Paulus Sokolowski & Sartor, LLC

Your Dental Plan

Policy No. 942923 022

Underwritten by Starmount Life Insurance Company

9/21/2023

Starmount Life Insurance Company
8485 Goodwood Blvd.
Baton Rouge, LA 70806

Group Dental Insurance Certificate of Coverage

We welcome you as a customer and are committed to providing quality service. This is your certificate of coverage and describes the benefits to which you are entitled as an Insured. Dental insurance coverage can help ease the costs associated with routine and unforeseen dental procedures.

Policyholder: Paulus Sokolowski & Sartor, LLC

Policy Number: 942923 022

Policy Effective Date: November 1, 2023

Policy Anniversary: November 1

Governing Jurisdiction: New Jersey

This certificate is issued to you under the policy which is a contract between us and the Policyholder. If the provisions of this certificate are different from the provisions of the policy, the provisions of the policy will govern. A copy of the policy provisions may be made available to you upon request. The policy is delivered in and is governed by the laws of New Jersey and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This certificate provides benefits under the non-participating policy. This certificate contains proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate. Please read your certificate carefully and keep it in a safe place.

Defined terms, provision titles, and section headings have been capitalized.

If you have any questions about the provisions of this certificate, please contact your Employer, or you may contact us at (888) 400-9304 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

If you still have questions, you may contact the New Jersey Department of Banking and Insurance at (800) 446-7467.

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

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This section contains provisions which highlight the requirements an Insured must satisfy in order to receive benefits. Refer to the Schedule of Covered Procedures to determine class of service for Covered Procedures.

Coverage Type Preferred Provider Organization (PPO) plan.

Eligible Group(s)

Owners Low Plan Dental in Active Employment in the United States working a minimum of 30 hours per week.

All Eligible Full-Time Employees Low Plan Dental in Active Employment in the United States working a minimum of 30 hours per week.

Owners Low Plan Dental

Paying for Coverage *Non-Contributory Coverage*
Your Employer must make premium contributions for your coverage.

All Eligible Full-Time Employees Low Plan Dental

Paying for Coverage *Contributory Coverage*
You and your Employer must make premium contributions for your coverage.

Deductible The Deductible is the amount Insureds must pay each Policy Year before benefits will be payable for Basic and Major Covered Procedures. The Deductible is not applicable to Preventive Covered Procedures.

Deductibles applied for each Insured will count toward satisfying the Per Family Deductible. Once the Per Family Deductible is satisfied, no further Deductibles are required. Only Covered Procedures included in this certificate will count towards satisfying the Deductible.

Per Policy Year	Per Insured
	$50

Per Policy Year	Per Family
	3x

If an Insured visits an In-Network Provider, the Insured is responsible for paying the In-Network Deductible. If an Insured visits an Out-of-Network Provider, the Insured is responsible for paying the Out-of-Network Deductible.

Coinsurance Coinsurance is the percentage of the Reimbursement for Covered Procedures paid after any required Deductible has been satisfied. The percentages for which the Policy Pays and Insured Pays for a Covered Procedure are shown below.

Procedure Class	Policy Pays	Insured Pays
Preventive	100%	0%
Basic	80%	20%
Major	50%	50%

Benefit Waiting Period The Benefit Waiting Period is the period of time during which Insureds must have continuous coverage before benefits for Covered Procedures in the following Procedure Classes become payable.

Procedure Class	Benefit Waiting Period
Preventive	None
Basic	None

Major	None

Reimbursement for Covered Procedures

Reimbursement for Covered Procedures is the lesser of:
- the Providers actual charge; or
- the amount calculated by the applicable Reimbursement Method.

Reimbursement for Covered Procedures is subject to any applicable Deductible, Coinsurance, and Maximum Benefit. Insureds may choose any Provider for treatment and services for Covered Procedures included in this certificate.

Reimbursement Method

In-Network

In-Network Providers have agreed to accept a negotiated reimbursement from us for Covered Procedures in this certificate and any applicable riders. Insureds will typically have less out-of-pocket expenses when a Covered Procedure is performed by an In-Network Provider.

A listing of In-Network participating Providers is available online at www.Unumdentalcare.com or by contacting us directly at (888) 400-9304.

Out-of-Network

Out-of-Network Providers have not entered into an agreement with us to limit the charges for any procedures. Reimbursement for Covered Procedures is based on an In-Network negotiated fee within the general geographic area, made for the same Covered Procedure. The Insured is responsible for any remaining charges after we have paid our portion.

Maximum Benefit

The Maximum Benefit is the total amount of benefits that will be paid for Preventive, Basic, and Major Covered Procedures on an annual basis.

Per Policy Year	Per Insured
	$1,000

In the event an Insured reaches the Maximum Benefit, the Insured is responsible for all costs associated with all further Covered Procedures.

The information in this section provides details on the Covered Procedures included in this certificate and any applicable Exclusions and Limitations.

Start and End of Dental Treatments

For benefits to be payable, Covered Procedures must be started and completed while an Insured's coverage is in force.

A prosthetic dental appliance installed or delivered after an Insured's coverage ends, may be payable for up to 30 days from the date coverage ended.

Start of Dental Treatments

A dental treatment is considered to be started as follows:

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

End of Dental Treatments

A dental treatment is considered complete as follows:

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

Pre-Estimate

Pre-authorization is not required for any service. If the charge for any treatment is expected to exceed $300, we recommend that a dental treatment plan be submitted to us by your Provider for a pre-estimate before treatment begins. We may request additional information from an Insured or the Insured's Provider to help us determine benefits payable.

An estimate of the benefits payable will be sent to you and your Provider. 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 will be covered by benefits. Our estimate may be for a less expensive Alternative Benefit if it will produce professionally satisfactory results.

See the attached Schedule of Covered Procedures for the procedures included in your coverage.

This certificate is subject to all Exclusions and Limitations in this section, unless stated otherwise within a Covered Procedure or a specific provision.

Exclusions

We will not provide benefits for any of the following and we will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

1. services or supplies not included in the Schedule of Covered Procedures;
2. treatments which are elective or primarily cosmetic in nature and not generally recognized as an accepted dental practice by the American Dental Association, this also includes any replacement of prior elective or cosmetic procedures;
3. experimental or investigational drugs, devices, treatments, or procedures;
4. the correction of congenital malformations or congenital missing teeth except for your newly-born Children. This exclusion does not apply to care of a newborn's disease or injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities medically diagnosed congenital defects and birth abnormalities;
5. replacement of a removeable device or appliance that is lost, missing or stolen, and for the replacement of removeable appliances that have been damaged due to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or denture;
6. replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional and is older than the limitation in the Schedule of Covered Procedures. This may include but not be limited to bridges, dentures, and crowns;
7. any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion;
8. any appliance, service, or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis;
9. procedures provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, and myofascial pain;
10. orthognathic surgery;
11. prescribed medications, pre-medication, or analgesia;
12. general anesthesia, intravenous sedation, and the services of anesthetists or anesthesiologists, except in conjunction with complex oral surgery in which anesthesia is medically necessary;
13. instruction for diet, plaque control, and oral hygiene;
14. war or any act of war, whether declared or undeclared;
15. committing or attempting to commit a felony;
16. being engaged in an illegal occupation;
17. being engaged in an illegal activity;
18. charges for implants unless specified in the Covered Procedures, 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;
19. restorations for teeth, unless necessary due to deterioration from extensive decay or accidental Injury;
20. treatment of malignancies, cysts, and neoplasms;
21. orthodontic treatment;
22. charges for failure to keep a scheduled visit or for the completion of claim forms];
23. procedures which do not offer a favorable prognosis, are not medically necessary, or do not meet generally acceptable standards of care;
24. requests for a duplicate removeable device or appliance;
25. the replacement of 3rd molars;
26. restorations used to restore teeth with micro fractures or fracture lines, undermined cusps, or large existing restorations without over pathology;
27. expenses provided or paid for by any governmental program or law;
28. 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), adoption, or is normally a member of the Insured's household.

Limitations

Alternate Benefit

There are multiple options for dental treatment, all of which provide acceptable results. An Alternate Benefit may be applied if there is a less expensive Covered Procedure appropriate for the course of treatment, capable of producing acceptable results. When an Alternate Benefit is applied, the less expensive Alternate Benefit is used to determine the amount payable under the certificate.

Other

Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations.

On any given day, more than 8 periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph.

Coordination of Benefits establishes an order in which Plans pay their claims when an Insured has dental coverage under more than one Plan.

Purpose of this Provision

An Insured may be covered for dental benefits or services by more than one Plan. For instance, the Insured may be covered by this Certificate as an Employee and by another Plan as a dependent of his or her Spouse. If the Insured is covered by more than one Plan, this provision allows us to coordinate what we pay or provide with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured is covered.

