



## NATIONAL GUARDIAN LIFE INSURANCE COMPANY

### 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**

### NON-PARTICIPATING

**NOTICE TO BUYER: THIS POLICY PROVIDES LIMITED BENEFITS ONLY. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. SUPPLEMENTAL DENTAL ONLY.**

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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: (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:

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

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

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

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

1. Your spouse or lawful Domestic Partner;
2. Your unmarried dependent child who is less than 26 years of age, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is a resident of New Hampshire or is enrolled as a student at a public or private institution of higher education, and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S.C. 1395 et seq.
3. Your unmarried child who has reached age 26 and who is who is mentally or physically incapable of earning his or her own living on the date on which such child attains the limiting age and would otherwise lose their coverage, will continue to be covered under this policy while it remains in force. Coverage will continue for as long as such incapacity continues and for as long as said child remains chiefly financially dependent on You.

If Your covered dependent child is a full-time students, as defined by the appropriate educational institution, beyond the age of 18, such dependent's coverage will include coverage for a dependent's medically necessary leave of absence from school for a period not to exceed 12 months or the date on which coverage would otherwise end pursuant to the terms and conditions of the Policy, whichever comes first. Any breaks in the school semester will not disqualify the dependent child from coverage. Documentation and certification of the medical necessity of a leave of absence will be submitted to Us by the student's attending physician and will be considered prima facie evidence of entitlement to coverage under the Policy. The date of the documentation and certification of the medical necessity of a leave of absence will be the date the insurance coverage under the Policy commences.

Except in the case of a mentally or physically incapable dependent child, insurance of any dependent child will terminate on the policy anniversary date following the end of the month of the child's 26<sup>th</sup> birthday, or the child's marriage, whichever occurs first. Termination will be without prejudice to any claim originating prior hereto. In the case of a dependent child who is mentally or physically incapable of earning his or her own living and who remains dependent on You at the time he or she attains the limiting age, You must furnish proof of such incapacity and dependency to Us within 31 days of the dependent child's attainment of the limiting age. At Our request, You must furnish proof of loss of continued incapacity and dependency, but not more often than annually after the two-year period following the end of the month of the child's attainment of the limiting age.

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

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

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

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

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

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

Newborn Coverage: Any child born to You or Your Covered Dependent spouse or Domestic Partner is covered from the moment of birth to 31 days or until released from the hospital. A notice of birth, together with any 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: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 31 days of the placement in order to continue the coverage beyond the initial 31-day period.

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

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

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

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

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

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

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

The benefit is subject to the following:

1. The Covered Procedure must start and be completed while the Insured's coverage is in force, except as provided in the Takeover Benefits provision.
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. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
21. any procedure that does not offer a favorable prognosis or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured's household;
23. expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law;
24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the "Payment of Claims" provision;
25. procedures started but not completed;
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation, including the services of anesthetists or anesthesiologists, unless: the person requiring such services is a covered child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or hospital setting; or (b) is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.;
28. the replacement of 3<sup>rd</sup> molars;

29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

## PART VIII. CLAIM PROVISIONS

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

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 Us within 90 days after the date of such loss. Failure to furnish such proof within such time required will not invalidate nor reduce any claim if it is shown not to have reasonably possible to furnish such proof within such time and that such proof was furnished as soon as was reasonably possible.

**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:** Benefits will be paid within 30 calendar days of Our receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.

If We denying or pending the claim, We will have 15 calendar days upon receipt of an electronic claim or 30 days upon receipt of a non-electronic claim to notify the health care provider or You of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon Our receipt of the requested additional information, We will adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim will be treated as a clean claim and will be adjudicated in accordance with the above paragraph.

Payment of a claim will be considered to be made on the date a check is issued or electronically transferred. We will mail checks no later than 5 business days after the date a check was issued. Failure to mail a check within 5 business days will constitute a violation subject to enforcement in accordance with New Hampshire law.

Our failure to comply with the time limits in this provision will not have the effect of requiring coverage for an otherwise non-covered claim. This provision will only apply to payments made on a claims basis and will not apply to capitation or other forms of periodic payment.

For purposes of this provision:

"Clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements.

"Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the insurer and, if covered by the Health Insurance Portability and Accountability Act (HIPAA), is in such form and substance as to be in compliance with such act.

Any initial clean claim submission not paid within the time periods specified above will be deemed overdue. In that case:  
a. We will pay You or the health care provider the amount of the overdue claim plus an interest payment of 1.5 percent (1.5%) per month beginning from the date the payment was due; and

- b. The health care provider may recover from Us, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing the health care provider in a successful action against Us for payment of the claim.

Exceptions to the requirements of this provision are as follows:

- a. We will not be in violation of this provision for a claim submitted by a health care provider if:
  - (1) Failure to comply is caused by a directive from a court or a federal or state agency;
  - (2) We are in liquidation or rehabilitation or are operating in compliance with a court-ordered plan of rehabilitation;  
or
  - (3) Our compliance is rendered impossible due to matters beyond Our control which are not caused by Us.
- b. We will not be in violation of this provision for any claim submitted more than 90 days after the service was rendered.
- c. We will not be in violation of this provision while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process.

**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 an Insured has a complaint regarding coverage under the Policy, the Insured may contact Our Grievance Committee at:

**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**

The Insured may request, at his option, that the voluntary grievance procedures below be followed. The Insured may also request the assistance of the New Hampshire Insurance Department by calling its consumer services division at 1-800-852-3416, or 21 South Fruit Street, Suite 14, Concord, New Hampshire 03301.

