully compensated for Your damages. You agree to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action We may require to facilitate enforcement of Our right of subrogation. We agree to pay our portion of Your attorneys' fee or other costs associated with a claim or lawsuit to the extent that We recover any portion of the benefits paid under the Policy pursuant to Our right of subrogation.

Coordination of Benefits

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

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

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

1. **Definitions**
   a. **Plan** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
      (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
      (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs,

of the United States Social Security Act, as amended).

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

b. **This Plan** is the part of the Policy that provides benefits for health care expenses.

c. **Primary Plan/Secondary Plan**: The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

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

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

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

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

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

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

2. **Order of Benefit Determination Rules**

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

a. The other Plan has rules coordinating its benefits with those of This Plan; and

b. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

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

a. Non-Dependent/Dependent - The benefits of the Plan which covers the Insured as an Employee, member or subscriber are determined before those of the Plan which covers the Insured as a Dependent; except that: if the Insured is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(1) Secondary to the Plan covering the Insured as a Dependent and

(2) Primary to the Plan covering the Insured as other than a Dependent (e.g. a retired Employee),

then the benefits of the Plan covering the Insured as a dependent are determined before those of the Plan covering that Insured Person as other than a Dependent.

b. Dependent Child/Parents Not Separated or Divorced - Except as stated in Paragraph 3 below, when This Plan and another Plan cover the same child as a dependent of different persons, called parents:

(1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

c. Dependent Child/Separated or Divorced - If two or more Plans cover an Insured as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with custody;

(3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall follow the order of benefit determination rules outlined in Paragraph 2.

e. Active/Inactive Employee - The benefits of a plan which covers an Insured as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Insured as a laid off or retired Employee. The same would hold true if an Insured is a Dependent of a person covered as a retiree and an

Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

f. Continuation Coverage - If an Insured whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   (1) First, the benefits of a Plan covering the Insured as an Employee, member or subscriber (or as that Insured);
   (2) Second, the benefits under the continuation coverage.

   If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

g. Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Insured for the shorter term.

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

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

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

a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

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

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

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

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

5. **Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. **Right to Recovery**

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

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

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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
Grievance Committee
P.O. Box 98100
Baton Rouge, LA 70898-9100

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

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

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

of this panel provider plan relative to the Insured.

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

PART IX. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by written notice delivered to the Policyholder stating when, not less than 60 days thereafter, such cancellation shall be effective. The Policyholder may cancel the Policy at any time by written notice delivered or mailed to Us, effective on receipt or on such later date as may be specified in the notice. 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 and 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.

Premiums: Premiums for coverage under the Policy are payable as described therein. Coverage for all Insureds covered under a Policyholder's coverage will terminate on the premium due date, subject to the Grace Period, if premiums on behalf of all of the Policyholder's Insureds are not submitted to the Administrator. Premiums may be changed by Us on any Policy Anniversary date or on any premium due date if We notify the Policyholder of the change at least 45 days before such premium due date. Premium rates will not increase in the Initial Term of coverage and not more than once in a six month period thereafter. If premiums are payable on a basis other than monthly, and if a change occurs during a premium payment period which affects premiums, a pro rata charge or credit will be made for such change on the next closest premium due date. Premium adjustments may also be arrived upon by any other method agreeable to both the Policyholder and Us.

Grace Period: If the Policyholder does not pay in full any premium on or before its due date, the Policyholder will have a grace period in which to pay that premium. The Policy will remain in force during the grace period if premium is timely paid. If the premium is not paid in full before the grace period ends, the Policy will end on the premium due date for which premiums were not paid. On the date the Policy ends, the Policyholder must pay all premiums then due.

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.

X. REPLACEMENT OF EXISTING COVERAGE

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

Waiting Period Credit. When We immediately take over an entire dental group from another carrier, those persons insured by the prior carrier's plan on the day immediately prior to the takeover effective date will receive waiting period credit for the number of continuous uninterrupted months of coverage they had under the prior carrier, if they are eligible for coverage on the effective date of Our plan. The waiting period credit does not apply to new Employees, dependent add-ons, or Late Entrants, or Re-enrollees.

