



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: Clearway Energy Group LLC - Low Plan
Policy Number: 00430910
Policy Effective Date: January 1, 2022
Policy Anniversary: January 1
Governing Jurisdiction: California

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 the governing jurisdiction 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 California Department of Insurance at (800) 927-4357.

Your certificate may include notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the department of insurance in your residence state.

Dental Schedule of Benefits	3
Coverage Type	3
Eligible Group(s)	3
Paying for Coverage	3
Deductible	3
Coinsurance	3
Benefit Waiting Period	3
Reimbursement for Covered Procedures	4
Maximum Benefit	4
Certificate Riders	4
Dental Details.....	5
Start and End of Dental Treatments	5
Pre-Estimate	5
Dental Details Exclusions and Limitations	6
Exclusions.....	6
Limitations.....	7
Coordination of Benefits	8
Carryover Benefit	10
Takeover Benefit.....	11
Start of Coverage.....	13
End of Coverage	14
Claim Provisions	16
General Provisions.....	19
Glossary	21

Dental Schedule of Benefits

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

Coverage Type Preferred Provider Organization (PPO) plan.

Eligible Group(s) All Employees in Active Employment in the United States working a minimum of 30 hours per week.

Paying for Coverage You 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 Insured	
Per Policy Year	In-Network	Out-of-Network
	\$50	\$50

	Per Family	
Per Policy Year	In-Network	Out-of-Network
	2x	2x

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.

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

	Out-of-Network	
Procedure Class	Policy Pays	Insured Pays
Preventive	90%	10%
Basic	70%	30%
Major	40%	60%

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.

Dental Schedule of Benefits

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. Diagnosis, consultation, and treatment for Covered Procedures will be reimbursed on the same basis and to the same extent whether delivered through Telehealth services or through in-person diagnosis, consultation or treatment. Insureds may choose any Provider for treatment and services for Covered Procedures included in this certificate. If medically necessary care cannot be provided by a Participating Provider, the insurer shall help arrange for the required care with available and accessible Non-Participating Providers, with the Insured responsible for paying only cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that or a similar service by a participating provider subject to applicable Deductible, Coinsurance, and Maximum Benefit.

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.AlwaysAssist.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 the Usual and Customary Charges. The Insured is responsible for any remaining charges after we have paid our portion.

Usual and Customary Charge is determined by a review of charges within the general geographic area, made for the same Covered Procedure by Providers of similar training or experience. Usual and Customary Charges are periodically reviewed and updated.

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 Insured
Per Policy Year	\$1,500

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

Certificate Riders

The following riders are attached to this certificate.

Temporomandibular Joint (TMJ) Benefit Rider

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.

Dental Details | Exclusions and Limitations

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. 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 dentures;
5. 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;
6. any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion;
7. any appliance, service, or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis;
8. procedures provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, and myofascial pain;
9. orthognathic surgery;
10. prescribed medications, pre-medication, or analgesia;
11. general anesthesia, intravenous sedation, and the services of anesthetists or anesthesiologists, except in conjunction with complex oral surgery in which anesthesia is medically necessary;
12. instruction for diet, plaque control, and oral hygiene;
13. war or any act of war, whether declared or undeclared;
14. committing or attempting to commit a felony;
15. being engaged in an illegal occupation;
16. 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;
17. restorations for teeth, unless necessary due to deterioration from extensive decay or accidental Injury;
18. treatment of malignancies, cysts, and neoplasms;
19. orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of claim forms;
21. procedures which do not offer a favorable prognosis, are not medically necessary, or do not meet generally acceptable standards of care;
22. requests for a duplicate removeable device or appliance;
23. the replacement of 3rd molars;
24. restorations used to restore teeth with micro fractures or fracture lines, undermined cusps, or large existing restorations without over pathology;
25. expenses for Covered Procedures which are covered under your medical plan;
26. expenses provided or paid for by any governmental program or law;
27. 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.

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

Allowable Expense is an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Plan refers to any Plan, including this one, that provides benefits or services for dental expenses on either a group or individual basis.

Types of Plans include:

- group and blanket insurance;
- self-insured plans;
- prepaid plans;
- government plans;
- plans required or provided by statute (except Medicaid); and
- no fault insurance (when allowed by law).