Definitions Related to the Coordination of Benefits

The following terms are defined for the purposes of this section:

Allowable Expense: The charge for any dental care service, supply or other item of expense for which the Insured is liable when the dental care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.
When this Certificate is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.
We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.
When this Certificate is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or any portion of a Calendar Year, during which an Insured is covered by this Certificate and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
(a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
(b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
(c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
(d) Group hospital indemnity benefit amounts that exceed $150.00 per day;
(e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.
Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;];
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Insured except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150.00 per day or less;
e) School accident-type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for an Insured's vision care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:
(a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
(b) All Plans which cover the Insured use order of benefit determination rules consistent

with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If an Insured is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary and Secondary Plan

We consider each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Rules for the Order of the Benefit Determination

The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Insured as a dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the Insured as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the Insured as a laid off or retired employee, or as such a person's dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the Plan that covers the Insured under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

The benefits of the
(a) Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.

(b) If both parents have the same birthday, the benefits of the Plan which covered the

parent for a longer period of time shall be determined before those of the plan which covered the other parent for a shorter period of time.

(c) "Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.

(d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

(a) The benefits of the Plan of the parent with custody of the child shall be determined first.

(b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.

(c) The benefits of the Plan of the parent without custody shall be determined last.

(d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.
Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

(a) The basis on which the Primary Plan and the Secondary Plan pay benefits; and

(b) Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the; Reasonable and Customary Charge (R&C) , or some similar term. This means that the provider bills a charge and the Insured may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan ."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Insured uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that the HMO or other plan pays the provider a fixed amount per Insured. The Insured is liable only for the applicable deductible, coinsurance or copayment. If the Insured uses the services of a non-network provider, the HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan ."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The Secondary Plan shall pay the lesser of:

(a) The difference between the amount of the billed charges and the amount paid by the Primary Plan; or

(b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

(a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

(b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the Insured shall not exceed the fee schedule of the Primary Plan. In no event shall the Insured be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

(a) The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or

(b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The Insured shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Insured has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the Insured be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

(a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule

Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Insured receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

(a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If the Insured receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Insured shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.
Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

Benefit Coordination

Benefits will be adjusted so that the total payment under all Plans does not exceed 100% of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of Coordination of Benefits.

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

Right to Receive and Release Needed Information

You are required to give us information necessary for Coordination of Benefits. Information may be released to or obtained from any other insurance company, organization, or person necessary for Coordination of Benefits. This will not require the consent of, or notice to you or any claimant.

Right to Make Payments to Another Plan

Coordination of Benefits may result in payments made by another Plan that should have been made by us. We have the right to pay any other Plan all amounts it paid which would otherwise have been by us. Amount paid in this manner will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

Right to Recover

Coordination of Benefits 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.

The Carryover Benefit offers Insureds, upon satisfaction of the Eligibility Requirements, to have a portion of their unused Maximum Benefit carry over to the next Calendar Year. If an Insured reaches their Maximum Benefit, the Carryover Account balance will be used to pay for Covered Procedures.

Eligibility Requirements

Each Insured will be eligible for the Carryover Benefit provided the following requirements are satisfied during the prior Calendar Year:

- at least one cleaning;
- at least one routine exam; and
- the total amount of benefits paid for Preventive, Basic, Major Covered Procedures, in excess of any Deductibles during the prior Calendar Year does not exceed a $500 threshold limit.

An Insured's eligibility for the Carryover Benefit will be reviewed and determined at the beginning of each Calendar Year.

Carryover Benefit Amount

$250

Carryover Account Maximum

$1,000 is the maximum amount an Insured may accumulate in their Carryover Account.

Any Carryover Account balance will no longer be available if there is any break in an Insured's coverage.

Takeover Benefits may prevent you from having a lapse in dental insurance when your Employer replaces other group dental coverage with comparable benefits under this certificate. For Takeover Benefits to apply, you must be insured under the Prior Plan on the day before the effective date of this certificate.

Takeover is also available to new hires, those who enroll during open enrollment, or due to a Qualifying Life Event with prior-like group dental coverage, provided there has not been a lapse in coverage greater than 63 days. You are responsible for providing proof of your Prior Plan which should include, but not be limited to, coverage effective dates, a benefit summary, certificate of coverage, etc.

For purposes of this section, Prior Plan means your prior group dental insurance policy with your employer.

Takeover Details

Benefit Waiting Period

If Insureds qualify for Takeover Benefits, they will receive Benefit Waiting Period credit for Preventive, Basic, and Major Covered Procedures.

Deductible

Deductible credit will be equal to the amount of the Deductible satisfied under the Prior Plan during the current plan year upon receipt of proof that the expenses were incurred.

Maximum Benefit

Subject to receipt of proof, any benefits paid under the Prior Plan during the current plan year with respect to such replaced coverage will be applied to and deducted from the Maximum Benefit payable under this certificate.

Carryover Credits

Accumulated Carryover Amounts under the Prior Plan will be applied to the Insured's Carryover Account under this certificate subject to availability of applicable data from the prior insurance carrier.

If an Insured exceeds their Maximum Benefit, we will apply their Carryover Account balance to pay for Covered Procedures.

Prior Carrier's Responsibility

The prior carrier is responsible for costs for procedures begun prior to the Policy Effective Date.

Coverage for Treatment in Progress

We may cover dental expenses for treatment already in progress on the Policy Effective Date provided the dental expenses are covered under this certificate and the Prior Plan.

Extension of Benefits under Prior Plan

We will not pay benefits for treatment if:
- the Prior Plan has an extension of benefits provision;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was completed during the extension of benefits.

No Extension of Benefits under Prior Plan

We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:
- the Prior Plan has no extension of benefits when that plan terminates;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was completed while insured under this certificate.

Treatment Not Completed during Extension of Benefits

We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan and during the extension if:
- the Prior Plan has an extension of benefits;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was not completed during the Prior Plan's extension of benefits.

Only the percentage of treatment completed beyond the extension period will be considered when determining if any benefits are paid under this certificate.

Owners Low Plan Dental

Eligibility Waiting Period

The Eligibility Waiting Period is the continuous period of time you must be in an Eligible Group before you are eligible to enroll for coverage.

Immediately following the first day of Active Employment.

All Eligible Full-Time Employees Low Plan Dental

Eligibility Waiting Period

The Eligibility Waiting Period is the continuous period of time you must be in an Eligible Group before you are eligible to enroll for coverage.

First of the month coinciding with or next following the first day of Active Employment.

Enrolling for Coverage

You may enroll for coverage:
- within 31 days from the date an Insured is eligible;
- within 31 days from the date of a Qualifying Life Event; or
- during the annual Enrollment Period.

You must be enrolling in coverage for yourself or have existing coverage under this certificate in order to apply for coverage for your Spouse or Children.

Your newborn or newly adopted Children will automatically be covered for 60 days from the date the Child becomes eligible, provided you are insured. If you wish to continue Child coverage, you must notify us on or before the end of the 60 day period and pay any additional premium.

Coverage Effective Date

Coverage for an Insured will begin on the date the Insured is eligible for coverage.

Coverage Effective Date for Changes in Coverage

Changes to an Insured's coverage will begin:
- the date determined by the Enrollment Period; or
- the date you apply for a change in coverage due to a Qualifying Life Event, if you apply within 31 days of the Qualifying Life Event.

A cancellation in coverage will take effect:
- the date the cancellation in coverage is made;
- the first day of the pay period in which deductions are taken; or
- the date agreed upon by us and your Employer.

Any change or cancellation in coverage will not affect a Payable Claim which occurs prior to the change or cancellation.

Coverage Effective Date if you are not in Active Employment

You must be in Active Employment in order for coverage to become effective.

If you are not in Active Employment due to an Injury, Sickness, or Leave of Absence on the date coverage would become effective, coverage will begin on the date you return to Active Employment.

The Coverage Effective Date and Coverage Effective Date for Changes in Coverage provisions are subject to this provision.

Continuation of your Coverage During Extended Absences

Leave of Absence, other than a Family and Medical Leave of Absence or Leave of Absence due to Military Service

You will be covered for 1 year from the date your absence begins, provided premium is paid.

Family and Medical Leave of Absence

We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence provided premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a Family and Medical Leave of Absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Eligibility Waiting Period.

Leave of Absence due to Military Service

You will be covered for 1 year from the date your absence begins, provided premium is paid.

If you have not returned to work after the allotted time for continuation of coverage, your coverage will be suspended and reinstated in accordance with the requirements of the federal Uniformed Services Employment and Reemployment Rights Act (USERRA).

Injury or Sickness

You will be covered for up to 1 year from the date your absence begins due to an Injury or Sickness, provided premium is paid.

End of Coverage

For You

You may cancel your coverage during an Enrollment Period or during a Qualifying Life Event. Your coverage will end the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the first of the month following the earliest of:

- the date the policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Extended Absences provision.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate. In no event will a Covered Procedure started after an Insured's coverage ends be payable.

For your Spouse

If, while your coverage is in force, you choose to cancel your Spouse's coverage under this certificate, your Spouse's coverage will end the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the first of the month following the

earliest of:
- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this certificate.

