Starmount Life Insurance Company
8485 Goodwood Blvd
Baton Rouge, LA 70898

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 - High 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.

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	60%	40%

	Out-of-Network	
Procedure Class	**Policy Pays**	**Insured Pays**
Preventive	90%	10%
Basic	70%	30%
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. 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	$2,500

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.

Orthodontics Benefit Rider
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.

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

- 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 $800 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

$400

Carryover Account Maximum

$1,500 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.

Orthodontics Benefit Rider Maximum Benefit

If an Insured's coverage under this certificate includes the Orthodontics Benefit Rider, benefits will be paid for orthodontic treatment started while covered under the Prior Plan if:

- bands or appliances were inserted while insured under the Prior Plan;
- orthodontic treatment is continued while an Insured has coverage under this certificate; and
- we receive proof that an Insured's treatment while covered under the Prior Plan has not exceeded the Orthodontics Benefit Rider Maximum Benefit.

If you submit the required proof, the Orthodontics Maximum Benefit will be the lesser of the Orthodontics Maximum Benefit included in the Orthodontics Benefit Rider or the Prior Plan's orthodontic maximum benefit. The Orthodontic Maximum Benefit will be reduced by the amount paid or payable under the Prior Plan.

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.

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.

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

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 signed applications for coverage only when a claim occurs during the first two years after an Insured's Coverage Effective Date.

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

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.

	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.

Starmount Life Insurance Company
8485 Goodwood Blvd
Baton Rouge, LA 70898

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**
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	

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.	

Orthodontics Benefit Rider

The Orthodontics Benefit Rider provides benefits for comprehensive and interceptive Orthodontics Covered Procedures related to an Insured's initial orthodontic treatment which may consist of diagnosis, evaluation, pre-care, and insertion of bands or appliances. The Takeover Benefit in the certificate does apply to benefits for Orthodontics.

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 changed or added by this Rider.

Policyholder: Clearway Energy Group LLC - High 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.

Eligibility All Insureds are eligible for benefits under this rider.

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

	In-Network	
Procedure Class	**Policy Pays**	**Insured Pays**
Orthodontic	50%	50%
	Out-of-Network	
Procedure Class	**Policy Pays**	**Insured Pays**
Orthodontic	50%	50%

Orthodontics Maximum Benefit The Orthodontics Maximum Benefit is the total amount of benefits that will be paid for Orthodontic Covered Procedures during an Insured's lifetime.

	Per Insured
Lifetime	$2,000

Benefits end when orthodontic treatment ends or the Maximum Benefit is reached, whichever comes first. In the event an Insured reaches the Maximum Benefit, the Insured is responsible for all costs associated with Orthodontic Covered Procedures for the remainder of their lifetime.

The Maximum Benefit will apply even if coverage is interrupted.

Start of Covered Procedures

Covered Procedures must be started while an Insured's coverage is in force.

Orthodontic Covered Procedures are considered to begin the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered, is considered to be started and completed on the date the orthodontic treatment is rendered.

Payment of Benefits

Benefits will be paid as follows:

- Initial orthodontic treatment: 25% of the lesser of the total billed amount or the Orthodontics Lifetime Maximum Benefits payable on the date of initial orthodontic treatment consisting of diagnosis, evaluation, pre-care and insertion of bands or appliances; and
- Ongoing treatment: Monthly based on the Reimbursement of Covered Procedures subject to Coinsurance, proof of continued treatment, and the Orthodontics Lifetime Maximum Benefit.

If orthodontic aligners are elected, benefits will be paid the same as fixed orthodontic appliances.

Insureds over the Eligibility age limitation may continue to receive benefits, provided:

- treatment started while the Insured was under the age limitation;
- treatment continues;
- coverage for orthodontic services remains in-force under the certificate;
- the Insured continues to be covered under the certificate; and
- the Orthodontics Maximum Benefit has not been reached.

Orthodontics Covered Procedures

Covered Procedure Description	ADA Code
limited orthodontic treatment of the transitional dentition	**D8020**
limited orthodontic treatment of the adolescent dentition	**D8030**
limited orthodontic treatment of the adult dentition	**D8040**
interceptive orthodontic treatment of the primary dentition	**D8050**
interceptive orthodontic treatment of the transitional dentition	**D8060**
Frequency & Limitations	
Limited to any 1 of these procedure codes per 3 years.	
comprehensive orthodontic treatment of the transition dentition	**D8070**
comprehensive orthodontic treatment of the adolescent dentition	**D8080**
comprehensive orthodontic treatment of the adult dentition	**D8090**
Frequency & Limitations	
Limited to any 1 of these procedure codes per 3 years.	
periodic orthodontic treatment visit	**D8670**
Frequency & Limitations	
exposure of an unerupted tooth	**D7280**
Frequency & Limitations	
Maximum 1 procedure per tooth, per lifetime	
2D cephalometric radiographic image – acquisition, measurement and analysis	**D0340**
Frequency & Limitations	
Maximum of 1 procedure per banding per 3 years.	
3D photographic image	**D0351**
Frequency & Limitations	
Maximum of 1 procedure per banding per 3 years.	
diagnostic casts	**D0470**
Frequency & Limitations	
Maximum of 1 procedure per banding per 3 years.	
extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	**D0250**
Frequency & Limitations	

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 - High 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 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	90%	10%
Major	60%	40%

	Out-of-Network

Procedure Class	Policy Pays	Insured Pays
Preventive	90%	10%
Basic	70%	30%
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, 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	$2,500

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 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. 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.