Primary Plan is the Plan that, according to the rules for The Order of Benefit Determination, pays benefits before all other Plans.

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.

The Order of Benefit Determination

When this is the Primary Plan, we will pay benefits as if there were no other Plans. In the event a person is covered by a Plan without a Coordination of Benefits provision, the Plan without the provision will be the Primary Plan.

When a person is covered by more than one Plan with a Coordination of Benefits provision, the order of benefit payment is determined as follows:

Insured Spouse and Insured Children

A Plan which covers a person as a Spouse or Child will pay second to the Plan covering such person as an employee, member, policyholder, subscriber, or retiree.

Children of Parents Not Separated or Divorced

For Children, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Children for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, we will also use that basis.

Children of Separated or Divorced Parents

If two or more Plans cover Children of separated or divorced parents, benefits for the Children are determined in the order that follows:

- the Plan of the parent who has responsibility for providing insurance as determined by a court order;
- the Plan of the parent with custody of the Child;
- the Plan of the spouse of the parent with custody; and

Coordination of Benefits

- the Plan of the parent without custody of the Child.

Children of Parents with Joint Custody

If the joint custody court decree does not specifically state which parent is responsible for the Children's medical expenses, the rules shown for Children of Parents Not Separated or Divorced shall apply.

Persons in Active/Inactive Employment

The Plan which covers the person as an active employee or as that employee's dependent, is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Length of Coverage

When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

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 \$700 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 \$350

Carryover Account Maximum \$1,250 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

Annual

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.

Takeover Benefit

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

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.

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 31 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 31 day period and pay any additional premium.

Coverage Effective Date

Coverage for an Insured will begin on the later of:

- the date the Insured is eligible for coverage; or
- the first day of the month coincident with or next following the date the Insured is eligible.

Coverage Effective Date for Changes in Coverage

Changes to an Insured's coverage will begin immediately following the latest of:

- the date you apply for the change in coverage;
- the first day of the next Policy Year;
- 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 immediately following the latest of:

- 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 one 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 one 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 one 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 immediately following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on immediately 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.

End of Coverage

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 immediately following the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end immediately 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 immediately following the date you provide notification to your Employer.

Otherwise, your Children's coverage will end immediately 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. Claim forms are also available on our website www.AlwaysAssist.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 within one year, 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 State 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 and issue payment for a Payable Claim 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 are legal impediments to Payment of Benefits under this certificate which depend on the actions of parties other than us, we may hold further benefits due until such impediments are 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 the furnishing provider, or 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.AlwaysAssist.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	<p>We will provide the Policyholder with a certificate for distribution to each insured Employee. The certificate describes:</p> <ul style="list-style-type: none">- 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. <p>If the provisions of this certificate are different from the provisions of the policy, the provisions of the policy will govern.</p>
Certificate of Coverage Contents	<p>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.</p> <p>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.</p>
Cancellation or Modification to the Policy and this Certificate of Coverage	<p>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.</p> <p>All policy and certificate modifications will take effect according to the provisions in the Start of Coverage section of this certificate.</p>
Assignment	<p>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:</p> <ul style="list-style-type: none">- 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. <p>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.</p> <p>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.</p>
Contestability	We can take legal or other action using statements made in signed applications for coverage only when a claim occurs during the first two years after an Insured's Coverage Effective Date.
Misstatement of Information	<p>If we receive information about an Insured that is incorrect, we will:</p> <ul style="list-style-type: none">- review the information to decide whether the Insured has coverage and in what amounts; and- if necessary, make the applicable premium adjustments.
Fraud	If any false statement was made in the application with actual intent to deceive or any false statement materially affected either the acceptance of the risk or the hazard assumed by us, this may bar the right to recovery under the policy.

General Provisions

We will cooperate with relevant authorities to the maximum extent allowed under federal and state law to combat 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 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, after the two-year period following the Child's 26th birthday.

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.

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

The Policy Effective Date as shown on the face page of this certificate ending on the Policy Anniversary Date of the following year and each subsequent year thereafter.

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.AlwaysAssist.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 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, civil union, domestic partnership (established by a declaration), or your legally separated Spouse.