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

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

Maximum Benefit Credit. All paid benefits applied to the maximum benefit amounts under the prior plan will also be applied to the maximum benefit amounts under this Certificate.

If You had orthodontic coverage for Your covered dependent children under the Policyholder's prior plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

a. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the prior plan;
b. orthodontic treatment was started and bands or appliances were inserted while insured under the prior plan; and
c. orthodontic treatment is continued while Your covered dependent is insured under this Certificate.

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

Verification. The 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 Policyholder's previous plan.

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

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

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

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

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

XI. SCHEDULE OF COVERED PROCEDURES

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

Key for Schedule of Covered Procedures

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

¶ Limitations

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 12 films per 36 months
(d) Limited to Dependent Children under age 19
(e) Maximum of 1 procedure per 12 months
(f) Limited to Dependent Children under age 14
(g) Limited to Dependent Children under age 12
(h) Maximum of 1 procedure per 24 months
(j) Applications made to permanent molar teeth only
(k) Maximum of 2 procedures per arch per 24 months
(l) Maximum of 1 per 5 year period per tooth
(m) Maximum of 1 each quadrant per 12 months
(n) Maximum of 1 each quadrant per 24 months
(o) Maximum of 1 each tooth per 24 months
(p) Subject to a yearly and a lifetime maximum
(q) Maximum of 1 each quadrant per 36 months
(r) Replacement of existing only if in place for 12 months (insured under age 19)
(s) Replace existing only if in place for 36 months(insured over age 19)
(t) Benefits will be based on the benefit for the corresponding non-cosmetic restoration.
(u) Maximum 1 time per tooth
(v) Maximum of 1 per lifetime
(w) Only in conjunction with listed complex oral surgery procedures and subject to review.
(x) Limited to Dependent Children under age 16
(y) Maximum of 1 per 24 months for age 17+
(z) Maximum of 1 per 12 months for age 16 & under
(aa) Limited to those age 25+
(bb) 6 months must have passed since initial placement
(cc) Maximum of 1 per 7 year period
(dd) Maximum of 1 per 10 year period

Procedures	Procedure Class*	Waiting Period§	¶Limitation
Comprehensive Oral Exam or	A	(i)	(a)
Periodic Oral Exam	A	(i)	(a)
Problem Focused Exam	B	(i)	(e)
Emergency Palliative Treatment	A	(i)	(e)
Single Film	A	(i)	
Additional Films	A	(i)	
Intra-Oral Occlusal Film	A	(i)	
Panoramic Film, or	A	(i)	(h)

