



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 coverage provided by this Certificate is governed by the laws of the State of Oklahoma.

RIGHT TO RETURN THIS CERTIFICATE WITHIN 30 DAYS OF RECEIPT

Carefully read this Certificate as soon as You receive it. If You are not satisfied for any reason, You may return it to Us, or Our authorized agent, within thirty (30) days after You receive it. We will immediately refund all of the premiums paid in full. If We fail to refund all of the premiums paid within thirty (30) days from the date of cancellation, We will pay interest on the amount to be refunded. Such interest will be paid at the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year plus two (2) percentage points. Such interest will accrue from the date of cancellation until the date on which the refund is paid to You.

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

Sherri Kliczak, Secretary

John Larson, President

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

CERTIFICATE IS ALWAYS ATTACHED TO THE POLICY

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: (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.

Domestic Partner - means two people in a relationship that satisfy the following. Both persons:

1. Are at least eighteen (18) years of age;
2. Share a close personal relationship and are responsible for each other's common welfare;
3. Are each other's sole Domestic Partner;
4. Are not married to anyone nor have had another Domestic Partner within the prior six months;
5. Are not related by blood;
6. Have jointly shared the same regular and permanent residence for at least six (6) months; and
7. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household."

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 under age 21, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian.
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
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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 and Adopted Children: Newborn children are automatically covered under the terms of the policy from the moment of birth, and adopted children or a child placed with You, regardless of the age at which the child is adopted or placed, are covered from the date of placement. Coverage for newborn and adopted child will last for 31 days beginning with the date of birth or date of placement as the case may be.

Upon notification of birth or adoption, We will advise You of the additional premium due, if any. If premium is due, and you wish coverage to continue beyond the initial 31-day period, We must receive the additional premium amount during the initial 31-day period. If You wish any other person to be covered after the effective date of the policy, You must apply for such coverage, and that person must be added by endorsement. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

For purposes of this provision:

1. "Placement" means the assumption by You of the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child.
2. A child who is in Your custody, pursuant to an interlocutory decree issued under Section 7505-6.1 of Title 10 of the Oklahoma Statutes vesting temporary care of the child in You, is an adopted child during the pendency of the 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.

Extension of Benefits: Termination of Your coverage under the Policy, will be without prejudice to any claim for continuous loss that commenced while such coverage was in force; however, the payment of benefits after the termination date will be predicated upon continuing loss for which benefits were payable prior to such termination date and limited to the duration of the benefit period or the payment of the maximum benefits payable for such loss.

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 during this 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.

This limitation does not apply to adopted children or for the continuation of benefits.

- 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 (This exclusion does not apply to adopted children or for the continuation of benefits.);
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 while serving in the military service or any auxiliary unit attached to the military or working in an area of war whether voluntary or as required by an employer;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);

18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
21. any procedure We determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured's household;
23. expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage);
24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the "Payment of Claims" provision;
25. procedures started but not completed (This exclusion does not apply to adopted children or for the continuation of benefits.);
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures, plus the services of anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

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

National Guardian Life Insurance Company
c/o Group Dental Service, Inc. – Claims Department
111 Rockville Pike, Suite 950
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 in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one (1) year from the time of proof is otherwise required.

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 45 days of the date on which We receive proper proof of loss. If We require additional information to determine whether to approve or deny the claim, We will notify You of the additional information within 30 days after We receive Your claim. We will then either approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, We will pay the claim within 45 days after We receive the additional information.

If We fail to pay the claim within the required 45-day time period: (1) the value of the final settlement will bear interest at the rate of ten percent (10%) per annum from and after the expiration of the 45-day period; and (2) You will be entitled to be reimbursed for any reasonable attorney's fees incurred by You in connection with this claim. If We reimburse you for reasonable attorney fees, no part of such reimbursement will be charged against benefits otherwise due You.

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. In the absence of fraud, this right will be limited to a period not to exceed 24 months following the date of any overpayment made by Us.

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.

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

Time Limit on Certain Defenses: After two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application will be used to void the coverage or to deny a claim for a loss commencing after the expiration of such two-year period.

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 (see the provision Extension of Benefits in Part IV).

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

PART XII. 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	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%
FILLINGS					
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, 6th 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: 1ST 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 & Forward</u>	
\$500	\$500	\$500	
Out-of- Network			
<u>Year 1</u>	<u>Year 2</u>	<u>Year 3 & Forward</u>	
\$500	\$500	\$500	

Waiting Periods See Schedule of Covered Procedures

