



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

**GROUP DENTAL INSURANCE CERTIFICATE**

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

Administrator: Group Dental Service, Inc  
111 Rockville Pike, Suite 950  
P.O. Box 10949  
Rockville, MD 20849

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.

**Sherri Kliczak, Secretary**

**John Larson, President**

**NEED ASSISTANCE?** If you have a question or wish to obtain information about Your coverage, or You require assistance in resolving a complaint, please contact us at 1-888-729-5433.

**DISPUTE RESOLUTION: SHOULD A DISPUTE ARISE CONCERNING THIS POLICY OR THE PAYMENT OF A CLAIM HEREUNDER, CONTACT US IN WRITING AT GROUP DENTAL SERVICE, INC., 111 ROCKVILLE PIKE, SUITE 950, ROCKVILLE, MD 20850 OR BY PHONE AT 1-866-910-0849. IF A DISPUTE IS NOT RESOLVED TO YOUR SATISFACTION, YOU MAY CONTACT THE CONSUMER SERVICES DIVISION OF THE CALIFORNIA DEPARTMENT OF INSURANCE AT 300 S. SPRING STREET, LOS ANGELES, CA 90013 OR BY PHONE AT 1-800-927-HELP (1-800-927-4357).**

**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.

**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 for necessary dental treatment to an Insured while His coverage under this Certificate is in force. 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.)

**Domestic Partners** are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.

A **Domestic Partnership** shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to California Family Code, Division 2.5, and, at the time of filing, all of the following requirements are met:

- (1) Both persons have a common residence.
- (2) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
- (3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
- (4) Both persons are at least 18 years of age.
- (5) Either of the following:
  - (A) Both persons are members of the same sex.
  - (B) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
- (6) Both persons are capable of consenting to the domestic partnership.

For purposes of this definition, "have a common residence" means that both domestic partners share the same residence. It

is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

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

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

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

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

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

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

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

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

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

**Insured Member**– Means a person:

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

**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. The "customary charge" will be determined from within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area.
2. **Participating Provider Maximum Allowable Charge (PMAC):** The PMAC may be used if a dentist who is a Participating Provider performs a Covered Procedure. This is the amount that the dentist has agreed with Us to accept as payment in full for a dental service or supply.

3. **Scheduled Fee (SF):** Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. The maximum charge for each Covered Procedure, regardless of the fee charged by the dentist, is shown in the fee schedule.

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

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

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

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

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

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

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

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

The list will be periodically updated.

**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.

**You or Your** – The Insured Member.

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

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

### **A. ELIGIBILITY**

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

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

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

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

### **B. ENROLLMENT**

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

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Eligibility Period.

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 31 days of the event. A change in family status means any of the following events:

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

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

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

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

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, entering into a Domestic Partnership, birth or adoption, coverage is effective on 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 Adopted Children:** Newborn children are automatically covered under the terms of the policy from the moment of birth. In the case of a newborn adopted child, coverage begins at the moment of birth if You have entered into a written agreement to adopt the child prior to the birth of the child, whether or not the agreement is enforceable. Adopted children, foster children and children in Your court-ordered temporary or other custody are covered from the date of Placement. Coverage for such children will be in effect until the 61st day following the date of birth or Placement, as the case may be. If You desire uninterrupted coverage for such children, You must notify Us within 60 days of the child’s birth or the date of Placement. If timely notice is given within this 60-day period, We may not charge an additional premium for such coverage for the duration of the 60-day notice period. If timely notice is not given, We may charge an additional premium from the date of birth or the date of Placement. In either case, We may not deny coverage for a child due to Your failure to send us timely notice.

For purposes of this provision, “Placement” means: (1) your assumption of the physical custody of an adopted, foster or step child and the financial responsibility for the support and care of such child; (2) your assumption of a child placed in your custody pursuant to an interlocutory decree vesting temporary care of the child to you; or (3) your assumption of a child placed in your custody during the pendency of an adoption proceeding, whether or not a final decree of adoption is ultimately issued.

### **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 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.

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

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a 12 month period. 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**

Benefits are payable under the policy if an Insured incurs expenses for a Covered Procedure, subject to 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.
2. Each Covered Procedure may be subject to specific Limitations, as shown on the Schedule of Covered Procedures.
3. A Certificate Year Maximum Annual Benefit may apply to each Insured. This is shown on the Schedule of Benefits.
4. A Maximum Annual and/or Maximum Lifetime Benefit may apply to each Procedure Class. If applicable, these maximums are shown in the Table of Covered Insurance Percentages on the Schedule of Benefits.
5. Other limitations and exclusions that may affect coverage are shown in the "Limitations and Exclusions" provision.

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

1. We consider a dental treatment to be started as follows:

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

2. We consider a dental treatment to be completed as follows:
  - a. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
  - b. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
  - c. for root canal therapy, the date a canal is permanently filled.

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

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

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

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

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

### **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. **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 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 Members have been covered under the plan for (3) three continuous years unless it is a replacement of an existing unserviceable prosthesis.
2. **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.