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

**Telemedicine or
Telehealth**

The appropriate delivery of health care services through the use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the Insured's evaluation, diagnosis, or treatment as would be practiced in person. This does not include requests for prescription refills or medical records.

**Starmount Life
Insurance
Company**

Referred to as "Starmount", "we," "us," or "our."

Writing or Written

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

CALIFORNIA CONTACT NOTICE

GENERAL QUESTIONS: If you have any general questions about your insurance, you may contact the Insurance Company by:

CALLING:

1-888-400-9304 (Customer Information Call Center)

-OR-

WRITING TO:

Starmount Life Insurance Company
8485 Good Wood Blvd.
Baton Rouge, LA 70806-7878

COMPLAINTS: If a complaint arises about your insurance, you may contact the Insurance Company by:

CALLING:

(Customer Relations Complaint Line)
Toll free: 1-800-321-3889, Option 2

-OR-

WRITING TO:

Deborah J. Jewett, Manager, Customer Relations
Unum Insurance Company
2211 Congress Street
Portland, Maine 04122

WHEN CALLING OR WRITING TO THE INSURANCE COMPANY, PLEASE PROVIDE YOUR INSURANCE POLICY NUMBER.

If the policy or certificate of coverage was issued or delivered by an agent or broker, please contact your agent or broker for assistance.

You also can contact the California Department of Insurance. However, the California Department of Insurance should be contacted only after discussions with the Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Department of Insurance
Consumer Communications Bureau
300 South Spring Street – South Tower
Los Angeles, California 90013
www.insurance.ca.gov
In-State Toll Free Hotline Telephone Number: 1-800-927-4357
TDD Number: 1-800-482-4833
Local Telephone Number: 213-897-8921
Office Hours: 8:00 a.m. – 5:00 p.m.

This form is for contact information only, and it is not to be considered a condition for the Policy or Certificate of Coverage.



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.

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	
Major	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	
Major	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	
Major	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	
Major	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	
Major	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
Major	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	
Major	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	
Major	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	
Major	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	D3332
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	

Major	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	
Major	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.	
Major	Retrograde filling - per root	D3430
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	
Major	Root amputation - per root	D3450
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	

Periodontics		
Procedure Class	Covered Procedure Description	ADA Code
Major	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	
Major	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	

Preventive	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.		
Major	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		
Major	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		
Major	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		
Major	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		
Major	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	
Major	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	
Major	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
Basic	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.	
Major	Occlusal guard – hard appliance, full arch	D9944
	Occlusal guard – soft appliance, full arch	D9945
	Occlusal guard – hard appliance, partial arch	D9946
	Frequency	
	Limited to 1 procedure per arch, per 24 months.	
	Limitation	
Procedure is limited to Insureds age 12 and older.		
Limited for the treatment of bruxism (grinding of teeth). Athletic mouthguards are not covered.		

Temporomandibular Joint (TMJ) Benefit Rider

The Temporomandibular Joint (TMJ) Benefit Rider provides benefits for TMJ Covered Procedures for treatment of problems that can be associated with temporomandibular joint dysfunctions. The Takeover Benefit in the certificate does not apply to benefits for TMJ.

This rider is made a part of the Group Dental Insurance policy and is subject to all provisions, limitations and exclusions, unless changed or added by this rider.

All references to provisions, sections, and defined terms have been capitalized. Defined terms that have been capitalized within this rider have the same meaning as the defined terms capitalized in the certificate of coverage unless added or changed by this rider.

Policyholder: Clearway Energy Group LLC - Low Plan

Policy Number: 00430910

Policy Effective Date: January 1, 2022

Rider Effective Date: January 1, 2022

Eligible Group(s)

All Employees in Active Employment in the United States working a minimum of 30 hours per week.

TMJ Coinsurance TMJ Coinsurance is the percentage of the Reimbursement for Covered Procedures paid. The percentages for which the Policy Pays and Insured Pays for TMJ Covered Procedures are shown below.

Procedure Class	Policy Pays	Insured Pays
TMJ	50%	50%

TMJ Benefit Waiting Period

The TMJ Benefit Waiting Period is the period of time during which Insureds must have continuous coverage before Covered Procedures included in this rider become payable. TMJ benefits are subject to a 12 month Benefit Waiting Period.