1. **First – Level Grievance Review.** A grievance may be submitted by an Insured or his provider acting on the Insured's behalf.
  - a) An Insured may submit an appeal within 180 days upon receipt of an adverse determination. Within three business days after receiving a grievance, We shall provide the Insured with the name, address, and telephone number of the coordinator and information on how to submit written material.
  - b) The review will be a de novo proceeding and will consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the denial.
  - c) The person or persons reviewing the grievance will not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom will be a medical doctor with appropriate expertise to evaluate the matter.
  - d) If the purpose of the review is a claim denial that is based in whole or in part on a medical judgment:
    - (1) The review will be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;
    - (2) The titles and qualifying credentials of the person conducting the review will be included in the decision; and
    - (3) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, will be made available to the claimant upon request.
  - d) We will issue a written determination to the Insured and, if applicable, to the Insured's provider, within 15 days after receiving a grievance. This written determination will be written in clear terms and include:
    - (1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;
    - (2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to the claimant upon request;

- (3) A statement describing all other dispute resolution options available to the claimant, including, but not limited to other options for internal review and options for external review and options for bringing a legal action;
  - (4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
2. **Second – Level Grievance Review.** We shall establish a second-level grievance review process for Insureds who are dissatisfied with the first – level grievance review decision or a utilization review appeal decision.

We shall, within 10 business days after receiving a request for a second-level grievance review, make known to the Insured:

- a) The name, address, and telephone number of a person designated to coordinate the grievance review for Us.
  - b) A statement of an Insured's rights, which includes the right to request and receive from Us all information relevant to the case; submit supporting materials.
  - c) Second level grievance review will be conducted by a peer review organization designated to perform such reviews and contracted with medical specialists that specialize in the area to which the grievance is related.
3. **Second – Level Grievance Review Decisions.** We will issue a written decision to the Insured and, if applicable, to the Insured's provider, within five business days after completing the review. The written decision issued in a second-level grievance review will be written in clear terms and will include the reasons, policies and procedures that were the basis of the decision. It will also advise the Insured of all other dispute resolution options that are available, including any remedies allowed by law.
4. **Expedited Second – Level Procedures.** We will make an expedited second-level review available where medically justified, whether or not the initial review was expedited. The provisions of subsections 2., and 3. above apply to this subsection except for the following timetable: When an Insured is eligible for an expedited second-level review, We will conduct the review proceeding and communicate its decision within 72 hours after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchanges of written information.
5. **Expedited Review for Urgent Care Claim.** In the case of an expedited appeal related to an urgent care claim, We shall make a decision and notify the Insured as expeditiously as the Insured's medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to the Insured until the Insured has been notified of the determination. We shall provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.

The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed with Us, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event the claimant fails to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date the claimant is notified in writing of precisely what is required until the date the claimant responds to the request. We shall provide notification of incompleteness as soon as possible; but in no event more than 24 hours after the filing of the appeal in appeals involving urgent care. In the event that the claimant fails, within a 45-day period from the date of notification, to provide sufficient information, We may deny the appeal on the basis of incompleteness. The appeal may be reopened upon receipt of the required information.

6. **Right to Independent External Review.** An Insured will have the right to independent external review of a determination by a health carrier or its designee utilization review entity when all of the following conditions apply:
- a) The subject of the request for external review is an adverse determination.
  - b) The covered person has completed the internal review procedures outline above, or the carrier or other entity has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the carrier or other licensed entity within the required time frames.
  - c) (1) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the New Hampshire Commissioner of Insurance within 180 days of the date of the carrier or

other licensed entity's denial decision, or if the carrier or other licensed entity has failed to make a first or second level, standard or expedited review decision that is past due, within 180 days of the date the decision was due.

(2) The covered person's or covered person's authorized representative's participation in any voluntary level of appeal offered by a carrier or other licensed entity as outlined above will not affect a covered person's ability to submit a request for external review. In the event that a covered person or covered person's authorized representative elects to proceed with a voluntary appeal, that person shall have 180 days from the date the decision is rendered on the voluntary appeal to submit a request for external review.

- d) The covered person's cost for the service, supply or drug that is the subject of the adverse determination is, or is anticipated in a 12-month period to be, equal to or in excess of \$400.
- e) The health carrier determination does not relate to any category of health care services that is excluded from the external review by this provision.
- f) The request for external review is not based on a claim or allegation of provider malpractice, professional negligence, or other professional fault excluded from the external review provisions by this provision.

Determinations relating to the following health care services shall not be reviewed under the review procedures set forth in this provision, but will be reviewed pursuant to the review processes provided by applicable federal or state law:

- a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier.
- b) Health care services provided to inmates by the Department of Corrections.
- c) Health care services provided pursuant to a health plan not regulated by the state, such as self-funded plans administered by an administrative services organization or third-party administrator or federal employee benefit programs.

The external review procedures set forth in this provision may not be utilized to adjudicate claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers or medical directors.

## **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 three (3) years from the time written proof of loss is required to be furnished.

**Statements by the Insured:** We will consider any statement made by You to be a representation and not a warranty. No statement will be used to void the insurance, reduce benefits, or deny a claim unless such statement is in writing and signed by You and a copy of that statement is given to You.

**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