### 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 days after an Insured's insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations;
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 crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
10. appliances, services or procedures relating to: (a) the change or maintenance of vertical dimension; (b) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (c) splinting; (d) correction of attrition, abrasion, erosion or abfraction; (e) bite registration or (f) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal

- deficiencies involving TMJ or related structures, myofascial pain;
- 12. orthognathic surgery;
- 13. prescribed drugs, premedication or analgesia;
- 14. any instruction for diet, plaque control and oral hygiene;
- 15. any loss caused by a declared or undeclared war or any act of war;
- 16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
- 17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
- 18. for treatment of malignancies, cysts and neoplasms;
- 19. for orthodontic treatment;
- 20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
- 21. 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. 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;
- 23. procedures started but not completed;
- 24. any duplicate device or appliance;
- 25. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures, plus the services of anesthesiologists or anesthesiologists;
- 26. the replacement of 3<sup>rd</sup> molars;
- 27. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

## PART VIII. CLAIM PROVISIONS

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

National Guardian Life Insurance Company  
 c/o Group Dental Service, Inc – Claims Department  
 P.O. Box 10949  
 Rockville, MD 20849

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

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

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

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

**Time of Payment Of Claims:** After receiving written proof of loss and premium payment, We will pay all benefits then

due for dental claims. We will pay all claims or any portion of any claims within 45 days, or as required by Your state, after receipt of the Claim. If a claim or a portion of a claim is contested by Us, the Insured or their assignee shall be notified in writing, that the claim is contested or denied, within 45 days after receipt of the Claim by us. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested from the Insured or their assignee, We shall pay or deny the contested claim or portion of the contested claim, within 60 days. We shall not pay or deny any claim later than 120 days after receiving the claim. We will, upon request, provide to the Insured an estimate of the amount We will pay for a particular dental service.

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

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

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

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

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

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

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

### **B. BENEFIT COORDINATION**

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

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

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

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
  - a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.
  - b. **Dependent Child/Parents Not Separated or Divorced.** For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.
  - c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
    - i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
    - ii. The Plan of the parent with custody of the child;
    - iii. The Plan of the spouse of the parent with custody; and
    - iv. The Plan of the parent without custody of the child.
  - d. **Dependent Child/Joint Custody:** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
  - e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
  - f. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

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

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

**E. Right to Make Payments To Another Plan**

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

**F. Right to Recovery**

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

## **PART X. GRIEVANCE PROCEDURE**

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

**National Guardian Life Insurance Company  
c/o Group Dental Service, Inc.  
Grievance Committee  
111 Rockville Pike, Suite 950  
P.O. Box 10949  
Rockville, MD 20849**

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 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 five (5) years from the time written proof of loss is required to be furnished.

## PART XII. 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

**Type of Maximum Reimbursement:**

- PMAC – Participating Provider Maximum Allowable Charge
- MAC – Maximum Allowable Charge (based on “Customary Charge”)

**¶ Limitations**

- (a) Maximum of 2 procedures per year
- (b) Maximum of 1 set per year
- (c) Maximum of 1 filling per year

Covered Procedures	Procedure Class*	Waiting Period Months	Limitation	Maximum Reimbursement	
				In-Network PMAC	Out-of-Network MAC
Periodic Oral Exam	A	0	(a)	PMAC 100%	MAC 100%
Bitewing – Two Films	A	0	(b)	PMAC 100%	MAC 100%
Prophylaxis	A	0	(a)	PMAC 100%	MAC 100%
<b>FILLINGS</b>					
One Surface Resin Based Composite – Posterior	B	0	(c)	PMAC 100%	MAC 100%

**PART XIII. SCHEDULE OF BENEFITS**

**Insured:** Members of the National Congress of Employees and their Dependents

**Policyholder:** National Congress of Employees

**Policyholder's Address:** 1001 Pennsylvania Ave, 6<sup>th</sup> Floor  
Washington, D.C. 20004

**Effective Date:** March 1, 2009

**Initial Term:** 12 Months

**Eligible Classes:** ACTIVE DUES PAYING MEMBERS OF THE NATIONAL CONGRESS OF EMPLOYEES ASSOCIATION (NCE)

**Eligibility Period:** 1<sup>ST</sup> day they become active members of the Association

**Mode of Premium Payment:** MONTHLY

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

**Certificate Year:** Your Certificate Year is on a Calendar Year Plan

**Deductible:** In-Network \$0 Individual Deductible.  
Out-of-Network \$0 Individual Deductible.

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

**Certificate Year Maximum Annual Benefit:**

Per Insured			
In-Network			
<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 &amp; Forward</u>	
\$500	\$500	\$500	
Out-of- Network			
<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 &amp; Forward</u>	
\$500	\$500	\$500	

**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	\$500
Class B	100%	100%	Yes	\$500

**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	\$500
Class B	100%	100%	Yes	\$500

**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	\$500
Class B	100%	100%	Yes	\$500

Plan Type:   Participating Provider Program:  
 In and Out-of-Network Benefits