Procedures	Procedure Class*	Waiting Period§	¶Limitation
Full Mouth X-Ray	A	(i)	(h)
Bitewing – Single Film, or	A	(i)	(y) (z)
Bitewing – Two Films, or	A	(i)	(y) (z)
Bitewing – Four Films	A	(i)	(y) (z)
Prophylaxis	A	(i)	(a)
Topical Application of Fluoride	A	(i)	(e) (x)
Sealant	B	(i)	(b) (x) (j)
Space Maintainer – Fixed Unilateral	B	(i)	(x) (o)
Space Maintainer – Fixed Bilateral	B	(i)	(x) (o)
Space Maintainer – Removable Unilateral	B	(i)	(x) (o)
Space Maintainer – Removable Bilateral	B	(i)	(x) (o)
FILLINGS			
One Surface Amalgam	B	(i)	(r) (s)
Two Surface Amalgam	B	(i)	(r) (s)
Three Surface Amalgam	B	(i)	(r) (s)
Four + Surface Amalgam	B	(i)	(r) (s)
One Surface Resin – Anterior	B	(i)	(r) (s)
Two Surface Resin – Anterior	B	(i)	(r) (s)
Three Surface Resin – Anterior	B	(i)	(r) (s)
Four + Surface or Incisal Resin – Anterior	B	(i)	(r) (s)
Sedative Fillings	B	(i)	(o)
ORAL SURGERY			
Extraction, erupted tooth or exposed root	B	(i)	
Coronal Remnants	B	(i)	
Surgical Extraction	B	(i)	
Impacted (soft tissue)	B	(i)	
Impacted (partial bony)	B	(i)	
Impacted (complete bony)	B	(i)	
Surgical Removal of Root	B	(i)	
Alveolectomy (with extraction) – per quadrant	B	(i)	
Alveolectomy (without extraction) – per quadrant	B	(i)	
Incision and Drainage of Abscess – Intraoral	B	(i)	
General Anesthesia/Intravenous Sedation	B	(i)	(w)
CROWN AND BRIDGE REPAIR			
Inlay Recementation	B	(i)	(bb)
Crown Recementation	B	(i)	(bb)
Bridge Repair	B	(i)	(bb)
Crown Repair	B	(i)	(bb)
Bridge Recementation	B	(i)	(bb)
DENTURE REPAIR			
Repair Denture Base	B	(i)	(e) (bb)
Repair Teeth – per tooth	B	(i)	(e) (bb)
Repair Partial Base	B	(i)	(e) (bb)
Repair Partial Framework	B	(i)	(e) (bb)
Repair Broken Clasp	B	(i)	(e) (bb)
Add Tooth to Existing Partial Denture	B	(i)	(e) (bb)
Add Clasp to Existing Partial Denture	B	(i)	(e) (bb)
Replace Teeth – per tooth	B	(i)	(e) (bb)
Reline Upper Denture	B	(i)	(h) (bb)
Reline Lower Partial Denture	B	(i)	(h) (bb)
Reline Upper Denture (Lab)	B	(i)	(h) (bb)
Reline Lower Denture (Lab)	B	(i)	(h) (bb)
Reline Upper Partial Denture (Lab)	B	(i)	(h) (bb)

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

Procedures	Procedure Class*	Waiting Period§	¶Limitation
BRIDGE (continued)			
Crown Resin with Noble Metal	C	(iii)	(l) (t)
Crown Resin with Predominantly Base Metal	C	(iii)	(l) (t)
Crown Porcelain / Ceramic; Porcelain Fused to High Noble Metal	C	(iii)	(l) (t)
Crown Porcelain Fused to Noble / High Noble Metal	C	(iii)	(l) (t)
Crown Porcelain Fused to Predominantly Base Metal	C	(iii)	(l) (t)
Crown Porcelain Fused to Noble Metal; Full Cast High Noble Metal	C	(iii)	(l)
Crown ¾ Cast High Noble Metal	C	(iii)	(l)
Crown Full Cast Noble Metal	C	(iii)	(l)
Crown Full Cast Predominantly Base Metal	C	(iii)	(l)
Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	C	(iii)	(l)
Core Build-up for Retainer, (including any pins)	C	(iii)	(l)
Core Build-up (including any pins	C	(iii)	(l)
Inlay	C	(iii)	(l)
Onlay	C	(iii)	(l)
Veneers – excluding cosmetic; restorative only	C	(iii)	(l)
DENTURES			
Complete Upper Denture	C	(iii)	(l)
Complete Lower Denture	C	(iii)	(l)
Immediate Upper Denture	C	(iii)	(l)
Immediate Lower Denture	C	(iii)	(l)
Upper Partial – Resin Base	C	(iii)	(l)
Lower Partial – Resin Base	C	(iii)	(l)
Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	C	(iii)	(l)
Core Build-up for Retainer, (including any pins)	C	(iii)	(l)
Core Build-up (including any pins)	C	(iii)	(l)
Inlay	C	(iii)	(l)
Onlay	C	(iii)	(l)
Veneers – excluding cosmetic; restorative only	C	(iii)	(l)
Upper Partial – Cast Metal Base	C	(iii)	(l)
Lower Partial – Cast Metal Base	C	(iii)	(l)
Removable Unilateral Partial Denture	C	(iii)	(l)
Denture Adjustment – Upper	C	(iii)	(a) (bb)
Denture Adjustment – Lower	C	(iii)	(a) (bb)
Partial Adjustment – Upper	C	(iii)	(a) (bb)
Partial Adjustment – Lower	C	(iii)	(a) (bb)
ORTHODONTIA *			
Initial Orthodontic Examination	D	(iii)	(d) (p)
Initial Placement of Braces or Appliances	D	(iii)	(d) (p)
Continuing Treatment for Braces or Appliances	D	(iii)	(d) (p)