TMJ Maximum Benefit

The TMJ Maximum Benefit is the total amount of benefits that will be paid for TMJ Covered Procedures.

	Per Insured
Lifetime	\$500

In the event an Insured reaches the TMJ Maximum Benefit, the Insured is responsible for all costs associated with TMJ Covered Procedures for the remainder of their lifetime.

TMJ Covered Procedures

Covered Procedure Description	ADA Code
Closed reduction of dislocation	D7820
Frequency	
Maximum of 1 procedure per 12 months.	
Limitation	
Manipulation under anesthesia	D7830
Frequency	

Maximum of 1 procedure per 12 months.	
Limitation	
Arthrocentesis	D7870
Frequency	
Maximum of 1 procedure per 12 months.	
Limitation	
Occlusal orthotic device, by report	D7880
Frequency	
Maximum of 1 procedure per 12 months.	
Limitation	
Temporomandibular joint arthrogram, including injection	D0320
Frequency	
Maximum of 1 procedure per 12 months.	
Limitation	
Other temporomandibular joint radiographic images, by report	D0321
Frequency	
Maximum of 1 procedure per 12 months.	
Limitation	

STARMOUNT LIFE INSURANCE COMPANY

GROUP DENTAL INSURANCE

OUTLINE OF COVERAGE

Policy Form Number: 20-GDN-POL

Read the policy and your certificate carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy and certificate provisions will control. The Policy itself sets forth in detail the rights and obligations of us and the Policyholder. It is, therefore, important that you **READ YOUR POLICY AND CERTIFICATE CAREFULLY!**

Your certificate provides coverage for group dental insurance. An Insured may choose to receive dental care services from a Provider who is either In-Network or Out-of-Network. Insureds will typically have less out-of-pocket expenses when a Covered Procedure is performed by an In-Network Provider.

A brief description of the benefits and coverage amounts that may be provided are included below. However, your certificate will include the actual benefits and coverage amounts issued to you.

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	
	In-Network	Out-of-Network
-	\$50	\$50

Per Policy Year	Per Family	
	In-Network	Out-of-Network
	2x	2x

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	In-Network	
	Policy Pays	Insured Pays
Preventive	100%	0%
Basic	80%	20%
Major	50%	50%
Out-of-Network		

Procedure Class	Policy Pays	Insured Pays
Preventive	90%	10%
Basic	70%	30%
Major	40%	60%

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, Co-Pay, 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.AlwaysAssist.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 the Usual and Customary Charges. The Insured is responsible for any remaining charges after we have paid our portion.

Usual and Customary Charge is determined by a review of charges within the general geographic area, made for the same Covered Procedure by Providers of similar training or experience. Usual and Customary Charges are periodically reviewed and updated.

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 Insured
Per Policy Year	\$1,500

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

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. 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 dentures;
5. 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;
6. any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion;
7. any appliance, service, or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis;
8. procedures provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, and myofascial pain;
9. orthognathic surgery;
10. prescribed medications, pre-medication, or analgesia;
11. general anesthesia, intravenous sedation, and the services of anesthesiologists or anesthesiologists, except in conjunction with complex oral surgery in which anesthesia is medically necessary;
12. instruction for diet, plaque control, and oral hygiene;
13. war or any act of war, whether declared or undeclared;
14. committing or attempting to commit a felony;
15. being engaged in an illegal occupation;
16. being engaged in of an illegal activity;
17. 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;
18. restorations for teeth, unless necessary due to deterioration from extensive decay or accidental Injury;
19. treatment of malignancies, cysts, and neoplasms;
20. orthodontic treatment;
21. charges for failure to keep a scheduled visit or for the completion of claim forms;
22. procedures which do not offer a favorable prognosis, are not medically necessary, or do not meet generally acceptable standards of care;
23. requests for a duplicate removeable device or appliance;
24. the replacement of 3rd molars;
25. restorations used to restore teeth with micro fractures or fracture lines, undermined cusps, or large existing restorations without over pathology;
26. expenses for Covered Procedures which are covered under your medical plan;

27. expenses compensable under Workers' Compensation or by other employer laws;
28. expenses provided or paid for by any governmental program or law;
29. 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.