For your Children

If, while your coverage is in force, you choose to cancel your Children's coverage under this certificate, your Children's coverage will end the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Children's coverage will end on the first of the month following the earliest of:
- the date your coverage under this certificate ends;
- the date your Children are no longer eligible for coverage;
- the date of your Child's death; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

Filing a Claim

We encourage notification of a claim for benefits under this certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact us or your Employer.

Step 1 - Claim Forms

Most Providers file claims electronically or have claim forms on hand if you choose to submit your own claim. Claim forms are also available on our website www.Unumdentalcare.com or by contacting us directly at (888) 400-9304. We will provide a claim form within 15 days of your request.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement that includes a description of services, billed charges, and any additional documentation you received from your Provider will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to us by mail, e-mail, or fax:

Mailing Address	Claims Department P.O. Box 80139 Baton Rouge, LA 70898-0139
Fax	(855) 400-9307
E-mail	DentalClaims@Unum.com

Step 2 - Proof of Loss

Proof of Loss must be sent to us no later than 90 days after the date of service. The Insured's receipt of charges for services rendered by a Provider is Proof of Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it must be provided as soon as reasonably possible. In any event, proof must be given to us, unless the Insured lacks the legal capacity to do so.

The receipt of charges submitted to us for proof must include the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and nomenclature, or a narrative description. X-rays, narratives, and other diagnostic information may be required to determine benefits.

We will request additional information if Proof of Loss is not complete.

Services Performed Outside the United States of America

Claims submitted for any dental treatment performed outside the United States must:
- be supplied in English;
- use American Dental Association (ADA) codes; and
- be in U.S. Dollar currency.

Claim Procedures

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision within 30 days. Benefits will be paid in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend this time period by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice of denial will state the specific reason for the denial of benefits.

Payment of Benefits

Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them

elsewhere. This is an assignment of benefits.

If there is any reason that is beyond our control and will cause us to withhold or prevent us from issuing payment for an otherwise payable claim under this certificate, we may hold further payment due until such issue is resolved and sufficient Proof of Loss of the same is provided to us.

In the event of your death, any unpaid benefits will be paid to your estate. If benefits are payable to your estate, we can pay benefits up to $1,000 to someone related to you by blood or marriage whom we consider entitled to the benefits. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Payment to a Minor or Incompetent Insured

If an Insured is a minor or is incompetent, we can pay up to $1,000 to the person or institution that appears to have assumed the custody and main support of the Insured or the minor unless or until that Insured, or minor's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

Overpayment of Claims

We have the right to recover any overpayments from Insureds and Providers due to:
- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

We will not recover more money than the amount we paid.

Underpayment of Claims

We have the responsibility to make additional payments if any underpayments have been made. Any underpayments will be paid in accordance with the Payment of Benefits provision.

Complaint and Appeal Procedures

Complaints

You shall report any complaints to us at (888) 400-9304. Complaints may be submitted to us verbally or in Writing. You may submit Written comments or supporting documentation concerning your complaint to assist in our review. We will address the complaint within 30 days after receipt or, unless special circumstances require an extension of time. In that case, resolution will be achieved as soon as possible, but not later than 120 days after our receipt of the complaint.

Claim Denial

If we deny all or any part of your claim, you can access the claim status detail on www.Unumdentalcare.com, you have the right to receive a Written notice of denial setting forth:
- the specific reasons for the denial;
- the specific policy provisions on which the denial is based; and
- a description of the appeal procedures and time limits.

Upon receipt of a claim denial you have the right, upon request and free of charge, to receive:
- copies of all documents, records, and other information relevant to your claim for benefits; and
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary.

Appeal

If, under the terms of the policy, a claim is denied in whole or in part, a request may be submitted to us by you, or by your authorized representative, for a full review of the denial. You may designate any person, including your Provider, as your authorized representative. References in this section to "you" include your authorized

representative, where applicable.

The request must be made within 60 days following your receipt of adverse benefit determination and should contain sufficient information to identify the person for whom the claim was submitted, including:
- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the Provider of services; and
- the claim number.

An Insured may request, free of charge, any documents held by us regarding the denial of your claim. You or your Spouse or Children may also submit Written comments or supporting documentation concerning the claim to assist in our review.

Our response to your request for review, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you or your Spouse or Children no later than 60 days after receipt of a request for an appeal from you or your Spouse or Children, unless, due to special circumstances, we need an extension of time to process your appeal. In the event that we do request an extension of time, notice will be provided to you prior to the expiration of the initial 60 day period, and the extension will not exceed a period of 60 days from the end of the initial 60 day time period.

Copies of all appeals and responses are available for inspection by the state insurance department or equivalent authority.

ERISA

If your Plan is governed by ERISA, claim denial and appeal procedures as well as your right to lawsuit should comply with ERISA requirements, which might be different from the state requirements stated above.
Additionally, under the provisions of ERISA (Section 502(a)) 29 U.S.C. 1132(a), you may have the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole, and you disagree with the outcome.

Other Remedies

When you have completed the appeals process described above, additional voluntary alternative dispute resolution options may be available, including mediation. One way to find out what may be available is to contact the U.S. Department of Labor and your State insurance regulatory agency.

Legal Actions

You or your authorized representative may initiate Legal Action on a claim if you or your authorized representative disagree with our decision. The time limit on Legal Actions is subject to applicable law in the state where the policy is issued. Unless stated otherwise under federal law, Legal Action may begin 60 days from the date Proof of Loss is required and up to two years from the date of the loss.

When Days Begin and End

For the purpose of all dates under this certificate, all days begin at 12:01 a.m. and end at 12:00 midnight.

Certificate of Coverage

We will provide the Policyholder with a certificate for distribution to each insured Employee. The certificate describes:
- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If the provisions of this certificate are different from the provisions of the policy, the provisions of the policy will govern.

Certificate of Coverage Contents

Coverage for an Insured is provided under the provisions of this certificate. The provisions of this certificate are made part of the policy issued to the Policyholder.

The policy consists of all provisions of the policy, the provisions of this certificate, the Policyholder's application, and all related schedules, riders, amendments, and endorsements.

Cancellation or Modification to the Policy and this Certificate of Coverage

The policy and this certificate may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

All policy and certificate modifications will take effect according to the provisions in the Start of Coverage section of this certificate.

Assignment

An Assignment transfers all or part of your legal title and rights under the policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the policy and this certificate if:
- the Written form has been signed by you and the assignee and the form is acceptable to us; and
- a signed or certified copy of the Written Assignment has been filed with us.

An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. Unless stated otherwise in or allowed by the Assignment, the Assignment does not change an Insured's coverage.

We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.

Contestability

We can take legal or other action using statements made in the signed enrollment form for coverage only when a claim occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take legal or other action at any time as permitted by applicable law.

Misstatement of Information

If we receive information about an Insured that is incorrect, we will:
- review the information to decide whether the Insured has coverage and in what amounts; and
- if necessary, make the applicable premium adjustments.

Fraud

We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if anyone knowingly, and with intent to injure, defrauds, or deceives us. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Agency

For purposes of the policy, your Employer acts on their own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

Communicating with you or your Employer

To protect our customers, when communicating with others in Writing, we will abide by all applicable privacy laws and regulations.

Active Employment

You are working for your Employer for earnings that are paid regularly and you are performing the usual and customary duties of your job. You must be regularly scheduled to work at least the minimum number of hours defined by your Eligible Group.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this Certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outage; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

Calendar Year

The period beginning on the Insured's Coverage Effective Date and ending on December 31 of the same year. For each following year, it is the period beginning on January 1 and ending on December 31.

Children

Any child from live birth to the end of the year in which they reach age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent child relationship that are dependent on you for primary financial support; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past the end of the year in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Dependent children may continue coverage up to age 30 if they are unmarried; have no dependents of their own; are a resident of the state of New Jersey or are enrolled as a full-time student at an accredited public or private institution of higher learning; and are not provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health benefit plans, group health plan, church plan or entitled to benefits under Social Security.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

Contributory Coverage Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amount of your coverage.

Covered Procedure The procedures listed in the Schedule of Covered Procedures. Benefits will only be paid for services identified in the Schedule of Covered Procedures.

Employee A person, also referred to as "you," who is in Active Employment.

Employer The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.

Enrollment Period A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

Injury Any damage or harm to the body that is the direct result of an accident and not related to any other cause. Injuries that occur prior to an Insured's Coverage Effective Date will be treated as any other Sickness.

Insured Any person who has coverage under the policy.

Leave of Absence Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time, holidays, or temporary business closure is not considered a Leave of Absence.

Non-Contributory Coverage Any amounts of coverage for which you are not required to pay any part of the premium, except where necessary for the Employer to comply with applicable tax law.

Payable Claim A claim for which we are liable under the provisions of the policy.

Policyholder The entity to which the policy is issued.

Policy Year November 1, 2023 to November 1, 2024 and each following November 1 to November 1.