*** Orthodontic Dental Services**

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

We will pay the co-insurance percentage amount shown in the Schedule after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each covered dependent child, while insured under the policy, for orthodontic services is shown in the Schedule. Those who receive orthodontic coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

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

1. We will determine the lesser of the Reasonable and Customary charge and the orthodontist's fee and multiply that amount by the co-insurance rate shown in the Schedule.
2. The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule will be the maximum benefit payable. An initial amount of 25% of the maximum benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.
3. The remaining 75% of the maximum benefit payable will be divided by the number of quarters that orthodontic treatment will continue to determine the amount which will be payable for each subsequent quarter of orthodontic treatment. The subsequent quarterly payments will be made only if Your dependent remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the maximum benefit payable has been paid, no further benefits will be paid.

PART XII. SCHEDULE OF BENEFITS

Policyholder:	East Baton Rouge Parish Schools
Policyholder's Address:	1050 South Foster Drive Baton Rouge, LA 70806
Effective Date:	January 1, 2006
Initial Term:	12 Months
Eligible Classes:	ALL FULL TIME EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK AFTER COMPLETING 1 MONTH OF SERVICE
Mode of Premium Payment:	MONTHLY
Certificate Year:	Your Certificate Year is on a Calendar Year Plan.
Deductible:	$50 per Insured Person per Certificate Year. Maximum per family: 3 Applies to Classes: B, C
Co-Pay:	0
Certificate Year Maximum Benefit:	Per Insured Person

Year 1	Year 2	Year 3 & Forward
$1,100	$1,100	$1,100

Waiting Periods	See schedule of covered procedures
ORTHODONTIA (CLASS D)	
In addition to Maximum Annual Benefit	No
Coverage Applies to	Dependent Children to Age 19 Only

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

	Coinsurance	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	100%	Yes	None/None
Class B	80%	Yes	None/None
Class C	50%	Yes	None/None
Class D	50%	Yes	$500/$1,000

*Class C and D covered following six month waiting period

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

	Coinsurance	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	100%	Yes	None/None
Class B	80%	Yes	None/None
Class C	50%	Yes	None/None
Class D	50%	Yes	$500/$1,000

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

	Coinsurance	Subject to Certificate Year Max Benefit	Maximum Annual/Lifetime Benefit
Class A	100%	Yes	None/None
Class B	80%	Yes	None/None
Class C	50%	Yes	None/None
Class D	50%	Yes	$500/$1,000

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

Covered Dental Expenses: √ Lesser of Dentist's actual charge or Usual, Customary or Reason ("UCR") Charge

□ Lesser of Dentist's actual charge or appropriate Fee Schedule amount

√ Lesser of Dentist's actual charge or Contracting Providers Program Maximum Allowed charge

STARMOUNT LIFE INSURANCE COMPANY PRIVACY NOTICE
January 2003

WE CARE ABOUT YOUR PRIVACY!

In compliance with Gramm-Leach-Bliley (GLB), this describes the privacy policy and practices followed by Starmount Life Insurance Co. ("Starmount").

Your privacy is a high priority for us and it will be treated with the highest degree of confidentiality. In order to provide insurance and services, we collect certain information. However, we are committed to maintaining the privacy of this information in accordance with law. Individuals with access to personal information about customers or former customers are required to follow this policy.

NON-PUBLIC INFORMATION COLLECTED.

- Information we receive from you on insurance and annuity applications, claim forms or other forms such as your name, address, date and location of birth, marital status, sex, social security number, medical information, beneficiary information, etc.
- Information about your transactions with us, our affiliates or others such as premium payment history, tax information, investment information, and accounting information; and
- Information we receive from consumer reporting agencies, such as your credit history.

NON-PUBLIC INFORMATION DISCLOSED.

- We may provide the non-public information we collect to affiliated or nonaffiliated persons or entities involved in the underwriting, processing, servicing and marketing of your Starmount insurance products. We will not provide this information to any other nonaffiliated third party unless we have a written agreement that requires such third party to protect the confidentiality of this information.
- We may have to provide the above described non-public information to authorized persons or entities to comply with a subpoena or summons by government authorities and to respond to judicial process or regulatory authorities having jurisdiction over our company for examination, compliance or other purposes as required by law.
- We do not disclose non-public personal information about customers or former customers to anyone except as permitted or required by law.

CONFIDENTIALITY AND SECURITY OF YOUR NON-PUBLIC PERSONAL INFORMATION.

- We restrict access of non-public personal information about you to only those who need to know that information to underwrite, process, service or market Starmount insurance and services.
- We maintain physical, electronic, and procedural safeguards that comply with government standards to guard non-public personal information.
- If we become aware that an item of personal information may be materially inaccurate, we will make a reasonable effort to re-verify its accuracy and correct any error as appropriate.
- If you prefer we not disclose nonpublic personal information about you to nonaffiliated third parties, write us at the address below.

INFORMATION ABOUT FORMER CUSTOMERS.

Non-public information about our former Clients is maintained by Starmount on a confidential and secure basis. If any such disclosure is made, it would be for reasons and under the conditions described in this notice. We do not disclose any non-public personal information about our former customers to anyone except as permitted or required by law.

FOR QUESTIONS, write E. Sternberg at: Starmount Life Insurance Co., 7800 Office Park Blvd., Baton Rouge, LA 70809; or e-mail erich@starmountlife.com.

Starmount Life Insurance Company, Inc.
Starmount Financial Corporation, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Starmount Life Insurance Company, Inc. and Starmount Financial Corporation, Inc. (collectively "Starmount") are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How Starmount May Use or Disclose Your Health Information

1. Payment Functions. Starmount may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. Health Care Operations. Starmount may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. Required by Law. As required by law, Starmount may use and disclose your health information. Starmount may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. Public Health. As required by law, Starmount may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. Coroners, Medical Examiners and Funeral Directors. Starmount may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. Organ and Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. Health and Safety. Starmount may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. Government Functions. Starmount may disclose your health information for military, national security, prisoner and government benefits purposes.

9. Worker's Compensation. Starmount may disclose your health information as necessary to comply with worker's compensation or similar laws.

10. Disclosures to Plan Sponsors. Starmount may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When Starmount May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Starmount will not use or disclose your health information without written authorization from you. If you do authorize Starmount to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. Starmount is not required to agree to the restrictions that you request.

2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. Starmount is not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, Starmount may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that Starmount amend your health information. Starmount is not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. Starmount will provide one list per 12 month period free of charge; Starmount may charge you for additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

Starmount's Obligations Under This Notice

Starmount is required by law to:

1. Maintain the privacy of your health information.

2. Provide you with a notice of its legal duties and privacy practices with respect to your health information.

3. Abide by the terms of this Notice.

4. Notify you if Starmount is unable to agree to a requested restriction on how your information is used or disclosed.

5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

Starmount reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that Starmount maintains. Revised Notices will be distributed to you by mail.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Starmount Financial Corporation, Inc.
7800 Office Park Boulevard
Baton Rouge, LA 70809

You may also file a complaint with the Secretary of the Department of Health and Human Services. Starmount will not retaliate against you in any way for filing a complaint.