Provider A dentist, dental hygiene therapist, independent practice dental hygiene therapist, or any dental professional that is:

- properly licensed or certified under the laws of the state where they practice; and
- perform tasks that are within the limits of their license.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Provider for a claim that you send to us.

In-Network Provider

A Provider who has agreed to accept a negotiated fee for Covered Procedures agreed to by us and the Provider. A listing of In-Network participating Providers is available online at www.Unumdentalcare.com or by contacting us directly at (888) 400-9304.

Out-of-Network Provider

A Provider who has not entered into an agreement with us to limit charges for any procedures.

Qualifying Life Event For coverage eligibility purposes, a Qualifying Life Event includes, but is not limited to:

- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a cessation of a civil union or domestic partnership
- a change in employment status; or

- death of an Insured.

Changes in coverage made as a result of a Qualifying Life Event must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's human resource policy.

Sickness An illness or disease.

Spouse The person who is your partner through lawful marriage, including your legally separated Spouse, a partner in a civil union relationship established pursuant to the New Jersey Civil Union Act, or a partner in a government-sanctioned, same-sex relationship validly established under the law of another jurisdiction providing rights that closely approximate those of New Jersey civil unions.

Your Spouse may not be Insured as both a Spouse and an Employee.

Starmount Life Insurance Company Referred to as "Starmount" and "we," "us," or "our."

Writing or **Written** A record on or transmitted by paper, electronic, or telephonic media consistent with applicable law.

Starmount Life Insurance Company
8485 Goodwood Blvd.
Baton Rouge, LA 70806

Group Dental Insurance Schedule of Covered Procedures

The following Schedule of Covered Procedures describes each procedure for which benefits are payable. All claims for Covered Procedures are subject to review. In addition, Covered Procedures are subject to the applicable Frequencies and Limitations. Procedure Frequencies are determined on a rolling basis, beginning on the date of service for that Covered Procedure. Procedure Frequencies for similar procedures under different ADA codes, such as oral evaluations, are based on accepted dental practices by the American Dental Association. Your provider may provide a recommended dental treatment plan. If the dental treatment plan is expected to exceed $300, we recommend that a pre-treatment estimate be submitted. See Pre-Estimate in the Certificate of Coverage. For more information on limitations, including the alternate benefit limitation, please refer to Limitations in the Certificate of Coverage.

Diagnostic

Procedure Class	Covered Procedure Description	ADA Code
Preventive	Periodic oral evaluation - established patient	**D0120**
	Oral evaluation for a patient under three years of age and counseling with primary caregiver	**D0145**
	Frequency	
	Limited to any 2 of these procedure codes per 12 months. D0150 is included in this limitation.	
	Limitation	
Preventive	Comprehensive oral evaluation - new or established patient	**D0150**
	Frequency	
	Limited to any 2 of these procedure codes per 12 months per provider. D0120 and D0145 are included in this limitation.	
	Limitation	
Preventive	Comprehensive periodontal evaluation - new or established patient	**D0180**
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
Preventive	Limited oral evaluation - problem focused	**D0140**
	Detailed and extensive oral evaluation - problem focused, by report	**D0160**
	Re-Evaluation - limited, problem focused (established patient; not post-operative visit)	**D0170**
	Frequency	
	Limited to any 1 of these procedure codes per 12 months.	
	Limitation	
	An alternate benefit may be provided.	
Preventive	Intraoral - complete series of radiographic images	**D0210**
	Frequency	
	Limited to any 1 of D0210 or D0330 per 36 months.	
	Limitation	
Preventive	Intraoral - periapical first radiographic image	**D0220**
	Intraoral - periapical each additional radiographic image	**D0230**
	Frequency	
	Maximum of 7 images combined D0220 and D0230 per visit.	
	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
Preventive	Intraoral - occlusal radiographic image	**D0240**

	Frequency	
	Maximum of 2 procedure per 12 months.	
	Limitation	
Preventive	Bitewing - single radiographic image	**D0270**
	Bitewings - two radiographic images	**D0272**
	Bitewings - three radiographic images	**D0273**
	Bitewings - four radiographic images	**D0274**
	Frequency	
	Limited to any 1 of these procedure codes per 12 months up to 4 radiograph images per visit.	
	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
Preventive	Vertical bitewings - 7 to 8 radiographic images	**D0277**
	Frequency	
	Maximum of 1 procedure per 12 months in combination with D0270, D0272, D0273, and D0274.	
	Limitation	
	An alternate benefit may be provided.	
Preventive	Panoramic radiographic image	**D0330**
	Frequency	
	Limited to any 1 of D0210 or D0330 per 36 months.	
	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
Major	2D oral/facial photographic image obtained intra-orally or extra-orally	**D0350**
	Frequency	
	Maximum of 1 procedure per lifetime.	
	Limitation	
Preventive	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	**D0431**
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
	Procedure is limited to Insureds age 40 and older. Procedure is only covered when there is presence of suspicious lesions or for those who demonstrate risk factors for oral cancer.	

Preventive		
Procedure Class	**Covered Procedure Description**	**ADA Code**
Preventive	Prophylaxis - adult	**D1110**
	Prophylaxis - child	**D1120**
	Frequency	
	Limited to 2 procedures per 12 months in combination of D1110, D1120 and D4910.	
	Limitation	
	One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at time of claim.	
Preventive	Topical application of fluoride varnish	**D1206**
	Topical application of fluoride - excluding varnish	**D1208**
	Frequency	
	Limited to any 1 of these procedure codes per 12 months.	
	Limitation	
	Procedure is limited to Insureds under the age of 16.	
Preventive	Sealant - per tooth	**D1351**
	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	**D1352**
	Frequency	
	Limited to any 1 of these procedure codes per tooth, per 36 months.	

	Procedure covered only for permanent molar teeth which have no prior occlusal restoration.	
	Limitation	
	Procedure is limited to Insureds under the age of 16. Alternate benefit may be given for D1352.	
Preventive	Space maintainer - fixed, unilateral - per quadrant	**D1510**
	Space maintainer - fixed - bilateral, maxillary	**D1516**
	Space maintainer - fixed - bilateral, mandibular	**D1517**
	Space maintainer - removable, unilateral - per quadrant	**D1520**
	Space maintainer - removable - bilateral, maxillary	**D1526**
	Space maintainer - removable - bilateral, mandibular	**D1527**
	Distal shoe space maintainer - fixed, unilateral - per quadrant	**D1575**
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
	Procedure covered only when used to hold space for permanent tooth after the loss of primary tooth.	

Restorative

Procedure Class	Covered Procedure Description	ADA Code
Basic	Amalgam - one surface, primary or permanent	**D2140**
	Amalgam - two surfaces, primary or permanent	**D2150**
	Amalgam - three surfaces, primary or permanent	**D2160**
	Amalgam - four or more surfaces, primary or permanent	**D2161**
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per 24 months.	
	Limitation	
Basic	Resin-Based composite - one surface, anterior	**D2330**
	Resin-Based composite - two surfaces, anterior	**D2331**
	Resin-Based composite - three surfaces, anterior	**D2332**
	Resin-Based composite - four or more surfaces or involving incisal angle (anterior)	**D2335**
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
Major	Resin-Based composite crown, anterior	**D2390**
	Frequency	
	Maximum of 1 procedure per 5 years.	
	Limitation	
Basic	Resin-Based composite - one surface, posterior	**D2391**
	Resin-Based composite - two surfaces, posterior	**D2392**
	Resin-Based composite - three surfaces, posterior	**D2393**
	Resin-Based composite - four or more surfaces, posterior	**D2394**
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
Basic	Gold foil - one surface	**D2410**
	Gold foil - two surfaces	**D2420**
	Gold foil - three surfaces	**D2430**
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Inlay - metallic - one surface	**D2510**
	Inlay - metallic - two surfaces	**D2520**
	Inlay - metallic - three or more surfaces	**D2530**
	Inlay - porcelain/ceramic - one surface	**D2610**
	Inlay - porcelain/ceramic - two surfaces	**D2620**
	Inlay - porcelain/ceramic - three or more surfaces	**D2630**