Effective Date of This Notice: April 14, 2003.

Starmount Life Insurance Company

FIRST NOTICE OF COBRA

VERY IMPORTANT NOTICE

A Federal law, usually called COBRA, requires that most employers sponsoring group dental and vision plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. [Both you and your spouse should take the time to read this notice carefully.]

You have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of employment (for reasons other than gross misconduct on your part), or because your employer files for reorganization under Chapter XI of the Bankruptcy Law while you are retired.

If you are the spouse of an employee covered by this employer, you have the right to choose continuation coverage for yourself if you lose your group health coverage for any of the following five reasons:

(1) The death of your spouse;

(2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

(3) Divorce or legal separation from your spouse;

(4) Your spouse becomes entitled to Medicare; or

(5) Your spouse's employer files for reorganization under Chapter XI of the Bankruptcy Law while your spouse is retired.

In the case of a dependent child of an employee covered by the plan, he or she has the right to continuation coverage if group health coverage is lost for any of the following six reasons:

(1) The death of a parent;

(2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with [Name of Employer];

(3) Parents' divorce or legal separation;

(4) A parent becomes entitled to Medicare;

(5) The dependent ceases to be a "dependent child" under [Name of Group Health Plan]; or

(6) The parent's employer files for reorganization under Chapter XI of the Bankruptcy Law while the parent is retired.

Under COBRA, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the happening of any such event. If notice is not received within that 60 day period, the dependent will not be entitled to choose continuation coverage. The employer has the responsibility to notify Starmount Life Insurance Company of the employee's death, termination of employment, or reduction in hours or Medicare entitlement.

When the employer is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have at least 60 days from the date you would lose coverage, because of one of the events described above, to inform the employer that you want continuation coverage.

If you do not choose continuation coverage, your group dental and vision insurance coverage will end.

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for 3 years unless you lost your group health coverage because of a termination of employment or reduction of hours. In that case, the required continuation coverage period is 18 months. If, during that 18-month period, another event takes place that would also entitle a dependent spouse or child (other than a spouse or child who became covered after continuation coverage became effective) to his or her own continuation coverage, (for example, the former employee dies, is divorced or legally separated, or be entitled to Medicare, or a dependent ceases to be a "dependent child" under the dental and vision plan the continuation coverage may be extended. However, in no case will any period of continuation coverage be more than 36 months.

If you are entitled to 18 months of continuation coverage, and if you are determined to be disabled under the terms of the Social Security Act as of the date your employment terminated (or the date your hours, were reduced), you are eligible for an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the employer within 60 days after you receive a determination of disability from the Social Security Administration, provided notice is given before the end of the initial 18 months of continuation coverage. During the additional 11 months of continuation coverage, your premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

However, the new law also provides that your continuation coverage may be cut short for any of the following four reasons:

(1) The employer no longer provides group dental and/or vision coverage to any of its employees;

(2) The premium for your continuation coverage is not paid in a timely fashion;

(3) You become covered under another group health plan, unless that other plan contains an exclusion or limitation with respect to any pre-existing condition affecting you or a covered dependent; or

(4) You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you may have to pay all or part of the premium for your continuation coverage. You will have an initial grace period of 45 days starting with the date you choose continuation coverage to pay any premiums; and after that initial 45 day grace period, you will have a grace period of [at least 30] days to pay any subsequent premiums. [COBRA also says that, at the end of the 18 month, 29 month or 3 year continuation coverage period, you must be allowed to enroll in any individual conversion health plan which may be provided under the plan.

If you have any questions about COBRA, please contact the employer. Also, if you have changed marital status, if a dependent ceases to be a "dependent child" under the plan, or if you or your spouse have a changed address, please notify the employer.