	Inlay - resin-based composite - one surface	**D2650**
	Inlay - resin-based composite - two surfaces	**D2651**
	Inlay - resin-based composite - three or more surfaces	**D2652**
	Frequency	
	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Onlay - metallic - two surfaces	**D2542**
	Onlay - metallic - three surfaces	**D2543**
	Onlay - metallic - four or more surfaces	**D2544**
	Onlay - porcelain/ceramic - two surfaces	**D2642**
	Onlay - porcelain/ceramic - three surfaces	**D2643**
	Onlay - porcelain/ceramic - four or more surfaces	**D2644**
	Onlay - resin-based composite - two surfaces	**D2662**
	Onlay - resin-based composite - three surfaces	**D2663**
	Onlay - resin-based composite - four or more surfaces	**D2664**
	Frequency	
	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Crown - resin with high noble metal	**D2720**
	Crown - resin with predominantly base metal	**D2721**
	Crown - resin with noble metal	**D2722**
	Crown - porcelain/ceramic	**D2740**
	Crown - porcelain fused to high noble metal	**D2750**
	Crown - porcelain fused to predominantly base metal	**D2751**
	Crown - porcelain fused to noble metal	**D2752**
	Crown - porcelain fused to titanium and titanium alloys	**D2753**
	Crown - 3/4 cast high noble metal	**D2780**
	Crown - 3/4 cast predominantly base metal	**D2781**
	Crown - 3/4 cast noble metal	**D2782**
	Crown - 3/4 porcelain/ceramic	**D2783**
	Crown - full cast high noble metal	**D2790**
	Crown - full cast predominantly base metal	**D2791**
	Crown - full cast noble metal	**D2792**
	Crown - titanium and titanium alloys	**D2794**
	Frequency	
	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Basic	Re-Cement or re-bond inlay, onlay, veneer or partial coverage restoration	**D2910**
	Re-Cement or re-bond crown	**D2920**
	Frequency	
	Maximum of 1 procedure per tooth, per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Prefabricated stainless steel crown - primary tooth	**D2930**
	Prefabricated stainless steel crown - permanent tooth	**D2931**
	Prefabricated resin crown	**D2932**
	Prefabricated stainless steel crown with resin window	**D2933**
	Prefabricated esthetic coated stainless steel crown - primary tooth	**D2934**
	Frequency	
	Limited to any 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Protective restoration	**D2940**
	Frequency	
	Maximum of 1 procedure per tooth per 24 months.	
	Limitation	

Major	Core buildup, including any pins when required	**D2950**
	Frequency	
	Maximum of 1 procedure per tooth, per 5 years.	
	Limitation	
Major	Post and core in addition to crown, indirectly fabricated	**D2952**
	Prefabricated post and core in addition to crown	**D2954**
	Frequency	
	Limited to any 1 of these procedure codes per tooth, per 5 years.	
	Limitation	
Major	Labial veneer (resin laminate) - chairside	**D2960**
	Labial veneer (resin laminate) - laboratory	**D2961**
	Labial veneer (porcelain laminate) - laboratory	**D2962**
	Frequency	
	Limited to 1 of these restorations including any type of crown, per tooth per 5 years.	
	Limitation	
Basic	Crown repair necessitated by restorative material failure	**D2980**
	Veneer repair necessitated by restorative material failure	**D2983**
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Inlay repair necessitated by restorative material failure	**D2981**
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Onlay repair necessitated by restorative material failure	**D2982**
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	

Endodontics

Procedure Class	Covered Procedure Description	ADA Code
Basic	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	**D3220**
	Frequency	
	Limited to any 1 of these procedures per tooth, per lifetime.	
	Limitation	
Basic	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	**D3230**
	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	**D3240**
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Basic	Endodontic therapy, anterior tooth (excluding final restoration)	**D3310**
	Endodontic therapy, premolar tooth (excluding final restoration)	**D3320**
	Endodontic therapy, molar tooth (excluding final restoration)	**D3330**

	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Basic	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	**D3332**
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Basic	Retreatment of previous root canal therapy - anterior	**D3346**
	Retreatment of previous root canal therapy - premolar	**D3347**
	Retreatment of previous root canal therapy - molar	**D3348**
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Apicoectomy - anterior	**D3410**
	Apicoectomy - premolar (first root)	**D3421**
	Apicoectomy - molar (first root)	**D3425**
	Apicoectomy (each additional root)	**D3426**
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Basic	Retrograde filling - per root	**D3430**
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	
Basic	Root amputation - per root	**D3450**
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	

Periodontics

Procedure Class	Covered Procedure Description	ADA Code
Basic	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	**D4210**
	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	**D4211**
	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	**D4240**
	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	**D4241**
	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	**D4260**
	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	**D4261**
	Pedicle soft tissue graft procedure	**D4270**
	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	**D4273**
	Non-Autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	**D4275**
	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	**D4277**
	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	**D4278**
	Frequency	

	Limited to any 1 of these procedure codes per quadrant, per 24 months.	
	Limitation	
Basic	Clinical crown lengthening - hard tissue	**D4249**
	Frequency	
	Maximum of 1 procedure per tooth, per 60 months.	
	Limitation	
Basic	Periodontal scaling and root planing - four or more teeth per quadrant	**D4341**
	Periodontal scaling and root planing - one to three teeth per quadrant	**D4342**
	Frequency	
	Maximum of 1 procedure per quadrant, per 24 months.	
	Limitation	
	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, or debridement.	
Basic	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	**D4346**
	Frequency	
	Maximum of 1 procedure per quadrant, per 24 months.	
	Limitation	
	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, scaling/root planing, or debridement.	
Basic	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	**D4355**
	Frequency	
	Maximum of 1 procedure per lifetime	
	Limitation	
	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, scaling/root planing, or debridement.	
Basic	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	**D4381**
	Frequency	
	Maximum of 1 procedure per quadrant, per 12 months.	
	Limitation	
Basic	Periodontal maintenance	**D4910**
	Frequency	
	Limited to 2 procedures per 12 months in combination with D1110 and D1120.	
	Limitation	
	Procedure is limited to Insureds age 16 and older. One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at time of claim.	

Oral & Maxillofacial

Procedure Class	Covered Procedure Description	ADA Code
Basic	Extraction, coronal remnants - primary tooth	**D7111**
	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	**D7140**
	Frequency	
	Maximum of 1 procedure per tooth.	
	Limitation	
Basic	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	**D7210**
	Removal of impacted tooth - soft tissue	**D7220**
	Removal of impacted tooth - partially bony	**D7230**
	Removal of impacted tooth - completely bony	**D7240**
	Removal of residual tooth roots (cutting procedure)	**D7250**
	Frequency	
	Maximum of 1 procedure per tooth.	

	Limitation	
Basic	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	**D7310**
	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	**D7311**
	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	**D7320**
	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	**D7321**
	Frequency	
	Limited to any 1 of these procedure codes per quadrant, per 24 months.	
	Limitation	
Basic	Incision and drainage of abscess - intraoral soft tissue	**D7510**
	Frequency	
	Limitation	

Prosthodontics (removeable)

Procedure Class	Covered Procedure Description	ADA Code
Major	Complete denture - maxillary	**D5110**
	Complete denture - mandibular	**D5120**
	Immediate denture - maxillary	**D5130**
	Immediate denture - mandibular	**D5140**
	Frequency	
	Limited to 1 procedure per arch, per 5 years including overdenture, implant/abutment supported denture.	
	Limitation	
Major	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	**D5211**
	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	**D5212**
	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	**D5213**
	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	**D5214**
	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	**D5221**
	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	**D5222**
	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	**D5223**
	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	**D5224**
	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	**D5225**
	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	**D5226**
	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	**D5282**
	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	**D5283**
	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	**D5284**
	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	**D5286**
	Frequency	
	Limited to 1 procedure per arch per 5 years including replacement of teeth and acrylic on frameworks, partial overdentures, partial dentures, implants, mini-implants, implant /abutment supported partial dentures.	
	Limitation	

	An alternate benefit may be provided.	
Basic	Adjust complete denture - maxillary	**D5410**
	Adjust complete denture - mandibular	**D5411**
	Adjust partial denture - maxillary	**D5421**
	Adjust partial denture - mandibular	**D5422**
	Frequency	
	Maximum of 1 procedure per arch per 6 months. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Repair broken complete denture base, mandibular	**D5511**
	Repair broken complete denture base, maxillary	**D5512**
	Replace missing or broken teeth - complete denture (each tooth)	**D5520**
	Repair resin partial denture base, mandibular	**D5611**
	Repair resin partial denture base, maxillary	**D5612**
	Repair cast partial framework, mandibular	**D5621**
	Repair cast partial framework, maxillary	**D5622**
	Repair or replace broken retentive clasping materials - per tooth	**D5630**
	Replace broken teeth - per tooth	**D5640**
	Add tooth to existing partial denture	**D5650**
	Add clasp to existing partial denture - per tooth	**D5660**
	Frequency	
	Maximum of 1 procedure per tooth, per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Rebase complete maxillary denture	**D5710**
	Rebase complete mandibular denture	**D5711**
	Rebase maxillary partial denture	**D5720**
	Rebase mandibular partial denture	**D5721**
	Frequency	
	Maximum of 1 procedure each per 24 months. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Reline complete maxillary denture (chairside)	**D5730**
	Reline complete mandibular denture (chairside)	**D5731**
	Reline maxillary partial denture (chairside)	**D5740**
	Reline mandibular partial denture (chairside)	**D5741**
	Reline complete maxillary denture (laboratory)	**D5750**
	Reline complete mandibular denture (laboratory)	**D5751**
	Reline maxillary partial denture (laboratory)	**D5760**
	Reline mandibular partial denture (laboratory)	**D5761**
	Frequency	
	Limited to any 1 of these procedure codes per arch, per 24 months. 6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Tissue conditioning, maxillary	**D5850**
	Tissue conditioning, mandibular	**D5851**
	Frequency	
	Maximum of 1 procedure per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	

Prosthodontics (fixed)

Procedure Class	Covered Procedure Description	ADA Code
Major	Pontic - indirect resin based composite	**D6205**
	Pontic - cast high noble metal	**D6210**
	Pontic - cast predominantly base metal	**D6211**
	Pontic - cast noble metal	**D6212**
	Pontic - titanium and titanium alloys	**D6214**
	Pontic - porcelain fused to high noble metal	**D6240**
	Pontic - porcelain fused to predominantly base metal	**D6241**
	Pontic - porcelain fused to noble metal	**D6242**
	Pontic - porcelain fused to titanium and titanium alloys	**D6243**
	Pontic - porcelain/ceramic	**D6245**
	Pontic - resin with high noble metal	**D6250**
	Pontic - resin with predominantly base metal	**D6251**
	Pontic - resin with noble metal	**D6252**
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including partial overdentures, partial dentures, implants, mini-implants, implant /abutment supported partial dentures, and bridges.	
	Limitation	
Major	Retainer - cast metal for resin bonded fixed prosthesis	**D6545**
	Retainer crown - porcelain/ceramic	**D6740**
	Retainer crown - porcelain fused to high noble metal	**D6750**
	Retainer crown - porcelain fused to predominantly base metal	**D6751**
	Retainer crown - porcelain fused to noble metal	**D6752**
	Retainer crown - 3/4 cast high noble metal	**D6780**
	Retainer crown - 3/4 cast predominantly base metal	**D6781**
	Retainer crown - full cast high noble metal	**D6790**
	Retainer crown - full cast predominantly base metal	**D6791**
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including inlays, onlays, crowns, bridges and partial dentures.	
	Limitation	
Major	Retainer crown - indirect resin based composite	D6710
	Retainer crown - resin with high noble metal	D6720
	Retainer crown - resin with predominantly base metal	D6721
	Retainer crown - resin with noble metal	D6722
	Retainer crown - porcelain fused to titanium and titanium alloys	D6753
	Retainer crown - 3/4 cast noble metal	D6782
	Retainer crown - 3/4 porcelain/ceramic	D6783
	Retainer crown 3/4 - titanium and titanium alloys	D6784
	Retainer crown - full cast noble metal	**D6792**
	Retainer crown - titanium and titanium alloys	**D6794**
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including inlays, onlays, crowns, bridges and partial dentures.	
	Limitation	
Basic	Re-Cement or re-bond fixed partial denture	**D6930**
	Fixed partial denture repair necessitated by restorative material failure	**D6980**
	Frequency	
	Maximum of 1 procedure each per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	

Implant Services		
Procedure Class	**Covered Procedure Description**	**ADA Code**
Major	Surgical placement of implant body: endosteal implant	**D6010**

	Surgical placement of mini implant	**D6013**
	Surgical placement: eposteal implant	**D6040**
	Surgical placement: transosteal implant	**D6050**
	Frequency	
	Limited to any 1 procedure for implants, partial dentures, and bridges per tooth, per lifetime.	
	Limitation	
Major	Prefabricated abutment - includes modification and placement	**D6056**
	Custom fabricated abutment - includes placement	**D6057**
	Frequency	
	Maximum of 1 procedure per tooth, per 5 years.	
	Limitation	
	Only covered if an implant is covered.	
Major	Abutment supported porcelain/ceramic crown	**D6058**
	Abutment supported porcelain fused to metal crown (high noble metal)	**D6059**
	Abutment supported porcelain fused to metal crown (predominantly base metal)	**D6060**
	Abutment supported porcelain fused to metal crown (noble metal)	**D6061**
	Abutment supported cast metal crown (predominantly base metal)	**D6063**
	Implant supported porcelain/ceramic crown	**D6065**
	Implant supported crown - porcelain fused to high noble alloys	**D6066**
	Frequency	
	Limited to 1 replacement for implants, partial dentures, and bridges per tooth per 5 years.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Abutment supported cast metal crown (high noble metal)	**D6062**
	Abutment supported cast metal crown (noble metal)	**D6064**
	Implant supported crown - high noble alloys	**D6067**
	Implant supported crown - porcelain fused to predominantly base alloys	**D6082**
	Implant supported crown - porcelain fused to noble alloys	**D6083**
	Implant supported crown - porcelain fused to titanium and titanium alloys	**D6084**
	Implant supported crown - predominantly base alloys	**D6086**
	Implant supported crown - noble alloys	**D6087**
	Implant supported crown - titanium and titanium alloys	**D6088**
	Abutment supported crown - titanium and titanium alloys	**D6094**
	Abutment supported crown - porcelain fused to titanium and titanium alloys	**D6097**
	Frequency	
	Limited to 1 replacement for implants, partial dentures, and bridges per tooth per 5 years.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	**D6080**
	Frequency	
	Maximum of 1 procedure per prosthesis, per 6 months.	
	Limitation	
Basic	Re-Cement or re-bond implant/abutment supported crown	**D6092**
	Frequency	
	Maximum of 1 procedure per 12 months. 6 months must have passed since initial placement/treatment.	
	Limitation	

Adjunctive General Services

Procedure Class	Covered Procedure Description	ADA Code
Preventive	Palliative (emergency) treatment of dental pain - minor procedure	**D9110**
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
Basic	Deep sedation/general anesthesia - first 15 minutes	**D9222**

	Deep sedation/general anesthesia - each subsequent 15 minute increment	**D9223**
	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	**D9239**
	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	**D9243**
	Frequency	
	Limitation	
	Covered for complex oral surgery, periodontal surgery or impactions, only under specific conditions (pre-estimate recommended). Clinical records, including anesthesia information, will be required for consideration.	

Summary Plan Description - Supplement Information

This Supplement is intended to provide you with additional information regarding the dental benefit plan (the "Plan") that is not addressed in your Certificate of Coverage. Capitalized terms not defined in this Supplement have the meaning set forth in the Certificate of Coverage.

This Supplement, together with your Certificate of Coverage, constitutes the Summary Plan Description ("SPD") for the Plan. An SPD is intended to provide you with important Plan information as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Plan document consists of the Certificate of Coverage and the Policy and, if applicable, your employer's umbrella or "wrap" plan document. Benefits are determined by the Policy, your Certificate of Coverage and the information contained in this document.

If there is a conflict between the SPD and Policy, the terms of the Policy will control with the exception that the grant of discretionary authority in the SPD will always control with respect to the interpretation and administration of the Policy and all benefit determinations made under the Policy.

This SPD and the Plan document, Policy, Certificate of Coverage, and other applicable documentation may be amended at any time.

Name of Plan:
Paulus Sokolowski & Sartor, LLC Plan

Name and Address of Employer:
Paulus Sokolowski & Sartor, LLC
3 Mountainview Rd
Warren, New Jersey
07059

Plan Identification Number:
a. Employer IRS Identification #: 90-0590653
b. Plan #: 503

Type of Welfare Plan:
Dental

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the Claims Administrator, and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
October 31

Plan Administrator, Name, Address, and Telephone Number:
Paulus Sokolowski & Sartor, LLC
3 Mountainview Rd
Warren, New Jersey
07059
(732) 584-0421

Paulus Sokolowski & Sartor, LLC is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan if Plan assets are held in trust, in which case the Administrator will advise you separately of the name, title and address of each Trustee. In the event the benefits under the Plan are subject to collective bargaining, You may request a copy, or request to examine a copy, of the collective bargaining agreement by contacting the Plan Administrator.

Agent for Service of Legal Process on the Plan:
Paulus Sokolowski & Sartor, LLC
3 Mountainview Rd
Warren, New Jersey

07059

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions

Benefits are provided through an insurance contract issued by Starmount Life Insurance Company, 8485 Goodwood Blvd., Baton Rouge, LA 70806 under policy number 942923 022. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

Eligibility for Participation and Summary of Benefits

Refer to the Certificate of Coverage (including its Schedule of Benefits and Schedule of Covered Procedures) for provisions dealing with eligibility for benefits and for a description of benefits payable under the dental options under the Plan.

QMCSO Procedures

A qualified medical child support order ("QMCSO") is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits, which may include dental benefits, and meets certain requirements under ERISA. Generally, a QMCSO is issued as a part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO and then take steps to notify you of the QMCSO determination and corresponding enrollment if required.

You may obtain, without charge, a copy of procedures governing QMCSOs from the Plan Administrator.

Extension of Certain Deadlines Due to COVID-19

Certain deadlines provided in this document and in the Certificate of Coverage may be extended due to guidance provided by the Internal Revenue Service, Department of Labor, Department of the Treasury, Department of Health and Human Services, or other governmental body with proper authority to extend such deadlines (the "Departments"). Pursuant to guidance issued by the Departments on May 4, 2020, the Departments have extended deadlines for you to file certain claims and appeals, certain deadlines related to COBRA, and certain deadlines related to your special enrollment rights under HIPAA, due to COVID-19. The Departments require the otherwise applicable deadlines to be disregarded during the "Outbreak Period." Subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A, "Outbreak Period" is the period beginning on March 1, 2020, and ending 60 days after the announced end or the expiration of the National Emergency. The Plan will comply with all deadline extensions provided by the Departments, now and in the future. Please contact the Claims Administrator with any questions about the extension of these deadlines.

Filing a Claim Under Your Plan

If you wish to file a claim for benefits, you should follow the claims procedures described in the Certificate of Coverage. If your Certificate of Coverage has been lost or misplaced, please contact the Employer identified above.

Claims and Appeals Procedures for Plans Covered by ERISA

If your Plan is subject to ERISA, the following requirements will apply (in addition to the requirements in your Certificate of Coverage) with respect to claims made under the Plan. "Your" and "you" in this section include any Insured (as defined in the Certificate of Coverage) or an authorized representative of an Insured. The term "claimant" may also be used for this purpose.

There are two types of claims for benefits under the Plan:

1. Urgent Care Claim - An Urgent Care Claim is any claim for medical care (which includes dental care) or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. Except with respect to Claims determined by physician with knowledge of the claimant's medical condition to be Urgent Care Claims, whether a claim is an Urgent Care Claim is to be determined by the

Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

2. Post-Service Claim - A Post-Service Claim is any claim that does not require approval (in whole or in part) in advance of obtaining the dental care. All claims under the Plan are Post-Service Claims, except for Urgent Care Claims.

Notification of Initial Decision. For Urgent Care Claims, you will be notified of the Claims Administrator's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after the Claims Administrator receives the claim. If the claim does not include sufficient information for the Claims Administrator to determine whether, or to what extent, benefits are covered or payable under the Plan, you will be notified within 24 hours after receipt of the claim of the need to provide additional information and the specific information necessary to complete the claim. You will have at least 48 hours to respond to this request; the Claims Administrator then will inform you of its decision within 48 hours of receiving the additional information or, if earlier, the end of the period afforded to you to provide the specified additional information.

For Post-Service Claims, you will receive a response within 30 days after the claim is received by the Claims Administrator unless it determines that additional time is necessary (of up to 15 days) to make a decision regarding the claim due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension and the date by which it expects to render a decision. If an extension is necessary because you failed to include the information necessary to decide the claim, the notice of extension will describe the information necessary from you and will provide at least 45 days to provide the specified information.

For all types of claims, the time period beginning on the date which the Claims Administrator notifies you of the need for additional information and ending on the date you provide such additional information is not included in computing the time frame in which the Claims Administrator will respond to the claim.

Denial of Initial Claim. If the Claims Administrator denies all or any part of your claim, you can access the claim status detail on www.AlwaysAssist.com. You have the right to receive a Written notice of denial setting forth:

- the specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following the denial of your claim on appeal;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of that specific rule, guideline, protocol, or other similar criterion, or a statement that such specific rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- if your claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgement underlying the claim denial, as applied to your medical circumstances, or a statement that you will be provided such explanation free of charge upon request; and
- for Urgent Care Claims, a description of the Plan's expedited review process applicable to such claims.

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To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator.

Upon receipt of a claim denial you have the right, upon request and free of charge, to receive copies of all documents, records, and other information relevant to your claim for benefits.

Appeal. If, under the terms of the Plan, a claim is denied in whole or in part, a request may be submitted to the Claims Administrator by you, or by your authorized representative, for a full and fair review of the denial (i.e., an appeal). You may designate any person, including your Provider, as your authorized representative.

The request must be made within 180 days following your receipt of adverse benefit determination, must be Written unless the claim is an Urgent Care Claim (in which case the request may be made orally, by telephone, fax, email or other reasonable method), and should contain sufficient information to identify the person for whom the claim was submitted, including:

- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the Provider of services; and
- the claim number.

An Insured may request, free of charge, any documents held by the Claims Administrator regarding the denial of your claim. You [or your Spouse or Children or an authorized representative] may also submit Written comments, documents, records, or other information concerning the claim.

An appeal will not afford deference to the initial denial of the claim, and will be decided by someone who is different from, and who is not a subordinate of, the individual who made the initial decision on the claim. Also, if the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate, then the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same as any health care professional who was consulted in connection with the initial claims denial, nor a subordinate of that professional. If the appeal is denied, you will be advised if any medical or vocational expert's advice was obtained on behalf of the Plan, including the identity of any such medical or vocational expert, in connection with the appeal, regardless of whether the advice was relied on by the Plan.

The Claims Administrator's response to your request for review, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you or your Spouse or Children no later than:

1. Urgent Care Claims - not later than 72 hours after receiving the request for a review.
2. Post-Service Claims - not later than 60 days after receiving the request for a review.

The Claims Administrator will consider the appeal, taking into account all comments, documents, records, and other information submitted, including information not submitted or considered in the initial decision on the claim. The Claims Administrator will not defer to the initial decision to deny the claim. Any decision made by the Claims Administrator on appeal will be final and conclusive.

If the Claims Administrator denies all or any part of your claim on appeal, you can access the claim status detail on www.AlwaysAssist.com. You have the right to receive a Written notice of denial setting forth:

- the specific reason(s) for the denial;
- reference to the specific Plan provisions upon which the denial was based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a statement describing any other voluntary appeal procedures offered under the Plan and your right to obtain the information about such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of that specific rule, guideline, protocol, or other similar criterion, or a statement that such specific rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- if your claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgement underlying the claim denial, as applied to your medical circumstances, or a statement that you will be provided such explanation free of charge upon request.

To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator.

Legal Action

If you believe your claim under the Plan is being improperly denied in whole or in part, you have the right to bring a legal action, subject to any time bar to bringing suit set forth in the Certificate of Coverage.

However, no legal action can be brought until you have exhausted all the steps in the appeal process provided under the Plan.

Plan Administration

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, having the sole discretionary authority (except to the extent delegated) to interpret the Plan, prescribe applicable procedures, determine eligibility for and the amount of benefits, authorize benefit payments, gather information necessary for administering the Plan, and determine all questions in the administration, interpretation and application of the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan grants to itself the discretionary authority to make all benefit determinations under the Plan.

All determinations of the Plan Administrator or its delegate shall be conclusive and binding on all parties.

Claims Administrator

The Plan, acting through the Plan Administrator, delegates to the Starmount Life Insurance Company and its affiliate Unum Group (collectively, the Claims Administrator") the discretionary authority to make all benefit determinations pursuant to the Plan documents, which include insurance policies and other documents evidencing funding for benefits provided under the Plan. The Claims Administrator may act directly or through its parents, affiliates, employees and agents or further delegate its authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and applying Plan terms and conditions. Exercising discretionary authority requires that a benefit determination must be made on a principled and reasoned basis, consistent with a reasonable interpretation of the terms of the Plan or insurance policy, and supported by the facts and circumstances of each claim.

Starmount Life Insurance Company
8485 Goodwood Blvd.
Baton Rouge, LA 70806
(888) 400-9304

COBRA Administrator

The Plan, acting through the Plan Administrator, has delegated to the COBRA Administrator the authority to administer COBRA continuation coverage (described below). The COBRA Administrator is identified in the initial COBRA notice that is provided to employees (and spouses, as applicable) at the time coverage is commenced under the Plan ("Initial COBRA Notice").

Employer's Right to Amend the Plan

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. No provision of the Plan or any of its related documents shall create any vested rights in any employee, retiree, participant, or any other person. No consent of any participant is required to terminate, modify, amend or change the Plan. The Plan many be amended, modified or terminated by written instrument duly adopted by the Employer or any of its delegates.

Family Medical Leave Act of 1993 (FMLA)

If a covered employee ceases active employment due to an employer-approved Family Medical Leave of Absence in accordance with the requirements of the FMLA, coverage will be continued under the same terms and conditions which would have applied had the employee continued in active employment, provided the employee continues to pay his share of the premium for the cost of coverage, in accordance with the rules for any required contributions. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other employees in the same classification).

Continuation of Coverage under COBRA

A federal law called "COBRA" requires the Plan to offer employees and their dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan otherwise would end due to the occurrence of a "qualifying event".

You and your covered spouse or domestic partner and covered dependents will be entitled to continue benefits under this Plan upon the occurrence of a qualifying event, as described further below. You may continue only the Plan coverage in effect at the time and must pay required premiums.

General

If you are a Qualified Beneficiary, you have the right to continue your coverage under the Plan if you lose that coverage due to a "Qualifying Event". If you are an employee, you are a Qualified Beneficiary if you are covered by the Plan on the day prior to a Qualifying Event that is your termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment. If you are the spouse or domestic partner (in the event domestic partner coverage is provided under the Plan) or dependent child of an employee, you are a Qualified Beneficiary if you are covered by the Plan on the day prior to a Qualifying Event. A child born to or placed for adoption with an employee during a period of COBRA coverage is also a Qualified Beneficiary.

A "Qualifying Event" means each of the following events, if it causes a Qualified Beneficiary to lose coverage under the Plan: (i) your reduced hours of employment, (ii) your employment ends for any reason other than gross misconduct, (iii) your death, (iv) your entitlement to Medicare benefits (v) your divorce or legal separation from your spouse or termination of domestic partnership, or (vi) for a dependent child, the child's ceasing to satisfy the definition of a dependent under the terms of the applicable program.

If you are a Qualified Beneficiary and you lose coverage under the Plan due to the first four Qualifying Events listed above, you will automatically receive a Qualifying Event notice from the COBRA Administrator of your right to elect COBRA continuation coverage. However, if you are a Qualified Beneficiary and you lose coverage under the Plan due to a divorce or legal separation, or due to a child's loss of dependency status, you must notify the COBRA Administrator of the event within 60 days after the Qualifying Event occurs or you will lose your right to elect COBRA continuation coverage.

Electing COBRA Coverage

If you are a Qualified Beneficiary and you experience a Qualifying Event, you will receive a Qualifying Event Notice and election form describing your rights to elect COBRA continuation coverage. Remember, if the Qualifying Event is a divorce, legal separation, or a child's loss of dependency status, you must first notify the COBRA Administrator of the event before this notice will be sent to you. If you do not receive a Qualifying Event Notice and election form within 30 days of your Qualifying Event (or within 14 days of the date you notified the COBRA Administrator of a Qualifying Event, if applicable), you should contact the COBRA Administrator.

Although each Qualified Beneficiary has an independent right to elect COBRA coverage, the Qualifying Event Notice and election form will usually only be sent to the employee and spouse or domestic partners, at the employee's address shown in the records of the Plan. For this reason, it is very important that you keep the COBRA Administrator informed of your current address and the addresses of your spouse and covered dependents. Covered employees may elect COBRA continuation coverage on behalf of their spouses and domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA coverage will be provided only if it is elected by a Qualified Beneficiary during the COBRA election period. The COBRA election period begins on the date of the Qualifying Event and ends 60 days after the date a Qualifying Event Notice and election form is sent to the Qualified Beneficiary or, if later, the date the Qualified Beneficiary would otherwise lose coverage as a result of the Qualifying Event. For elections sent by mail, the postmark date is used to determine whether an election was made prior to the end of the COBRA election period.

If elected, COBRA coverage begins on the date coverage would otherwise have been lost.

Prior to the time a Qualified Beneficiary elects COBRA coverage, his or her coverage under the Plan will be terminated. However, the coverage will be retroactively reinstated to the date coverage was lost following a timely election of COBRA coverage and the timely payment by the Qualified Beneficiary of the first premium payment.

Paying for COBRA Coverage

Qualified Beneficiaries must pay for each one-month period of COBRA coverage on a monthly basis. A period of COBRA coverage runs from the first day of the month through the end of that month, except that the initial period of coverage runs from the date coverage was lost due to the Qualifying Event, through the end of the month in which the Qualifying Event occurred.

The cost for each one-month period of COBRA coverage (which may change at the beginning of each Plan Year) depends on the type of coverage that is being continued and will be communicated to you.

In order to maintain your right to COBRA coverage, the first payment for COBRA coverage must be postmarked or received by the Plan no later than 45 days after the date you elect COBRA coverage (including payment for all one-month periods of coverage that have begun between the date coverage was lost and the date the first premium payment is received).

Payments for subsequent one-month periods are due on the first day of those periods. You will have a 30-day grace period to make monthly payments otherwise COBRA coverage will be terminated retroactively to the first day of that period and cannot be reinstated. Any payment that is less than the full premium payment due will not be accepted unless the balance is paid prior to the end of the normal grace period. Please refer to the Initial COBRA Notice for further details on coverage in the event payment is received during the grace period.

Duration of COBRA Coverage

When the Qualifying Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse or domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the COBRA Administrator is notified of the SSA's determination before the end of the 18-month period of COBRA continuation coverage and not later than 60 days after the latest of (i) the date of the disability determination by the SSA, (ii) the date on which a Qualifying Event occurs, or (iii) the date on which you or another Qualified Beneficiary loses (or would lose) coverage under the program as a result of the Qualifying Event. If a Qualified Beneficiary who was previously determined by the SSA to be disabled is subsequently determined by the SSA to be no longer disabled, you must notify the COBRA Administrator of that determination within 30 days of the date you receive the determination from the SSA.

- If your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse (or domestic partner) and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second event would have caused the spouse (or domestic partner) or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, you must make sure that the COBRA Administrator is notified of the second Qualifying Event within 60 days of the event. Only individuals who were Qualified Beneficiaries in connection with the first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event are eligible for this extension.

COBRA coverage will end prior to the 18-, 29- or 36-month period described above under the following circumstances: (i) the first day of a coverage period for which timely payment is not made, (ii) the date the Plan Sponsor ceases to provide any group health plan to you, (iii) the date, after the date a COBRA election is made, upon which the Qualified Beneficiary first becomes covered under another group health plan or entitled to Medicare benefits; (iv) the first day of the coverage period that is more than 30 days after the date a Qualified Beneficiary entitled to a disability extension is finally determined to not be disabled; or (v) the date coverage is terminated for cause.

If the COBRA coverage of a Qualified Beneficiary terminates early, the COBRA Administrator will send a notice regarding the termination of COBRA coverage to you as soon as practicable.

How to Notify the COBRA Administrator

You must send written notice* of a Qualifying Event that is a divorce, a legal separation, or a child's loss of dependent status, to the COBRA Administrator within 60 days of the event. Also, if you elect COBRA coverage and you are eligible for an 11-month extension of that coverage due to the disability of a Qualified Beneficiary, or for an 18-month extension of that coverage due to the occurrence of a second Qualifying Event, you must provide written notice of the disability determination or the second Qualifying Event to the COBRA Administrator. Notice must be sent by first class mail or other nationally-recognized courier service, by fax, e-mail or by hand-delivery. Oral notice will not be accepted. Your notice must include your name and the names of other affected family members, the type of Qualifying Event and written documentation of the event that identifies the date on which the event occurred. You should keep a copy, for your records, of any notices you send to the COBRA Administrator.

Any notices required to be provided to the COBRA Administrator may be provided by the employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of either of them, and will be sufficient for all beneficiaries affected by the same Qualifying Event.

*The COBRA Administrator will determine the form of the written notice. For example, the COBRA Administrator may determine that written notice includes providing notice through the COBRA Administrator's online platform.

The contact information for the COBRA Administrator is in the Initial COBRA Notice.

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Under USERRA, you have certain rights regarding continuance of Plan benefits while you are on a leave of absence for military service or uniformed service (referred to herein as a "military leave of absence"). The terms "uniformed services" or "military service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If you are absent from work for less than 31 days due to your active military service, your Plan participation will be continued at active employee rates. If your absence is for 31 days or more, you and your covered family members will have the opportunity to elect continuation group health coverage for up to 24 months or the period of your military service, whichever is shorter; provided, you pay up to 102% of the normal premium for this continued coverage. If you elect not to continue coverage under the Plan, your coverage will be reinstated to the extent required under USERRA upon your return to employment.

USERRA continuation coverage is considered to be alternative coverage for COBRA purposes. As a result, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Please refer to the applicable booklet for more information about continuation coverage available under USERRA.

Successors and Assigns

Except as otherwise provided in the Plan or under applicable law, all benefits, rights, or interests of Participants under the Plan are expressly non-assignable, non-transferable, including to any dental care provider, and shall not be subject to anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such participants, and accordingly the right of any Participant to receive any benefits under the Plan shall not be subject to any claims by any creditor of or claimant against the participant. Any attempt to assign, transfer, anticipate, alienate, sell, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any rights, benefits, or causes of action under the Plan shall be void and unenforceable. This prohibition applies to all rights and interests under the Plan, including rights to benefits, claims for fiduciary breach, claims for statutory penalties, and any other rights that may be asserted by a participant under or related to the Plan. Nothing in this provision prevents a Claims Administrator, in its sole discretion, from paying dental benefits directly to a dental care provider that provides services to a participant, but a participant has no authority or right to obligate the Claims Administrator to make direct payment to a dental care provider and any attempt to obligate a Claims Administrator to make direct payment to a dental care provider is void and unenforceable. Further, the Plan does not create any right or legal relationship or third-party beneficiary status between the Employer or any Claims Administrator and any dental care providers.

Tax Consequences and Withholding

The Employer does not guarantee the federal, state, or local tax treatment of any benefits provided under the Plan. Benefits provided under the Plan shall be subject to federal, state, or local income tax withholding or employment tax withholding in accordance with the rules applied to such benefits as interpreted by the Employer under applicable federal, state, or local laws.

Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Coverage

Continue dental care coverage for yourself, spouse or domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event if the Plan is subject to COBRA. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after exhausting the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

CONTACTING US
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

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NOTICE
NEW JERSEY LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center, 9th Floor
Newark, New Jersey 07102

State of New Jersey Department of Banking & Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Guaranty Association Act, N.J.S.A.17B:32A-1,et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association;

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities--again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.